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When Clients Who Got Worse Believe They Got Better: A Qualitative Analysis of OQ-Deteriorators Reporting Improvement in Therapy

Eric Alexander Ghelfi

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

Doctor of Philosophy

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ABSTRACT

When Clients Who Got Worse Believe They Got Better: A Qualitative Analysis of OQ-Deteriorators Reporting Improvement in Therapy

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Doctor of Philosophy

A recent study highlighted discrepancies between client self-reports of outcome and OQ-45 reports. Specifically, only 8.8% of clients who deteriorated during a course of therapy based on the OQ-45 perceived that they had deteriorated, while 50% of these clients perceived that they had improved in therapy (Top et al., 2018). This phenomenon, where different means of tracking outcomes yield divergent results, has been called "paradoxical outcome." The trend suggests that the most advanced forms of tracking psychotherapy outcomes might not detect important facets of outcome from the perspective of psychotherapy clients. The current study is a qualitative investigation of the experience of psychotherapy clients who reported improvements in therapy despite meeting criteria for deterioration per the Outcome Questionnaire-45.2 (OQ-45; Lambert et al., 1996). We used a consensual qualitative research (CQR) protocol (Hill, 2012). CQR uses group consensus to detect themes in participant interviews. Common themes included attributing negative changes to factors outside of therapy, endorsing complicated circumstances, and reporting positive outcomes that were not well detected by the OQ-45. More results and their implications are discussed.

Keywords: psychotherapy, deterioration, OQ-45

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Introduction

Although it is widely accepted that psychotherapy can effectively treat many forms of mental illness (Kolvin et al., 1988; Lambert & Bergin, 1994), it remains the case across most large-scale outcome studies that for some clients (usually ranging from 5%-14%), symptoms worsen over the course of psychotherapy (Lambert, 2011; Lambert, 2010; Lambert & Bergin, 1994). This is alarming for several reasons, not the least of which is the ethical obligation of psychologists to "avoid harming their clients/patients" (American Psychological Association, 2002, p. 1065). Even though deterioration in psychotherapy does not imply that therapists or therapy cause deterioration, it would still seem that therapists have an ethical duty to monitor and prevent deterioration when possible.

Recently, researchers (Top et al., 2018) found that among clients who deteriorated in therapy based on a widely-used outcome measure, the Outcome Questionnaire-45.2 (OQ-45; Jacobson & Truax, 1991; Lambert & Burlingame, 1996), exactly half (17 out of 34) reported that therapy had been helpful to them. Forty-one percent (14 out of 34) believed they had neither worsened nor improved in therapy. Only 8.8% (three out of 34) reported that they had worsened in therapy. Thus, a significant portion of clients who deteriorated on the OQ-45 believed they had gotten better as a result of psychotherapy, and a large majority reported that they did not deteriorate. The current study aims to investigate the experience of the group of clients who deteriorated on the OQ-45 but believe they improved in psychotherapy.

There are many possible explanations for these results. For example, clients might attribute increasing distress to factors outside of therapy (e.g., life stress) while believing therapy

was, on the whole, beneficial (Andes et al., 2018; Bohart, 1995; Wampold, 2015). Clients might also have had more interest in outcomes that the OQ-45—largely a measure of general distress, although the OQ-45's factor structure is unclear (Kim et al., 2010; Rice et al., 2014; Tabet et al., 2020)—failed to capture (e.g., well-being or self-knowledge; Hayes et al., 2013; Levitt et al., 2016). This, however, is speculative, and little about such discrepant scores has been studied.

Quantitative Outcome Measurement in Psychotherapy

Psychotherapy met a crisis of credibility after Hans Eysenck (1952) accused it of producing, at best, no positive effects. This claim incited action on the part of psychotherapy practitioners and researchers to study the process and outcomes of psychotherapy at greater depth and with greater rigor. Measuring outcomes in psychotherapy has become an essential element of evidence-based practice (Scott & Lewis, 2015). For most of psychotherapy's history, however, clinicians used no formal or statistically rigorous outcome measurement tools (Miller et al., 2015). Today, although quantitatively tracking psychotherapeutic progress is far from universal (Overington et al., 2015), many consider outcome measurement part of best practices in psychotherapy (Lambert, 2010; Miller et al., 2015).

Validity and Usefulness

The OQ-45 creators stated that the measure seeks to assess psychotherapy outcome (Lambert et al., 1996). The most widely used quantitative outcome measures share this aim, and they have displayed several strengths in terms of their validity. For example, proponents of these measures have shown both high convergent validity (Evans et al., 2002) and strong correlations with common measures of anxiety and depression (Boswell et al., 2013), the most common mental health concerns (American Psychiatric Association, 2013). Their increasing adoption by

emerging clinicians perhaps indicates their intuitive credibility and usefulness as well (Boswell et al., 2013).

Indeed, outcome measurement (OM) offers to improve clinical practice in several ways. Perhaps most importantly, using outcome measures, such as the OQ-45, reduces deterioration and treatment failure (e.g., Lambert, 2010; Mohr, 1995). Brown and colleagues (2001) found that, at least as measured by the OQ-45, clinicians tended to underestimate the risk of deterioration and client dropout in therapy (Hannan et al., 2005). With timely feedback, non-response and deterioration decline (de Jong et al., 2014; Shimokawa et al., 2010).

Limitations to Validity and Usefulness

Still, the use of OM has contemporary critics. First, some point to its impracticability. Miller and colleagues (2015) found that therapists objected to OM on the grounds that, although OM increases their costs and takes time for the client and therapist, it does not increase their pay. In other words, private practitioners have argued OM is economically inefficient. This is similar to the argument for excluding shoulder straps on airplane seatbelts. Airlines have calculated that, although including shoulder straps would likely save some lives in accidents, the number of lives saved would not equal the cost of installing the straps, counting each life as $4 million (Roach, 2004). Psychotherapy likely can't perform such a concrete cost-benefit analysis. Still, in the context of psychotherapy, these arguments seem unsound, since client care should trump practice profitability (American Psychological Association, 2002). This is especially true when there exist several free and quick-to-administer OM options (e.g., Evans et al., 2002; Miller et al., 2003)

Others have objected on treatment-related grounds. They have argued that imposing OM could change the way clinicians work with clients. It might, for example, incentivize clinicians to

target symptoms accounted for in common outcome measures despite what those clients are needing or requesting (Miller et al., 2015). Miller and colleagues identified other similar concerns, such as the possibility that over-reliance on OM might affect the hiring and promotion process in such a way as to instill fear in clinicians. For example, clinicians might prematurely terminate cases when distress scores decrease, even when termination is not otherwise clinically indicated. Additionally, clinicians might transfer or refer out clients whose scores are less likely to reflect positively on them, such as clients beginning at lower distress levels (Lambert, 2010); autistic clients, who may make slower progress (Anderberg et al., 2017); or clients with eating disorders (Wilson et al., 2007), who often begin therapy with suppressed distress scores. Of course, these are not all issues directly caused by OM but rather ways in which OM might interact negatively with actual systems of care.

The role of testing in education can help us draw some useful parallels. In the American public education system, standardized testing has served as an evaluative tool not just for students but for their teachers (Croft et al., 2015). In many states, promotion and tenure depend on how well a teacher's students perform on state-wide testing. Many teachers have taken issue with how this distorts their teaching style. That is, many feel professionally compelled to "teach to the test" rather than to consider the unique needs and traits of each student (e.g., Bhattacharyya et al., 2013). The worries of therapists in regard to OM reflect the issues that have arisen in education, although it is rare for therapy settings to base promotion or hiring based on OM data.

As is the case for academic testing, the beneficence of OM depends in part on the validity of scales clinicians use. Wampold (2015) has suggested some limitations in OM measures themselves. While paying homage to their usefulness, he argues that the theory underlying the

nature of their feedback is underdeveloped. Although this feedback appears to improve outcomes (Slade et al., 2008), Wampold wondered what exactly the feedback is telling clinicians. As I'll discuss, some preliminary research (Georgaca, 2021; Top et al., 2018) calls into the question the validity of the OQ-45 as an indicator of failure and success in psychotherapy. Even if the OQ-45 adequately captures symptomatic distress, it may fail to capture more nuanced changes clients seek in therapy (e.g., interpersonal and behavioral changes). As such, until the theory underlying OM is strengthened, it remains possible that the use of symptom distress measures could unduly narrow therapists' view of good versus bad outcomes.

The factor analysis of the OQ-45 exemplifies the trickiness of nailing down its construct validity. Several different studies have identified different factor structures for the OQ-45 using different subsets of the questions (Bludworth et al., 2010; Kim et al., 2010; Rice et al., 2014). Even the creators of the OQ-45 failed to show that their proposed factor structure emerged from the data (Mueller et al., 1998). The factor structure and measurement invariance of the OQ-45 is still ambiguous. It is unclear, in other words, just what it measures and how well this maps on to what clients and clinicians hope to change in the therapeutic process.

In light of the measurement difficulties surrounding such measures, Levitt and colleagues (2005) objected to the use of current standardized outcome measures in the evaluation of humanistic therapies on the ground that they poorly assessed therapeutic success for that approach. In fact, they compared the assessment of humanistic outcomes through the most common measures to the weighing of oranges with a thermometer. Their team analyzed nine of the most commonly used outcome assessment measures in the literature at the time—including the Beck Depression Inventory, Symptom Checklist 90 Revised, and the Hamilton Rating Scale for Depression—on an item-by-item basis. They found 148 non-redundant items across these

measures. These items, they argued, poorly assessed the most central goals of humanistic therapy, such as personal growth, client agency in self-definition, and changes in emotional dependency.

Hayes and colleagues (2006) also objected to the use of traditional symptom distress measures for similar reasons. They believed that the outcomes of interest in Acceptance and Commitment Therapy (ACT) are radically different from those of other approaches—particularly cognitive-behavioral therapy (CBT), to which ACT is often compared in randomized trials. While changes captured by symptom distress measures would likely correlate with changes ACT clinicians hope to facilitate, there are important goals (e.g., increased life engagement, increased values clarity) that they do not specifically capture (Chin & Hayes, 2017). Much like Levitt and colleagues (2005) argued on behalf of humanistic therapies, Hayes and colleagues argued the validity of these kinds of measures is suspect.

In summary, outcome measures are becoming more broadly used not only in research but also in routine clinical care (Goodman et al., 2013; Lambert, 2010; Scott & Lewis, 2015). This has contributed to several positive changes in practice and research. Still, some have objected to the use of these measures as universal indicators of psychotherapy outcome. One reason for this is that their development has been largely quantitative and often symptom-focused. In addition, as researchers are beginning to discover, different ways of assessing outcomes often disagree with one another.

Paradoxical Outcomes

The European Journal of Psychotherapy and Counseling recently released a special issue on a phenomenon called "paradoxical outcomes." This refers to the finding that different methods of assessing therapy outcomes often yield discrepant results. In other words, both across

raters and across different means of assessing outcomes (e.g., self-report questionnaire versus qualitative interview), different sources diverge in their determinations of success and failure. Stänicke and McLeod (2021) describe this as a "lack of correspondence" between sources of information (para. 2). This presents a problem both to researchers and clinicians. It suggests, as Georgaca (2021) noted, that psychotherapy outcomes are multilayered and complex to the point where they might defy measures' ability to adequately capture them. She argued that the notion of psychotherapy outcome as a unified construct is a "fundamental fallacy" and at the root of paradoxical outcomes.

Wahlström (2021) specifically considered quantitative deteriorators who believed they had gotten better in qualitative interviews. In two long term case studies, he identified a pattern where clients got worse on specific symptom measures but, when looking more closely, noticed other improvements, even when observing at a more granular level within the measures on which they had worsened. Wahlström also theorized that clients within this category developed greater awareness of their symptoms in the course of treatment and were, therefore, better able to express them in the form of responses on questionnaires. Paradoxical outcomes like these represent a potential challenge or limitation to outcome monitoring. There are, however, many more methods for tracking outcomes available or in development.

Alternative Outcome Measurement Methods

There are currently several popular quantitative symptom distress-focused outcome measures clinicians can choose from, including the OQ-45, the CORE-OM (Evans et al., 2002), and the CCAPS (exclusively for counseling centers; Youn et al., 2015). There are, however, alternative methods for tracking outcomes in psychotherapy. Some have proposed using clinician reports as the primary means of detecting outcomes, but there is evidence clinicians are poor

detectors of outcome without the assistance of feedback (Hannan et al., 2005; Hatfield et al., 2009). These studies compare clinician reports to standardized symptom distress measures. If there are construct validity problems with these measures as sole indicators of therapeutic outcome, there could be problems with these claims. Still, evidence suggests clinicians are biased regarding the number and severity of their clients' difficulties (Mohr, 1995).

As early as 1966, Battle and colleagues explored the possibility of using target complaints measures to assess psychotherapy outcomes. Target complaints measures differ from standardized outcome measures in that they are tailored specifically to each client's therapeutic goals. Burton and Nichols (1978) found that these measures showed convergent validity with measures of anxiety and life satisfaction at the time. Today, many clinicians use these kinds of measures to customize the tracking system for each client (Levitt et al., 2005), sometimes in addition to standardized outcome measures. This practice is thought to help adjust for some of the limitations in standardized measures' validity and generalizability (Fuertes & Nutt Williams, 2017).

Others have noted that standardized measures largely derive from quantitative studies and have begun conducting qualitative research to explore the nature of outcomes from clients' perspective (Binder et al., 2009; Binder et al., 2010; Carey et al., 2007; Clarke et al., 2004; De Smet et al., 2020; Gallegos, 2005; Israel et al., 2008; Levitt et al., 2006; Paulsen et al., 1999; von Below & Werbart, 2012; Watson et al., 2012). The goal of this branch of research has been to develop and deepen theory about what facets of therapy clients find helpful or unhelpful. In doing so, many hope to elucidate how therapy leads to change in richer detail. Bohart (1995) reflected that clients and therapists tend to view outcomes differently. While both views likely

contain important information about outcomes, no rigorous outcome measures are currently rooted in qualitative psychotherapy research.

Levitt (2016; 2018), however, has begun developing a measure of client outcome based on qualitative research (i.e., research investigating client experiences of therapy) that might differ substantially from more strictly quantitative approaches (e.g., the OQ-45; Lambert et al., 1996). She and her colleagues have undertaken extensive qualitative research to better inform the theory about what outcomes clients value most. Although they do not yet have a finished product, they have begun creating what they call the Clients' Critical Experiences in Therapy Scale (CCETS).

The development of the CCETS follows a growing research program to understand clients' experiences in therapy and particularly of therapy outcomes. Levitt and colleagues (e.g., 2016) have fronted these qualitative investigations. They conducted a qualitative meta-analysis (2016) analyzing 109 qualitative studies investigating psychotherapy process and outcome to understand the lived experience of psychotherapy clients. They discovered five major thematic clusters, which were (paraphrased for conciseness): (1) therapy promotes change by helping clients identify patterns and restructure narratives, (2) caring therapists allowed clients to internalize positive messages and develop awareness, (3) the professional nature of therapy fosters credibility but casts suspicion on authenticity of therapists' caring, (4) therapy progresses collaboratively, and (5) recognition of client agency allows for responsive flexibility in intervention planning. This summary of the published qualitative literature of client experiences suggests, perhaps, some starting points from which to begin rethinking the nature of psychotherapy's process and outcomes.

In summary, that psychotherapy produces effects is one of the most robust, well-replicated findings in psychology (Kolvin et al., 1988; Lambert, 1979; Lambert, 2011). How and why psychotherapy produces these effects has been much more difficult for researchers to explain (Levitt, 2016). Quantitative outcome measures have doubtless helped advance this research, and emerging qualitative work might help advance it further, especially in terms of theory. The sections above reviewed some of the strengths and limitations of quantitative outcome measures as well as the potential of other methods to contribute to the development of outcome assessment. The following section reviews the construct of deterioration.

Deterioration in Psychotherapy

Deterioration has been of interest to researchers for decades. Even though it is the exception to the rule in therapy, it happens with great enough frequency that it is important to establish a deeper understanding of the phenomenon. The literature on deterioration is difficult to review, in part because there exists no uniform definition of deterioration across studies (Lazar, 2017). The goals of psychotherapy vary from treatment to treatment and setting to setting, as do the measures and rubrics used to determine treatment success and failure (Lazar, 2017). That is, different studies often use different outcome measures (e.g., symptom distress vs. symptom count) to track progress, and the measures themselves can affect rates of deterioration (Mohr, 1995). So, although the theory might be underdeveloped, the measures used still operationalize and form our understanding of deterioration to some degree. Across studies attempting to track deterioration, there is broad agreement that somewhere between 5% and 14% of clients deteriorate over the course of therapy (Cooper, 2008; Lambert 2011; Lambert, 2013).

Factors Contributing to Deterioration

Much of this research has sought to identify factors that contribute to deterioration. Researchers often split these factors into therapeutic versus non-therapeutic domains. For example, therapist behaviors (e.g., Coady, 1991, Henry et al., 1990) or therapeutic modality (e.g., Lilienfeld, 2007) might contribute to lower or higher rates of deterioration. On the other hand, clients might experience adverse life events (e.g., loss of a job, death of a family member) that impact their levels of distress independent of their work in therapy (Pilkonis et al., 1984). These events, as well as any others that occur outside the psychotherapeutic context, would fall into the domain of non-therapy factors. The following sections examine what therapy and non-therapy factors contribute to deterioration.

Therapy Factors. One of the more often-studied contributors to differential outcomes in therapy is the behavior of therapists in session. Coady (1991) and Henry and colleagues (1990) examined the role of the therapeutic alliance, and both studies found that therapists who struggled to build and maintain a strong alliance (i.e., a congenial agreement on goals and tasks) saw higher deterioration rates and less positive change. Similar to these studies, Llewelyn (1988) found that clients and therapists both associated lack of empathy and positive regard with worse outcomes. Other therapist behaviors shown to have a negative impact on outcomes are countertransference (in groups; Yalom & Lieberman, 1971) and rejection of clients (Muran et al., 2005). Together, these results indicate that ineptitude concerning many common factors skills (Wampold & Imel, 2015) can lead to worse outcomes. The ultimate upshot from this group of studies is that the way therapists behave with clients potentially impacts treatment outcomes for the worse.

Beyond therapist behaviors, others have pointed to facets of therapeutic practices more generally as contributors to deterioration. For example, some have investigated the extent to which certain therapy approaches cause unwanted experiences as a matter of expected course and others when therapy causes unwanted experiences due to malpractice (e.g., a clinician incorrectly selecting or administering an intervention; Lilienfeld, 2007; Linden & Shermuly-Haupt, 2014). Lilienfeld (2007) classified several treatments as "potentially harmful." He considered not only harm to clients directly but also harm to friends, family members, and harm that would indirectly impact clients (e.g., the harm of instilling distrust in therapy for clients who might need it in the future). His list of potentially harmful treatments included: critical incident stress debriefing (for trauma), Scared Straight interventions (for conduct problems), facilitated communication, rebirthing therapy, and a few others. His reading of the literature on this topic provided strong evidence that, beyond specific harmful behaviors of therapists, some therapeutic approaches are themselves often harmful to clients.

Still, some evidence suggests rates of deterioration may depend on factors other than treatment modality. Vittengl and colleagues (2016), for example, found consistent deterioration rates in the treatment of depression between cognitive-behavioral therapy (CBT) and psychopharmacology. Across 16 studies, they found similar deterioration rates (5%-7%) and an equal reliable (i.e., statistically significant) deterioration rate of 1%. Notably, attrition rates were higher among patients in psychopharmacology-only groups than in CBT-only groups. Still, this meta-analysis suggests that, at least for the treatment of unipolar depression and using specific symptom measures (e.g., the Beck Depression Inventory and the Hamilton Depression Rating Scale), reliable deterioration is both rare and depends on factors other than the treatment being administered.

Non-Therapy Factors.

Client Diagnosis. Deterioration is also the expected course of some psychiatric disorders without intervention (e.g., personality disorders, prodromal bipolar, and schizophrenia; Grande et al., 2016; Kernberg, 1971; Links et al., 1998; Rautio et al., 2016). It is possible that, although a client deteriorated in therapy, he or she did not deteriorate as much as he or she would have without therapy. It would seem inaccurate in such an instance to consider the dose of therapy a failure. Thus, deterioration marked by symptom distress measures might not invariably indicate that the therapist or client has gone off track.

Current evidence is insufficient to precisely compare expected deterioration rates between diagnostic categories. Studies are emerging, however, attempting to answer these questions (e.g., Cujipers et al., 2018). Cujipers and colleagues calculated a deterioration rate for depressed clients of 4%. In their data, participants in psychotherapy groups showed a 61% decrease in deterioration. The authors noted, however, that only 6% of studies including a psychotherapy and control group reported deterioration. They suggested a lack of accurate reporting on deterioration rates may represent a systematic flaw in the literature. This flaw makes it nearly impossible to estimate deterioration rates between diagnoses.

Episodic disorders can also muddy the meanings of deterioration and true treatment failure even more (Wells et al., 1992). A client who has, for example, gone through several major depressive episodes might sense that she or he is entering another. Remembering the difficulty of prior episodes, the client might notice a significant improvement compared to her or his expected course of deterioration. In such a case, while many measures would detect deterioration, one could not reasonably say that the course of treatment had failed. Clients might recognize this and report benefits of therapy that are not otherwise detectable. Current

operationalizations of deterioration aren't capable, on their own, of accounting for the complexity that episodic disorders involve.

Attrition. Not only is deterioration part of the natural course in many disorders; it can also arise artificially based on attrition and premature termination (Roseborough et al., 2016). Many psychotherapies expect increased distress at points in treatment (e.g., Foa et al., 2007). In such treatments (e.g., prolonged exposure for PTSD), client attrition tends to be higher due to the increased difficulty of therapy (Roseborough et al., 2018). While therapists might perform their tasks with high fidelity to supported protocols, and their clients might be on course to recovery, attrition can still contribute to the appearance of deterioration independent of therapeutic factors.

Other Factors. Other research has focused on demographic and presenting concerns variables as predictors of deterioration (Fox et al., in prep). This study examined the relationship between suicidality, physical health problems, and perceived interpersonal support and deterioration. Of these, only suicidality predicted deterioration, and it did so meaningfully. For example, while the base rate of deterioration in this sample was 6.3%, the rate for participants who endorsed "rarely" having thoughts of suicide throughout treatment was 10%; for "sometimes," 16%; for "frequently," 25%; and for "almost always," 41%. Although only one study, it had a large sample size (N = 3,505) and suggests suicidality and deterioration in therapy might have overlapping risk factors.

We can be reasonably confident that *some* clients experience increased distress over the course of therapy (Lambert, 2013; Lambert & Ogles, 2004; Lazar, 2017) and that some therapists have higher deterioration rates than others (Baldwin & Imel, 2013). Even some of the causes of and contributors to deterioration appear well supported. Yet, increased distress is considered an expected and even necessary part of many psychotherapies (e.g., exposure and response

prevention), just as a moderate amount of pain is routine in many medical procedures. Therefore, it is likely insufficient to notice only that client distress has increased without accounting for the type of therapy, stage of therapy at termination, and reason for termination. In addition, because there is no universally accepted definition of outcomes in psychotherapy (i.e., no single, definitive measure), the definition of deterioration differs across studies (Ogles, 2013). In sum, while knowledge about deterioration has accumulated and taken some form over the past four decades, it is still imperfectly understood.

Gaps in Our Understanding of Deterioration

There remains much to learn about the nature of client deterioration. For example, it is unclear what factors lead to deterioration most reliably. Perhaps more importantly, it is unclear how we ought, as a field, to define deterioration. To what extent should we prioritize changes in distress levels versus changes in, say, life satisfaction or symptom reduction? How much should therapists consider informal client reports of improvement and deterioration versus the outcomes generated by standardized measures? If the answers to these questions differ from context to context, what criteria should we use to change the way we track outcomes in different contexts?

Arguably some of the most important gaps in our understanding of deterioration reflect gaps in our understanding of and consensus about what constitutes good versus bad outcomes (Levitt, 2016; Wampold, 2015). Here there are as many ethical questions as professional or empirical questions, because one aim of psychotherapy (at least in many forms of psychotherapy) is to help clients live a better life (e.g., Luoma et al., 2007; Slife, 2009). Wampold (2015), again, argued that the theory underlying outcome monitoring has lagged behind the creation and dissemination of outcome measures. In other words, he suggested the validity of these scales was inadequately understood.

In addition, what might make people who deteriorate in psychotherapy unique as a group is also poorly understood. Researchers have studied clients who reported negative experiences in therapy (e.g., Cuijpers et al., 2018; Stricker, 1995). Likely, however, there are important differences between clients who fail to respond to treatment and those who significantly worsen in treatment (Lambert, 2011). So, even assuming current means of measuring deterioration are valid, people who get worse in therapy have been studied much less than clients who show signs of improvement or non-response (Lazar, 2017).

These debates and gaps in understanding concerning measurement and validity might also reflect conflicts between the therapeutic orientations and theories of change of the clinicians and researchers involved. That is, definitions of success and failure in therapy depend on what and how therapists are aiming to help clients change. If someone believes symptom reduction is the correct goal of therapy, then that person would want to monitor symptoms most closely. If someone believes self-acceptance or -actualization is the highest goal of therapy, that person would design and select measures to track those variables. While this study's scope is too small to make a case on either side of this debate, it can potentially highlight important elements of change from the perspective of clients in a college counseling center. This, in turn, might suggest ways to approach the tension between different background theories of change. Regardless, it is important to acknowledge that this undercurrent of tension might shape how researchers and clinicians approach the issues discussed in this study.

Goals of the Current Study

There are holes in the literature concerning the reconciliation of client reports and outcome monitoring scores. We do not yet have even the beginnings of a definitive explanation for this discrepancy. This study aims to provide a starting point on the path of making sense of

this phenomenon by providing a detailed understanding of these clients' experience in therapy. The results of this study could have implications for ongoing outcome assessment and outcome conceptualization. They might point to important facets of psychotherapy that go unmeasured by traditional psychological distress measures. In addition, the study and interview are designed to identify and highlight important elements of the therapeutic process that might have gone overlooked in previous literature.

This study examines the experience of deteriorators who believe they have improved as a result of therapy. It aims to elucidate some of the potential strengths and limitations of relying on the OQ-45 and on similar distress measures in tracking psychotherapy outcomes. Although client goals in therapy vary widely (Lindhiem et al., 2016), one of the most common methods of tracking outcomes involves using measures of psychological functioning (Lambert, 2010), and as helpful as these measures are, they might fail to capture consistently important facets of change from clients' perspectives.

Since there is no comparison group, this study will not be able to speak directly to the uniqueness of deteriorators' experience. Still, it may, in conjunction with previous research (e.g., Fox et al., in prep), suggest fruitful avenues of inquiry in this population. The study's primary contribution might be the light it casts on questions about the validity of OQ-45, and similar measures, as demarcaters of therapeutic failure.

Any such critique of validity might speak less about the weaknesses of the measures themselves and more about the poorly understood nature of deterioration and treatment failure. Bystedt and colleagues (2014) called deterioration and negative effects in psychotherapy a "fairly unexplored area of clinical research" (p. 319). As noted above, Wampold (2015) argued that the theory underlying routine outcome measures is underdeveloped and, therefore, so is the

field's notion of what constitutes treatment success versus failure. For this reason, Dimidjian and Hollon (2010) stressed the prioritizing of qualitative research. Qualitative research, they argued, could help lay the groundwork for better-informed theory about what outcomes are important from the vantage point of psychotherapy clients. After all, as Slife and Reber (2012) put it, clients are the consumers of psychotherapy. As helpful and informative as outcome measures have been, listening more closely to clients' stories about therapy promises to help inform their continued improvement (Fuertes & Nutt Williams, 2017). Another important aim of this study, then, is to lay some of the qualitative groundwork to better understand deterioration and the process and outcomes of therapy from clients' point of view more broadly.

Recently, the notion of evidence-based practice has received increasing attention. Lists of evidence-based treatments (i.e., treatments that have garnered moderate to strong evidence of efficacy) have proliferated (APA Presidential Task Force on Evidence-Based Practice, 2006). A treatment qualifies to be on such a list based on its performance in quantitative studies, particularly in randomized controlled trials. While these studies have with little doubt contributed to our knowledge about psychotherapy outcomes and process, they typically aggregate results across participants. The specific stories of psychotherapy clients are not taken into account in the creation of evidence-based practice lists.

This seems to leave out vital elements of the therapeutic process (Levitt et al., 2016). Researchers have defined psychotherapy outcome and determined what constitutes best practice largely without asking directly and openly what clients are seeking and receiving from psychotherapy. The current study aims to contribute to the best practice literature by expanding knowledge about what clients value in treatment. This population might offer particularly helpful insights by highlighting factors that go overlooked in routine outcome monitoring.

Finally, this study builds on previous research conducted by members of the Psychotherapy Process and Outcome Research Group (PPORG) at Brigham Young University (Andes et al., 2018; Fox et al., in prep; Top et al., 2018). Top and colleagues (2018) showed that psychotherapy clients often report improvement when the OQ-45 indicated worsening distress, an early documentation of what would later be called paradoxical outcomes (e.g., Wahlström, 2021). In a study where researchers measured participants' OQ-45 scores every other day, Andes and colleagues found that client perceptions still "often give a different picture than the OQ score would imply" (slide 17). Similar to Lambert and Barley's results (2002), Andes and colleagues' data suggest clients attribute the majority of change in distress, both positive and negative, to extratherapeutic factors and events (e.g., changes in their relationships, school, and work). It is, therefore, important to develop a sharper picture of the benefits and drawbacks of the therapeutic process—and particularly how therapy contributes to positive and negative change—a vital aim of this dissertation.

Method

We applied a consensual qualitative methodology (Hill, 2012) to explore the lived experiences of psychotherapy deteriorators who believed their condition improved during therapy. Consensual qualitative research (CQR) aims to identify experiential themes across a relatively small sample of participants through group consensus (Hill, 2012). That is, in most cases, researchers gather data via in-depth, semi-structured interviews (Burkhard et al., 2012). In this case, after transcribing these interviews and double-checking transcriptions for fidelity, several team members analyzed the data for core ideas within predefined domains of interest (Thompson et al., 2012). Then they cross-analyzed these core ideas across interviews to identify

themes, called "categories." Throughout this process, team members were required to come to a consensus about each step.

Once they reached a consensus about domains, core ideas, and categories, an auditor reviewed their findings and provided feedback. CQR employs consensus as a means of reducing the effect of individual bias on study results. CQR researchers, however, acknowledge that bias cannot be fully accounted for or eliminated. For this reason, Sim and colleagues (2012) recommend thoroughly documenting the biases and presuppositions of the research team members in the limitations section of CQR papers to best understand and communicate how they might have affected data collection and interpretation. The end of this section includes this information concerning the research team involved in this study. We also included specific information about researchers' presuppositions on the Open Science Framework page, linked in the same section.

Sample and Procedure

Data collection began in fall of 2019. Participants were drawn from a pool of clients at Brigham Young University Counseling and Psychological Services (CAPS). We selected a sample from a dataset of the most recent six months of terminations. The sample consisted of 106 clients who had terminated therapy at CAPS in the past 120 days, agreed to participate in the study, and who had deteriorated per Jacobson and Truax's (1991) reliable change index. Jacobson and Truax's criteria for this index state that a client's degree of change must be significant at the $p = .05$ level. On the OQ-45, this means that clients must end therapy with a score at least 14 points higher or lower than when they began therapy. Potential participants received surveys and consent forms via email until there were enough participants who met criteria for deterioration and agreed to be interviewed.

Fifteen participants were interviewed. All consented to participate in the study and were contacted at their university-listed email address. Participants received $20 for completing the survey and were offered an additional $20 for participating in the qualitative interview. Some incentives were paid in the form of electronic Amazon. Later, incentives were paid in cash to boost response rates.

To reiterate, from the initial sample of about 106 deteriorators, participants were selected to be interviewed based on several criteria. First, they had to have participated in at least four psychotherapy sessions spaced no more than 60 days apart. Their OQ-45 scores needed to be 14-points higher at the last session than at the first session (i.e., a significant difference per Jacobson and Truax's criteria; Jacobson & Truax, 1991; Lambert et al., 1996), and the score at termination must have been above 64 (the clinical cutoff for this measure). Interviewees must not have terminated treatment more than 120 days prior to the initial survey. However, to ensure that their last OQ data point represented a true post-treatment score, 60 days must have passed since their last appointment, and they must not have had another appointment scheduled.

Measures

The Outcome Questionnaire 45.2. We used the OQ-45 to assess for quantitative deterioration. The OQ-45 uses a five-point likert scale where higher scores indicate higher distress. It has a clinical cutoff score of 64, and a 14-point difference indicates a statistically significant change in either direction. The OQ-45 is one of the most widely used outcome monitoring devices (Boswell et al., 2013) and offers clinicians a relatively easy-to-administer and -score measure of client progress. It was designed to capture a wide array of clinical presentations and serve as a useful tool across many mental health treatment settings.

Apart from the total score, which is easily compared with certain population means (e.g., outpatient, inpatient, general population), it records scores of three separate subscales: symptom distress, interpersonal role functioning, and social role functioning. However, only the overall score and symptom distress scales have shown strong validity and reliability in independent studies (Boswell et al., 2013). Boswell and colleagues (2013) estimated an overall internal consistency coefficient of .94 and a test-retest reliability of .84.

Initial Survey. The survey used to assess whether clients believed they got better, deteriorated, or did not respond to treatment asked, "Do you feel you got better, worse, or remained the same while receiving therapy at BYU CAPS?" This is the same question used in Top and colleagues' pilot study (2018). Answers to this survey indicated what proportion of clients' perceptions agreed with the reliable change index (Jacobson & Truax, 1991) of the OQ-45. In addition to this question, we asked a second question: "If you feel you got better or worse, what factors do you believe were responsible for that change?"

Interview

All the interviews were conducted by a 27-year-old, female, Caucasian third-year clinical psychology doctoral student. After introducing herself, this student explained the process of interviewing, reviewed confidentiality, and ensured participants that they would be compensated with a $20 Amazon gift card or cash after the interview. The interviewer explained that she had received two years of training and experience as a therapist to promote participant comfort and self-disclosure. The interviewer recorded all interviews through a phone call-to-audio recording app called TapeACall Pro. All recordings have been kept confidential in a HIPPA-compliant BYU Box folder.

The semi-structured interview consisted of eleven questions, some with follow-up questions. Each interviewee responded to the same prompts, but the interviewer had latitude to probe for more or less detailed answers. The first two interviews served as pilot interviews. All changes made to the interview process have been documented on the Open Science Framework at this link: https://osf.io/ns9eu/. These changes consisted of minor shifts in how questions were worded based on the interviewer's preferences. Below is the final version of the interview used in the study:

1. *What mental health concerns brought you to therapy?*
2. *How did you expect therapy to help with your concerns?*
3. *Tell me about what was happening in your life when you were attending psychotherapy.* (Make sure to cover each of the following domains.)
    1. *In relationships*
    2. *With school*
    3. *With physical and mental health*
    4. *With your spirituality*
4. *What was going on in your life when you ended therapy?*
    a. *In Relationships*
    b. *With school*
    c. *With physical and mental health*
    d. *With your spirituality*
5. *Please describe how your therapist did therapy.*
6. *Please describe your relationship with your therapist.*

1. *Tell me about some specific interactions that stood out to you.*

7. *Tell me a story about an important event that happened in therapy.*
    a. *Positive*
    b. *Negative*
    c. *Neutral*
8. *If it was, why was psychotherapy beneficial to you?*
9. *What, if anything, did you learn about yourself?*
1. *How did you learn this about yourself?*
10. *How, if at all, did therapy fail to meet your needs?*
11. *The distress measure you took before each session indicated that your score increased during your time in therapy, but when we asked you, you said you had gotten better. Why do you think that's the case?*

Although the interviews took place at least several weeks after the termination of therapy, this does not necessarily present issues for CQR research. As Polkinghorne (2005) argued, retrospective interviews are well suited to elicit participants' memories of the most salient events of past experiences, since people tend to retain these experiences and develop narratives around them.

Analysis

Transcription

All interviews were transcribed by research assistants. They were instructed to eliminate fillers (e.g., "um," "ah") but otherwise preserve interview language verbatim. The transcription stage is important because it determines the accuracy of the data. As such, the transcriptions were double-checked by another team member.

Per the recommendations of Burkhard et al. (2012), the transcribers and those who checked transcriptions received specific instructions to protect participants' confidentiality. They accomplished this by omitting identifying information. They used initials instead of full names, and they omitted information concerning places of residence.

Domains

At the analysis stage, CQR involves several coders working together to identify themes in the interview data. It calls for the creation of "domains"—essentially, main areas of interest—based on interview data (Thompson et al., 2012). In some approaches, these domains are predetermined based on a literature review and on the content of interview questions. However, in this study, the analysis team independently created domains based on their interpretations of interviews. This allowed the analysis process to be as free as possible from the bias of the primary author of the study. This approach also seemed appropriate given the sparseness of research dedicated to understanding this specific population (i.e., OQ deteriorators who believe they improved).

The analysis team read transcripts and considered potential domains independently. During this process, they met together four hours weekly until they came to a consensus about the domains that appear in the data. As they analyzed each new interview, they revised the domain list as seemed fit until the domains stabilized. Each interview was analyzed in whole using the finalized domain list.

Core Ideas

After the team reached a consensus about the domains, they summarized chunks of the interview transcripts within those domains. The purpose of extracting core ideas from raw interview data was to summarize the raw data in a more interpretable form. Creating these

summary chunks smoothed later stages of CQR, when these chunks were cross-analyzed to identify themes within domains.

Cross-analysis

At this point, team members identified categories of responses occurring across interviews. They accomplished this by analyzing core ideas within specific domains for themes. The process of creating these categories enabled the analysis team to identify areas of overlap between interviews. In other words, it allowed the team to understand important clusters of data and potentially where participant responses might become more generalizable (Ladany et al., 2012).

Auditing

After the analysis team reached a consensus regarding domains and core ideas, they sent their work to the study auditor. The auditor reviewed their work and made suggestions for revisions. The team again worked collaboratively to ensure they reached a consensus concerning these revisions. This process took place until both the primary team and the auditor reached a consensus about the entire analysis process.

Disclosure of Information About Research Team

Analysis Team

The analysis team consisted of the primary author of this study along with 8 trained undergraduate research assistants. The primary author is a 28-year-old Caucasian male in his fifth year of a clinical psychology doctoral program. Three of the eight research assistants had participated in a CQR analysis team before participating in this study. None of the analysis team other than the primary author had had any training in providing psychotherapy.

Auditing Team

CQR involves an auditing team for several reasons. It is important that the analysis team, beyond a cross analysis, be checked by an external source. This helps to reduce the effect of groupthink on study results.

This study used one auditor. She is a 43-year-old Caucasian female assistant professor at Brigham Young University with 20 years of experience using consensual qualitative research methods. She is a licensed counseling psychologist and the chair of this dissertation.

Limitations and Theories of Change

Given that the primary author, the interviewer, and the auditor of this study all practice psychotherapy, it is particularly important to provide a thorough treatment of the researchers' biases. In theory, the way therapists conceptualize and facilitate change with clients depends on how they believe psychotherapy promotes change. In this section, I aim to describe the background theories of change that might affect researchers' and clinicians' approaches to measurement. For example, many people who defend the primary use of symptom distress measures view psychotherapy from a medical point of view. In other words, they hold that psychotherapy functions by identifying a symptom or set of symptoms, selecting an appropriate intervention, and delivering this intervention as skillfully as possible (Elkins, 2009). Others hold that psychotherapy works in a less strictly medical manner. Symptom reduction, to them, represents only one of its functions. A large part of what makes therapy work from this point of view are subtle relational factors (e.g., empathy, genuine connection), which both reduce symptoms and help clients make important changes in their lives.

Both the lead author and the interviewer ascribe to a theory of change more in line with the contextual model (Wampold & Imel, 2015). It is important for us to disclose this because it

may have colored our data collection and interpretation. We took measures to reduce this form of bias (e.g., conducting interviews over the phone, involving several people on the analysis team). But transparency remains important nevertheless.

Drawing from personal reading and clinical experience, the lead author believes the benefit and value of psychotherapy transcend what basic symptom distress measures capture. The measures clinicians find useful depend on the assumptions they make about how change occurs in therapy. An implicit conflict appears in the literature between clinicians and researchers who view psychotherapy through a medical model and others who see it through a contextual model. Debates about outcome measurement will naturally reflect the complexity of the debates about the outcomes themselves, and the lead author believes the field's understanding of how clients benefit from therapy is incomplete.

The interviewer ascribes to a theory of change that draws most heavily from cognitive-behavioral therapy and interpersonal process therapy. She also frames her theory of change within the contextual model. In her words:

> I situate my theory of change within the contextual model rather than the medical model (Wampold & Imel, 2015). What that means is that I am convinced that there are elements of psychotherapy that contribute to change beyond specific techniques, including the therapeutic relationship and client expectations, that are just as important. *I do not mean that specific techniques are unimportant.* (Original emphasis preserved.)

The other members of the analysis team are undergraduates who have yet to practice therapy or construct a detailed theory of change. However, each research assistant wrote a paragraph detailing their assumptions and biases about therapy before beginning the analysis

process. Those paragraphs are on the project's Open Science Framework page, here: https://osf.io/smhka/.

Results

General Findings

We surveyed 106 participants who met criteria for deterioration. Of these participants, 63 (58.5%) indicated that they had gotten better in therapy, 33 (31.1%) indicated that they had stayed the same, and 10 (9.4%) indicated that they had gotten worse. The majority of clients suggested a discrepancy between their OQ-45 scores and self-report. That is, most clients who had deteriorated on the OQ-45 believed they had improved, and less than one in ten believed they had gotten worse.

We interviewed a total of 15 participants. To ensure consistency across interviews, we omitted one that was conducted by the study auditor instead of the primary interviewer. We omitted another because they had gone through a course of group therapy, not individual therapy. Below are vignettes briefly documenting each case included in the study, which have been adapted from the study's interviews.

Table 1
Participant Descriptive Data

Participant	OQ-45 Pre	OQ-45 Post	OQ-45 Change	Age	Gender	Race	Sexual Orientation	Marital Status
1	57	73	16	23	Female	Caucasian	Heterosexual	Married
2	58	82	24	23	Non-binary	Caucasian	Asexual	Single
3	69	86	17	22	Female	Hispanic/Latina	Heterosexual	Single
4	53	81	28	20	Male	Caucasian	Heterosexual	Single
5	50	99	49	19	Male	Caucasian	Heterosexual	Single
6	52	68	16	20	Female	Caucasian	Bisexual	Single
7	73	92	19	18	Female	Caucasian	Heterosexual	Single
8	56	83	27	21	Female	Caucasian	Heterosexual	Single
9	33	69	36	21	Female	Caucasian	Homosexual	Single
10	88	108	20	21	Female	Caucasian	Heterosexual	Single
11	65	81	16	20	Male	Caucasian	Heterosexual	Single
12	55	73	18	26	Female	African American	Heterosexual	Married
13	64	79	15	19	Female	Caucasian	Heterosexual	Single

Note. The age listed for each participant represents the age at which the participant ended therapy.

Case 1

A married female college student approached counseling due to emotional distress around symptoms of depression, anxiety, and ADHD. Her pre-post OQ-scores were 57 and 73, marking an increase of 16 points over the course of treatment. She endorsed having frequent "emotional breakdowns." Her husband had encouraged her to seek mental health services. She also reported some concerns around sexual intimacy and communication with her husband. Specifically, she was concerned that she seemed to desire sex more than her husband, and she felt like he did not understand her emotional difficulties. Over the course of therapy, the client reported "doing a lot better" with her husband and feeling better understood. She reported that her therapist helped with her ADHD and emotional concerns by providing metaphors to better understand how her mind works. She also reported that she felt "really positive and hopeful" at

the end of therapy, mentioning that she learned she can be "really resilient." Therapy ended due to reaching the session limit, and she did not want to end at the time or to switch therapists.

Case 2

An unmarried, gender-non-binary, asexual college student approached therapy due to concerns in interpersonal relationships. Their pre-post OQ scores were 58 and 82, marking an increase of 24 points. The client reported having a passive interpersonal style that led to friends "walking all over" them. They reported low insight into their difficulties at the beginning of therapy. As their therapy course unfolded, they became both more aware of their interpersonal style and emotional needs, and they became more assertive in regard to enforcing boundaries and asking for needs to be met. Their therapist seemed to use a "humanistic style" that they found beneficial. The client felt their therapist treated them "like a person" as opposed to a "puzzle to be solved." They attributed their increased OQ-45 score to becoming more aware and assertive with the questionnaire itself. They also believed that even if their stress increased, their ability to cope with stress improved.

Case 3

A female client approached CAPS at the suggestion of her uncle due to anxiety and "family of origin type stuff." Her pre-post OQ-45 scores were 69 and 86, marking a change of 17 points. She reported that she felt anxious because of her family concerns and because of school. She had returned from a mission for the Church of Jesus Christ of Latter-day Saints three months prior to starting therapy, and adjusting to life after her mission introduced more anxiety. The client's family were not members of her church, and she felt judged by them for going on a mission. She reported that therapy was the first setting in which she was able to "talk about [her] family fully." Therapy benefitted her by providing someone to listen and provide "unbiased

feedback." She felt that her therapist helped her understand that her family issues were not her fault, which relieved anxiety. The client believed her distress scores rose at the end of therapy because school was "really starting up again." She stated that, despite feeling distressed, going to therapy helped her feel more hopeful.

Case 4

A male student began therapy at CAPS due to symptoms of OCD and bipolar disorder. His pre-post OQ scores were 53 and 81, marking a change of 28 points. At the start of therapy, he was experiencing a depressive episode and searching with his physician for a suitable medication. He was also experiencing OCD symptoms that included obsessions and rituals around cleanliness. These symptoms were particularly challenging with strained roommate relationships. The client endorsed having strong family relationships but poor relationships with roommates. He was not dating anyone throughout their therapy course. His therapist helped him with practical tasks, such as calling the doctor or setting up accommodations through the university. He reported that he had "loved" therapy, stressing its importance as a tool to process challenging emotions and to learn skills to solve problems. The client ended therapy at CAPS due to reaching the session limit. His therapist recommended seeing a long-term care provider in the community, and he did.

Case 5

A female college student approached therapy at CAPS due to symptoms of depression and anxiety, which she felt were being triggered by trauma from her past. Her pre-post OQ scores were 50 and 99, marking a change of 49 points. She endorsed symptoms such as loss of appetite, suicidal ideation, anhedonia, and panic symptoms. She stated that these symptoms were being triggered in "everyday situations," which made them especially troubling. The client felt

that her life was out of control and that going to therapy was one thing she could control. One of her primary hopes was to prevent another depressive episode, and she felt mentally healthy when therapy started. During the course of therapy, her symptoms seemed to worsen and then improve toward the end. During one session, after "breaking down her barriers," the client cried, and her therapist cried with her. The client felt moved by this interaction. Overall, she stated that therapy helped her develop the ability to understand and better cope with her emotions. Her last session coincided with finals week, which she found particularly stressful, and to which she credited her increased score.

Case 6

A female student approached therapy to be proactive about potentially experiencing anxiety and depression, which she had experienced as a high school student the previous year. Her pre-post OQ-45 scores were 52 and 68, marking a difference of 16 points. She described "complicated" family dynamics at home when she was starting therapy and stated that she had felt overwhelmed in school. She described the therapy process as "a lot of [her therapist] asking me what I wanted to talk about and listening." Her therapist did, however, provide some input and some guided breathing exercises to help regulate anxiety. The client stated that therapy helped primarily by giving her a space to verbalize and better understand what she was going through. This allowed the client to build awareness about her emotions and her interpersonal style. Finally, she explained the discrepancy between her OQ-45 scores and her perception by saying that, overall, her experience in therapy had been beneficial but that her family situation had "gotten worse and worse" and felt overwhelming at the end of therapy.

Case 7

A female college student approached CAPS to address symptoms of PTSD following a vehicle collision where she was struck as a pedestrian by a truck. Her pre-post OQ scores were 73 and 92, marking a difference of 19 points. She had been experiencing symptoms such as flashbacks and sympathetic nervous system arousal around roads and cars. She had felt that her reaction prevented her from "managing and functioning." She began therapy during a challenging semester about 4 months after returning home from an LDS mission. At the end of her therapy course, although she did not resolve her PTSD symptoms, she felt more hopeful about the future and stated that therapy "made a definite difference." The therapist provided handouts and worksheets to help with coping, which the client stated made "a world of difference." They also did mindfulness exercises, such as grounding, which the client also stated were helpful. She described a strong bond with her therapist, explaining that they had gotten along "really well." She also said that therapy was "exactly what [she] needed." She explained the discrepancy between her report and her OQ-45 scores as a result of sugarcoating her answers when she initially took the questionnaire and, later in therapy, becoming more open and forthright.

Case 8

A female client approached CAPS for therapy for symptoms of depression and PTSD. Her pre-post OQ-45 scores were 56 and 83, marking a difference of 27 points. She had experienced the suicide of a loved one and endorsed feeling persistently sad, lethargic, emotionally numb, and uninterested in life. By the end of therapy, she stated that her PTSD symptoms (i.e., nightmares, numbness, flashbacks) had gone away, while some of her depressive symptoms remained. She ended therapy inorganically due to COVID-19 restrictions and moving

out of state. This saddened her because she felt that she was in "mid-recovery." The client stated that her therapist helped her realize she can get through difficult times, how to calm herself with breathing, and that talking about her problems with someone she trusts can be helpful. When asked about the discrepancy between her OQ-scores and her self-report, she offered that she might have underreported how painful her symptoms were at the beginning of therapy.

Case 9

A gay female college student approached CAPS to work through concerns about emotional and sexual abuse in a romantic relationship that ended before she began college. Her pre-post OQ-45 scores were 33 and 69, marking a difference of 36 points. She had not attended therapy before. She reported that she had compartmentalized this adverse experience before and had felt ready to begin addressing it in therapy. Her course of therapy at CAPS was her first experience receiving mental health treatment. The client reported noticing some panic symptoms when sharing physical affection with her girlfriend, which suggested she had lingering issues associated with prior abuse. She was also nervous about being gay at a conservative university and about the possibility of being caught and punished. The client started therapy in part because she felt her mental health was stronger than normal and could tolerate "another emotionally heavy thing." Through the course of unpacking her history of abuse, she felt intense emotion but stated that it felt cathartic and healthy to do so. She was also exploring spirituality and religion for the first time in several years and feeling hopeful about that. At the end of therapy, she reported being "in a frantic job search" and experiencing increased stress in school and work to the point where the hour of therapy per week did not feel worthwhile. She felt comfortable with her therapist but felt that he did not approach her difficulties in a structured way and over-

emphasized her OQ-45 scores. She stated that she did not think she got worse in therapy but instead learned how to take the questionnaire "more accurately."

Case 10

A female student presented to CAPS with concerns about anxiety, depression, and PTSD. Her pre-post OQ-45 scores were 88 and 108, marking a difference of 20 points. She was experiencing flashbacks, nightmares, sleeplessness, panic attacks, anhedonia, and "constant hypervigilance." When she started therapy, the anniversary of her abuser's court date was approaching. She was also working full time and taking a full time courseload. The client endorsed having "lots of chronic illnesses" related to her trauma. She stated knowing that this course of therapy would constitute interim care before she could see someone longer term and that she wanted an outlet and to learn specific coping skills for nightmares and sympathetic nervous system arousal. The client's therapist provided breathing and grounding exercises as well as psychoeducation about trauma and trauma treatment. She described her therapist as "direct, transparent, and very affirming." She also appreciated that the therapist maintained professional boundaries, since her abuser had been an authority figure. Overall, she felt her experience in therapy was very positive and helped resolve some of her more troubling PTSD symptoms. However, she believed that her mental health on the whole was worse than when she had started due to external factors, such as problems with her family.

Case 11

A male student began therapy to address symptoms of depression and anxiety. His pre-post OQ-45 scores were 65 and 81, marking a difference of 16 points. He struggled with insomnia, poor concentration, and feeling persistently sad and attributed these difficulties to mental rather than physical factors. In regard to anxiety, the client endorsed "worrying all the

time." He had come home early from a church mission for medical reasons, and his mother and brothers had said "things that implied [he] was a failed missionary" and never apologized. He was hoping therapy could help with his mood, anxiety, and with navigating his family situation. In session, he and his therapist brainstormed new ways that he could interact with his family as well as explored coping mechanisms for his mood and anxiety. He stated that therapy was "a place to open up" even though he was normally reserved. He stated that it "was nice to just have a place to talk." When asked about the discrepancy in his OQ-45 scores and self-report, he said that although he continued to feel distressed from week to week, he felt that he had "a better idea of how to handle" his emotions and his family situation. He also suggested that his last session had been especially helpful and was not factored into his scores.

Case 12

A female graduate student started therapy at CAPS due to a challenging family conflict and stress associated with starting graduate school. Her pre-post OQ-45 scores were 55 and 73, marking a difference of 18 points. One of her advisors recommended she see a counselor. The client reported feeling more stressed and busy than she had before and having little time to engage with her family. A loved one was struggling with addiction, and her family hosted an intervention as the client was starting grad school. She stated that, in therapy, she wanted to work toward feeling like "her normal self" (i.e., happy and easygoing) again. The client worried throughout treatment about different relationships. She worried about growing distance between herself and her husband, and she felt annoyed by her brother's flakiness. Her therapist tended to let her lead sessions and decide what to discuss. The client described her therapist as "a very good listener." She stated that having a space to verbalize her feelings was "really helpful once [she] was done," citing increased feelings of self-esteem and -empowerment as important

outcomes in therapy. She stated that this was especially impactful because her parents were closed to this kind of dialogue. She also learned coping skills such as using a planner and meditation apps, which reduced her stress. The only in which therapy failed to meet her needs was that she wished she could have had more than seven sessions with her therapist. When asked about the discrepancy between her OQ-45 scores and self-report, she suggested that she might have had an "unconscious bias" to have improved. She also suggested that she learned a lot from therapy and that she benefitted from therapy even if she didn't feel better at the end.

Case 13

A female student started therapy due to increased anxiety and a desire to work through "some trauma from [her] childhood." Her pre-post OQ-45 scores were 64 and 79, marking a difference of 15 points. She denied having any diagnosable psychiatric disorders. Shortly before therapy, the client's parents had opened up to her about difficulties in their marriage, which included her father leaving the LDS Church. Near the end of therapy, the client's parents decided to divorce. She described an "awkward" relationship with her therapist, stating that the therapist asked few questions, which made it hard for the client to know what to talk about. When she told her therapist that her parents were getting a divorce, the therapist seemed to suggest she should have seen it coming, which she found offensive. Despite having several awkward and negative interactions with her therapist, the client stated that she learned to draw interpersonal boundaries in therapy and that this was beneficial. When asked about her OQ-45 score and self-report discrepancy, she guessed that she might have wanted to believe she got better when she hadn't. In addition, she stated that this finding made sense because "everything in [her] life fell apart at the end of therapy."

What follows are the detailed results of the qualitative analysis.

List of Domains

Thirteen domains emerged from the analysis process. They are summarized in Table 2, and each will receive more focused attention. The first domain is called *Expectations for Therapy* and includes information particularly about how participants expected therapy to help with their presenting concerns. The second domain, *Reasons for Starting Therapy*, captured participants' presenting concerns and motivations for starting their course of therapy. The third, called *Therapist Behaviors*, covered descriptions of therapists' actions and styles. *Therapy Activities*, the fourth domain, covers exercises and interventions engaged in during therapy. Domains five through seven cover *Extratherapeutic Factors* and events that occurred in the beginning, middle, and end of therapy. The eighth domain is called *Outcomes of Therapy* and includes the perceived benefits (or lack thereof) of going to therapy. The ninth covers problems and obstacles that arose in treatment and is called *Barriers to Improvement*. Participants also offered judgments and evaluations of their experiences in treatment. These are covered in the tenth domain, called *Evaluations*. Domain eleven was perhaps the most directly pertinent to this study's aims. It is called *Potential Reasons for OQ–Self-Report Discrepancy* and covers participants' own theories concerning the gap between their OQ-45 scores and their perceptions of change in therapy. *Perceived Wellbing*, the twelfth domain, attempts to capture participants' subjective state of being at the end of therapy to help further elaborate and explore the discrepancies between the OQ-45 and self-report. Lastly, *Reasons for Ending Therapy* includes reasons for termination.

Table 2
List of Domains

Number	Name
1	Expectations for Therapy
2	Reasons for Starting Therapy
3	Therapist Behaviors
4	Therapy Activities
5	Extratherapeutic Factors at the Start of Therapy
6	Extratherapeutic Factors in the Middle of Therapy
7	Extratherapeutic Factors at the End of Therapy
8	Outcomes of Therapy
9	Barriers to Improvement
10	Evaluations
11	Potential Reasons for OQ–Self-report Discrepancy
12	Perceived Wellbeing at the End of Therapy
13	Reasons for Ending Therapy

Domain 1: Expectations for Therapy

The majority of responses in this domain arose from the question: *How did you expect therapy to help with your concerns?* Four categories emerged: (A) Expected Therapy to be Helpful, (B) Expected Structured Space to Talk, (C) Didn't Know What to Expect, and (D) Expected Therapy Not to be Helpful.

Table 3
Domain 1: Expectations for Therapy

Category Name	Frequency	Examples
A. Expected Therapy to be Helpful	T (10)	Expected to learn useful coping skills and tools
B. Expected Structured Space to Talk and be Listened To	T (10)	Hoped therapy would provide a space to talk to someone
C. Didn't Know What to Expect	V (4)	Had not been to therapy, so arrived with few expectations about what it would be like
D. Expected Therapy Not to be Helpful	V (3)	Did not expect therapy to help

Note. N=13. G=General (12-13 participants), T=Typical (7-11 participants), V=Variant (1-6 participants).

(A) Expected Therapy to be Helpful

The majority of participants expected that therapy would be helpful in some way. Some expressed this expectation vaguely, and others expected specific kinds of help. One participant explained that she wanted to better understand a painful experience:

I also thought it would be interesting because, I don't know, sometimes it's like as a woman you don't really understand like what, especially when I was a teenager, I didn't really understand what constituted like sexual abuse or emotional abuse. So that's why I thought it would be interesting to go to therapy to be like, do these things count?

Most participants, across a diversity of presenting concerns, began therapy under the assumption that it would help them solve their current problems through receiving professional advice, help navigating relationships, and learning new tools and strategies to manage challenging experiences.

(B) Expected a Structured Place to Talk and be Listened to

The majority of participants expected therapy would provide them with a structured setting to talk with a trained professional who would know how to listen to them and help solve

their problems. One participant noted: “I think a lot of it was just being able to talk to somebody about the things that I was feeling and all of that.” Others expressed their expectation for “validation and support.”

(C) Didn’t Know What to Expect

Four participants stated that they did not know what to expect from therapy before attending. While some did not know what to expect outright, others stated that they generally did not know what to expect despite having some guesses about how therapy would help them:

> Um, and so I think that's what I was kind of expecting is we'd really like focus on that. Like those, those situations, those events like uniquely and like really kind of do an in depth analysis or something. But again, I hadn't ever gone to therapy before, so I didn't really like have an idea of what to expect.

(D) Expected Therapy Not to be Helpful

Three participants stated that they expected therapy would not help them. Within this category, some participants did not expect therapy to be helpful and only went because a family member suggested they do so, had had negative experiences in prior therapy and did not expect therapy to help this time, or reported that they did not expect therapy with a generalist to be helpful since they had experienced trauma. This last participant stated: “I wasn’t really expecting just general counseling to be that helpful for me.”

Domain 2: Reasons for Starting Therapy

The majority of responses in this domain were in response to the question: *What mental health concerns brought you to therapy?* and *What was going on in your life during therapy?* Depression and anxiety were the most common presenting concerns, followed by other mental health concerns, interpersonal concerns, trauma, and suicidal ideation specifically. Seven

domains arose from the data. They were (A) Anxiety Symptoms, (B) Depressive Symptoms, (C) Other Mental Health Concerns, (D) Interpersonal Concerns, (E) Trauma-Related Symptoms, (F) Referred by Other, and (G) Suicidal Ideation.

Table 4
Domain 2: Reasons for Starting Therapy

Category Name	Frequency	Examples
A. Anxiety Symptoms	T (11)	Came to therapy due to anxiety, stress, panic symptoms, etc.
B. Depressive Symptoms	T (9)	Started therapy due to concerns about depression
C. Other Mental Health Concerns	T (9)	Mania, desire to prevent future problems, feeling "unbalanced"
D. Interpersonal Concerns	T (7)	Issues with family, spouse, friends, or interpersonal style
E. Trauma-related Symptoms	V (6)	Wanted to discuss trauma from childhood
F. Referred by Other	V (5)	Attended therapy due to uncle's suggestion
G. Suicidal Ideation	V (3)	Was "a little suicidal"

Note. N=13. G=General (12-13 participants), T=Typical (7-11 participants), V=Variant (1-6 participants).

(A) Anxiety Symptoms

A majority—all but two participants—reported that concerns about anxiety were at least part of what brought them to therapy. Most of them, in fact, reported that anxiety formed one of their primary concerns. As one participant explained, "It was family of origin type stuff and anxiety. But that was mostly what it was, anxiety." Others noted anxiety-related concerns, such as OCD and perfectionism.

(B) Depressive Symptoms

The majority of participants reported concerns around depressive symptoms, such as low motivation, poor self-esteem, anhedonia, and sleep and appetite disturbances. Describing their

experience, one participant said: “I mean, [the depression] would come and go, but the, either loss of appetite or a really big appetite or loss of interest in literally everything . . .”

(C) Other Mental Health Concerns

The majority of participants endorsed mental health concerns aside from anxiety, depression, trauma, and suicidal ideation. Most of them endorsed sleep problems associated with mental health concerns that contributed to their desire to seek help. Some endorsed symptoms or suspicions of bipolar disorder symptoms. Lastly, one person reported vague “mental health problems.”

(D) Interpersonal Concerns

Most participants explained that they came to therapy hoping to resolve or work through interpersonal concerns. Of these, a majority reported that their concerns pertained to their families. For example, on participant stated:

> Um, I was having some family problems where there was a huge conflict in my family and so I just cut off talking to some of those members and it was just making me very sad and I felt, you know, a little depressed.

Others reported increased distress due to a family member’s mental illness or unresolved relationship issues from the past. Some reported “difficulty talking to people” or a sense of social awkwardness that they wanted to overcome.

(E) Trauma-Related Symptoms

Six of participants reported trauma histories and trauma symptoms as a significant reason why they started therapy. Half of them had received an official diagnosis of Post-Traumatic Stress Disorder and came to therapy seeking help to address the diagnosis. Others stated more

vaguely that they were, for example, “dealing with childhood trauma.” Other symptoms included in this category included flashbacks, numbness, and “constant hypervigilance.”

(F) Referred by Other

Five participants noted that they came to therapy because someone in their life had referred them to CAPS for treatment. They reported being referred by family, friends, and a professor.

(G) Suicidal Ideation

Three participants reported suicidal ideation as a cause of seeking treatment. Each of them associated their suicidal ideation with a mood disorder, two with depression and one with bipolar disorder: “I was having my mood swings from my bipolar and then I was also having suicidal thoughts with that.”

Domain 3: Therapist Behaviors

The majority of responses in this domain came from the questions: *Could you tell me how your therapist did therapy?* And *Tell me about an important interaction you had with your therapist.* Five categories emerged: (A) Used Humanistic Style; (B) Provided Tools, Interventions, and Skills; (C) Asked Questions, (D) Behaved Professionally, and (E) Behaved Problematically.

Table 5
Domain 3: Therapist Behaviors

Category Name	Frequency	Examples
A. Used Humanistic Style	T (11)	Made space for client to talk without judgment
B. Provided Tools, Interventions, and Skills	T (10)	Therapist provided metaphor to help client understand experience
C. Asked Questions	V (6)	Therapist asked open-ended or specific questions
D. Behaved Professionally	V (6)	Maintained professional boundaries
E. Behaved Problematically	V (3)	Seemed to forget information about client

Note. N=13. G=General (12-13 participants), T=Typical (7-11 participants), V=Variant (1-6 participants).

(A) Used Humanistic Style

The majority of participants reported that their therapists made some use of humanistic styles in therapy. Most participants noted that their therapists seemed to listen well and make space for them to express themselves without feeling judged. Others reported that their therapists showed genuine emotion with them in session, with one therapist even crying with the participant. One stated that their therapist treated them "like a person, not like a number," as a previous therapist had done.

The reader might note that not all of these behaviors are specific to a humanistic style and overlap with other therapeutic approaches. We categorized them this way because, within the humanistic approach, they characterize not just common therapeutic skills but also key elements of change.

(B) Provided Tools, Interventions, or Skills

The majority of participants reported that their therapist gave advice, provided insight, and offered new ways to think about problems. For example, one client explained how her therapist helped her understand that:

> When you're so stressed about making the right choice, you end up just being more dissatisfied overall no matter how good the choice ended up being. So that really impacted me because I was like, "Oh man, I totally saw that with my marriage, like I had such a hard time committing to getting married."

Others reported that their therapist provided tools and skills, including meditations, metaphors, and strategies to cope with ADHD.

(C) Asked Questions

Six participants noted that their therapists asked lots of questions, both open-ended and closed-ended, to help them explore their experiences.

(D) Behaved Professionally

Six participants noted that their therapist behaved professionally toward them. Some reported that their therapist helped refer them to outside sources (e.g., physicians) when necessary. Others reported that their therapist made eye contact, shook their hands, and behaved in an overall "professional" manner. In addition, some appreciated that their therapists seemed to approach things "scientifically" (e.g., showed them their OQ-45 scores and explained them throughout treatment).

(E) Behaved Problematically

Three participants noticed behavior on the part of their therapists that felt problematic. Two participants expressed complaints that their therapists seemed to forget information about them between sessions. Another felt that their therapist listened poorly and mismanaged time in session.

Domain 4: Therapy Activities

The majority of responses in this domain came from the questions: *Could you describe how your therapist did therapy?* and *Tell me about an important event that happened in therapy*. Four categories emerged: (A) Practices and Exercises, (B) Talking Through Problems and Relationships, (C) Meditation and Grounding, and (D) Psychoeducation. This domain pertained generally to structured activities that took place during the course of therapy.

Table 6
Domain 4: Therapy Activities

Category Name	Frequency	Examples
A. Practices and Exercises	T (8)	Role playing, letter writing, specific coping strategy practice
B. Talking Through Problems and Relationships	V (5)	Client would identify concerns and therapist would suggest ways to cope with concerns
C. Meditation and Grounding	V (5)	Meditated during therapy session
D. Psychoeducation	V (2)	Therapist provided information about PTSD

Note. N=13. G=General (12-13 participants), T=Typical (7-11 participants), V=Variant (1-6 participants).

(A) Practices and Exercises

The majority of participants reported practicing coping skills and exercises during their sessions. These skills ranged from self-talk strategies to imagery exercises. Some wrote letters (e.g., one participant recalled writing a letter to God during a session). Others practiced positive affirmations exercises and role-playing. For example, one recalled a role-playing activity involving their mother:

> We made this, I guess, my last session there, we were planning out, I guess, the game plan of what I should tell my mom. And we—I guess you could call it a roleplay—where it was just me saying everything I felt I needed to say, which, you know, coming up with that idea.

Another participant received coaching with tasks, such as signing up for classes, as a form of exposure to the anxiety normally involved in those tasks.

(B) Talking Through Problems and Relationships

Five participants said they verbally identified their concerns and then talked through ways to address or solve them with their therapists. In some cases, this involved spending time collaboratively talking through problems and brainstorming solutions, and in other cases the therapist specifically guided participants to talk about their psychological and social histories.

(C) Meditation and Grounding

Five participants practiced meditation or grounding during their therapy course. Their reasons for practicing grounding ranged from anxiety management to PTSD management. In one case, a participant recalled using a mindfulness-based approach to ground:

> There was one that we did pretty often. It was... there were a couple of things in his office and he would hand one to me and he would have one and he would tell me to describe the thing that I was holding in every way possible: like what it felt like, what it sounded like, what it smelled like. And then he would do it for his. We did that a lot. Or he would give me a piece of chocolate and I had to eat it and describe everything about it. Just kind of like to bring you back to the present.

(D) Psychoeducation

Two participants explained that their therapists helped them understand their concerns by providing education. For example, one wanted to learn about the nature of a traumatic sexual experience, and her therapist explained common responses to trauma as well as directed her to resources she could use to explore those ideas further:

> He gave me a handout out of different coping mechanisms for PTSD, which made a world of difference to me because it gave me a kind of starting point that I just didn't have before. It was just like, well, he gave me one that was like the steps to overcoming PTSD, so that was cool to see that there was like a specific way that you can overcome it. And then there was one that was just like different ways of—I don't know if it was like—I don't know how to describe it. It was just things you can do to kind of comfort yourself.

Domain 5: Extratherapeutic Factors at the Start of Therapy

The majority of responses in this domain came from the question: *Tell me about what was going on in your life when you started therapy*. The interviewer specifically inquired about relationships, school, physical and mental health, and spirituality with each participant. Answers were included in this domain when they were not explicitly part of why participants sought therapy. Nine categories emerged: (A) Adjustment to and Stress with School, (B) Negative Interpersonal Factors, (C) Adverse Mental Health Changes, (D) Physical Health Concerns, (E) Negative Spiritual Factors, (F) Positive Interpersonal Factors, (G) Financial and Work-Related Stress, (H) Positive Spiritual Factors, and (I) Mental Health Improving.

Table 7
Domain 5: Extratherapeutic Factors at the Start of Therapy

Category Name	Frequency	Examples
A. Adjustment to and Stress with School	T (10)	Starting school, experiencing stress in school
B. Negative Interpersonal Factors	T (9)	"Had family troubles going on"
C. Adverse Mental Health Changes	T (8)	Experienced manic episode, anxiety, depressive episode, etc.
D. Physical Health Concerns	T (8)	Chronic pain, sleep problems, lung issues
E. Negative Spiritual Factors	T (7)	Struggling spiritually
F. Positive Interpersonal Factors	V (6)	Made friends, had supportive family
G. Financial and work-related Stress	V (6)	Felt "overbooked" with work
H. Positive Spiritual Factors	V (4)	Felt spiritually strong, motivated to engage in church
I. Mental Health Improving	V (1)	Mental health seemed to be improving at start of therapy

Note. N=13. G=General (12-13 participants), T=Typical (7-11 participants), V=Variant (1-6 participants).

(A) Adjustment to School and Stress

The majority of participants felt stressed with school, whether that was because they felt overwhelmed or because they were beginning college for the first time. Some were starting school again after taking a break and found the transition challenging. As one participant explained: "I was just about to start back at school after an 8-month break of not being in school which was hard for me and I was also in 16 credits and working at the same time as well."

(B) Negative Interpersonal Factors

A majority of participants noted negative interpersonal factors in their lives at the start of therapy. For some, these factors involved family members. For example, one participant reported learning distressing news about her father:

> And then it's just a bunch of stuff I didn't want to know about my parents came to the surface. Like, that my dad had been suicidal his whole life. No one had ever told me that, and it was all coming out at once.

Others reported tension with roommates and general social isolation, whether it was because they did not feel that they fit in to the culture of their school and city or because they were new to it and did not yet know anyone. One participant, for example, reported having a "poor support system."

(C) Adverse Mental Health Changes

A majority of participants reported negative mental health changes occurring at or near the beginning of therapy. These mental health changes were included in this domain only if they were not originally the reason participants sought treatment. For example, some reported that the onset of a depressive or manic episode occurred shortly after they started therapy. Other reported increased stress, emotional instability, and complications with medication.

(D) Physical Health Concerns

Most participants also reported physical health concerns at the beginning of therapy. The majority of participants within this category reported difficulties sleeping. Others reported chronic pain or illness that required ongoing medical care. One participant recounted their experience with ongoing medical problems and their interface with psychological concerns around trauma:

> Essentially, I had a surgery in the beginning—well, middle—of last year that was trying to fix some of the damage that those health issues had caused because I had been throwing up all the time—not eating disorder-related. Just from nausea and from feeling really unwell when I was triggered. So, I'd been throwing up a lot, and that had done

> significant damage, along with medication that they were trying to get things under control. I had also done significant damage to my GI tract. And so, I had to have a surgery to essentially reconstruct my esophagus. With that there were some serious complications, and I ended up coding, and I've got some pretty serious lung issues now because of surgery complications.

(E) Negative Spiritual Factors

Most participants endorsed some negative or difficult spiritual factors at the beginning of therapy. Some struggled with doubt about their religious beliefs. Others felt guilt in regard to a decrease in spiritual engagement. For example, one participant stated:

> I didn't pray much and I didn't read my scriptures much. I kind of just fell out of habit for quite a while and I think, I would just kind of struggle getting back to what I was used to doing because it is hard to go back to those habits because I think I felt a little guilty that I wasn't as good as I used to be, you know?

Some reported feeling unhappy with their church role, apathetic toward church altogether, or that going to church felt triggering in regard to events that happened in their family.

(F) Positive Interpersonal Factors

Six participants reported positive or protective interpersonal factors at the beginning of therapy. These factors ranged from having engaged and active relationships with friends, to having strong support networks, to noticing relationships with family members improving. Others stated that their spouses or parents were especially supportive in regard to their psychological healing.

(G) Financial and Work-Related Stress

Six participants noted financial or work-related stress at the beginning of therapy. Most of them were working at least 20 hours per week while taking a full course load in school. Some of them were working fulltime and attending school fulltime and simply felt overwhelmed by the volume. As one participant put it, they were feeling "overwhelmed and overbooked by having too many commitments." One participant felt so overwhelmed at the time that they quit their job.

(H) Positive Spiritual Factors

Four participants noted positive spiritual factors at the beginning of therapy. Some reported feeling good about their faith and strong in their "testimony." Others reported that they were happily active in their church community. Lastly, one person reported feeling capable of exploring their spirituality for the first time in years.

(I) Mental Health Improving

One participant reported that their mental health was generally already improving when they started therapy.

Domain 6: Extratherapeutic Factors in the Middle of Therapy

The majority of responses in this domain arose while discussing the participants' therapy experience broadly. No single question asked specifically what was happening outside of therapy during the middle of therapy. Six categories emerged: (A) Adverse Mental Health Changes, (B) Positive Interpersonal Factors, (C) Academic Concerns, (D) Negative Interpersonal Factors, (E) Negative Spiritual Factors, and (F) Financial and Work-Related stress.

Table 8
Domain 6: Extratherapeutic Factors in the Middle of Therapy

Category Name	Frequency	Examples
A. Adverse Mental Health Changes	V (5)	Experienced manic episode, suicidality, depressive episode, etc.
B. Positive Interpersonal Factors	V (4)	Husband was supportive, family moved closer, etc.
C. Academic Concerns	V (3)	Felt busy with school
D. Negative Interpersonal Factors	V (3)	Parents announced they were getting divorced
E. Negative Spiritual Factors	T (2)	Struggling spiritually
F. Financial and Work-Related Stress	V (1)	Working full-time and "dreading it"

Note. N=13. G=General (12-13 participants), T=Typical (7-11 participants), V=Variant (1-6 participants).

(A) Adverse Mental Health Changes

Five participants indicated that they experienced some sort of negative mental health event, such as a manic episode, suicidality, or a depressive episode in the middle of their treatment course. Some reported that their mental health was generally declining. In one case, the participant had a negative reaction to medication that increased their suicidality. Another experienced an emergency for which they sought emergency services at CAPS.

(B) Positive Interpersonal Factors

Four participants recalled positive interpersonal features of their lives in the middle of therapy. While some participants noted specific interpersonal changes that occurred in the middle of therapy (e.g., a brother moved closer, spouse worked to become more supportive), others stated that their relationships were generally good and stable throughout that time.

(C) Academic Concerns

Three participants felt busy with school and had difficulty finding balance between school and other parts of life in the middle of therapy. Within this category, participants stated

feeling like they could not keep up with their demands in school, particularly as they tried to balance those demands with other aspects of their lives.

(D) Negative Interpersonal Factors

Three participants described having difficult interpersonal experiences in the middle of therapy. These ranged from sexual concerns, to strained family relationships, to a general lack of emotional connection.

(E) Negative Spiritual Factors

Two participants reported that they were struggling spiritually during therapy. These participants reported either feeling out of place and guilty during spiritual practices or reported discontinuing their spiritual practices altogether.

(F) Financial and Work-Related Stress

One participant noted of their fulltime job that they were "dreading it" but did not feel that they had to financial freedom to seek other forms of employment.

Domain 7: Extratherapeutic Factors at the End of Therapy

The majority of responses in this domain arose from the question: *What was going on in your life when you ended therapy?* The interviewer specifically inquired about relationships, school, physical and mental health, and spirituality with each participant. Ten categories emerged: (A) Academic Stress, (B) Negative Interpersonal Factors, (C) Adverse Mental Health Changes, (D) Positive Interpersonal Factors, (E) Positive Academic Factors, (F) Physical Health Concerns, (G) Life and Work Stress, (H) Mental Health Improving, (I) Negative Spiritual Factors, and (J) Positive Spiritual Factors.

Table 9
Domain 7: Extratherapeutic Factors at the End of Therapy

Category Name	Frequency	Examples
A. Academic Stress	T (10)	"Hanging on by a thread" in school
B. Negative Interpersonal Factors	T (10)	Parents began process of divorce, friends moved away
C. Adverse Mental Health Changes	T (8)	Mental health decline, depressive episode, face picking, etc.
D. Positive Interpersonal Factors	T (8)	Marital improvement, good family relationships
E. Positive Academic Factors	V (6)	Improved concentration, school improved, liked classes
F. Physical Health Concerns	V (6)	Sleep problems, chronic pain, etc.
G. Life and Work Stress	V (6)	Increased stress due to "life changes"
H. Mental Health Improving	V (4)	Mental health seemed to be improving, increased resilience
I. Negative Spiritual Factors	V (4)	Felt angry at God and church
J. Positive Spiritual Factors	V (3)	"I was slowly getting more comfortable with the concepts of spirituality"

Note. N=13. G=General (12-13 participants), T=Typical (7-11 participants), V=Variant (1-6 participants).

(A) Academic Stress

Most participants reported that academic stress impacted their experience at the end of therapy. Beyond reporting stress about school, some participants stated that they were ending therapy "right in the middle of finals, so I had a lot of stressful projects." Others stated that, at the time, they disliked their classes, struggling with the transition to online coursework during the COVID-19 pandemic, or getting ready to graduate. For this sample, academic stress contributed to overall distress at the beginning and end of therapy.

(B) Negative Interpersonal Factors

The majority of participants noted negative interpersonal factors or interpersonal changes at the end of therapy. Some noticed that "things were changing" between themselves and their friends in the transition to a new semester. Their responses to these changes ranged from sadness

to anxiety. One participant noted the difficulties they faced after their roommate started a romantic relationship:

> My roommate got a boyfriend, so she was like never home, which was a little bit hard because she was my companion, and we were in the accident together. So, I kind of depended on her presence a lot, but then she was gone frequently, so that changed.

Others mentioned that problems in their marriages or in their immediate family relationships were getting worse. Another participant reported that their significant other had gotten a job in another city and had been navigating the difficulties involved with maintaining a relationship at distance.

(C) Adverse Mental Health Changes

The majority of participants noted adverse mental health changes toward the end of therapy. While some reported a general decline in mental health, others reported more specific adverse changes, such as mood swings, anxiety, depressive episodes, and feelings of hopelessness. A participant recounted their experience with depression toward the end of treatment in the wake of a family crisis:

> I feel like I'm a fairly competent person, and I was handling things pretty well before things happened with my family. But that kind of derailed everything, so I stayed really behind. I got really depressed, and I ended up dropping most of my classes a few months later.

(D) Positive Interpersonal Factors

A majority of clients reported positive interpersonal factors at the end of therapy. Several stated that their relationships, both family and friends, were improving. Others reported that their

relationships were good and remained so at the end of treatment. One participant reported that they were staring a new romantic relationship and feeling excited about it.

(E) Positive Academic Factors

Six participants reported positive academic factors at the end of therapy. Some stated that, in response to the encouragement of their therapists, they had reduced their course loads and, therefore, felt much less stressed and more capable in school. Other reported that their concentration had improved, they had started an exciting internship, or that they had changed their major to be more consonant with their interests.

(F) Physical Health Concerns

Six participants reported physical health concerns at the end of therapy. Most of them reported difficulties with sleeping, whether it be hypersomnia, insomnia, or irregularities in their sleep schedules. Others reported continued stress associated with chronic health issues and pain:

> I got really behind in school, and working, as I said, fulltime, and also dealing with chronic health issues. Like, I was kind of just hanging on by a thread. I was taking seventeen and a half credits as well, which maybe wasn't smart.

(G) Life and Work Stress

Six participants indicated that life and work stress were present for them at the end of therapy. About half of the participants in this category reported going through a significant life change (e.g., graduating, moving, starting a job). Others reported increased stress due to the COVID-19 pandemic.

(H) Mental Health Improving

Four participants noted that their mental health seemed to be improving at the end of therapy. Generally, they reported that they either felt more resilient or that they were sleeping better at the end of therapy than at the beginning.

(I) Negative Spiritual Factors

Four participants noted negative spiritual factors at the end of therapy. Several stated that they were feeling spiritually disconnected. For example, one participant recounted their experience of going through the motions but feeling emotionally distant from their spiritual experience:

> I was doing all the things that you're characteristically supposed to do as a member of the church and all that. And then I just felt very distant from my spirituality, from God, from the church, and from kind of everything like that. So, I kind of just stepped back and didn't do any of those things anymore and didn't feel like going to church or anything.

Others reported feeling pressured from their church to express spirituality in ways that felt uncomfortable to them or feeling angry at "God and the church."

(J) Positive Spiritual Factors

In addition to noting negative spiritual factors, three participants also noted positive spiritual factors. Some participants felt that their spirituality had gotten stronger or improved during therapy. Another reported that they had increased the amount of time they were engaging with spiritual practices (e.g., prayer).

Domain 8: Outcomes of Therapy

The majority of responses in this domain arose from the questions: *If it was, why was psychotherapy beneficial to you?* and *What, if anything, did you learn about yourself?* Seven

categories emerged: (A) Increased Insight and Awareness, (B) Coping Tools and Strategies, (C) Interpersonal Improvements, (D) Symptoms and Distress Reduction, (E) Increased Resilience, (F) Remoralization and Increased Motivation, and (G) Improved Self-Image/Concept. To fall into this domain, responses needed to indicate outcomes or changes that were attributed to therapy itself.

Table 10
Domain 8: Outcomes of Therapy

Category Name	Frequency	Examples
A. Increased Insight and Awareness	T (11)	"I could identify [my mental state], and that made a difference"
B. Coping Tools and Strategies	T (10)	Trauma skills, relaxation skills, breathing exercises, etc.
C. Interpersonal Improvements	T (9)	Set boundaries, improved communications with family and friends
D. Symptom and Distress Reduction	T (8)	"I had fewer nightmares and flashbacks by the end"
E. Increased Resilience	V (6)	Was "able to bounce back faster and react less"
F. Remoralization and Increased Motivation	V (4)	"I came out of every session feeling motivated rather than overwhelmed"
G. Improved Self-Image/Concept	V (4)	Therapy "made me feel important in what I have to say"

Note. N=13. G=General (12-13 participants), T=Typical (7-11 participants), V=Variant (1-6 participants).

(A) Increased Insight and Awareness

The majority of clients reported that increased insight and awareness during their course of therapy. Most of them reported that they learned to better recognize their mental states and emotions. As one put it, "I was more aware of the things that were going on mentally—not necessarily, like, able to handle it completely, but I knew that something—like I could—I could identify it, I guess." Others gained relational insight, such as that they had made excuses for

friends who had treated them poorly. Another theme in this category involved the deepening of relationships through learning about personal patterns and assertiveness:

> [My therapist] also taught me how to say no to people and then not feel guilty about it. He helped me understand that not every single thought that I have is a spiritual prompting and it's okay to say no to things.

(B) Coping Tools and Strategies

A majority of participants indicated that they developed skills or learned strategies to deal with their mental health difficulties in therapy. Some noted that the skills they learned felt tailored to their situation and to their presenting concerns (e.g., PTSD): "Between sessions, I was able to consciously recognize when I was struggling and apply one of those specific skills that we had worked on in therapy rather than just going into a blind panic." For others, the coping tools were more general: "It gave me a toolbox of tools and a lot of the time it just made me feel good when I was leaving, just made me feel really positive and hopeful." Others reported learning skills like meditation and breathing to manage anxiety. Finally, one participant reported that they successfully downloaded and learned to use mental health apps.

(C) Interpersonal Improvements

The majority of participants reported positive changes in their interpersonal relationships as a result of going to therapy. In many of these cases, participants reported increased confidence in relationships, assertiveness, and increased skill in drawing boundaries. Some reported that in therapy, they learned how to safely practice self-disclosure and to foster greater closeness. One reported an increased ability to handle confrontation:

> I learned that when people hurt me, my first reaction isn't to retaliate. It's to try to protect them and their feelings because I know what it feels like to get hurt, and I don't want to

like, even if they were a person that hurt me emotionally and stuff like that. I learned that I am able to deal with hard confrontations.

Others stated more vaguely that their interactions with others had generally improved.

(D) Symptom and Distress Reduction

A majority of participants reported decreases in their overall distress or in specific symptoms for which they attended therapy. Some reported experiencing fewer symptoms related to their presenting concerns, such as flashbacks or nightmares, by the end of therapy. When asked what had changed, one participant said: "The nightmares. And I wasn't so distracted about it all the time. I wasn't thinking about it all the time. It had less control over me." Others vaguely stated that their mental health had improved. Finally, one reported feeling like they had "recovered" from the grief associated with a friend's suicide.

(E) Increased Resilience

Six participants cited increased resilience as a major outcome in therapy. One participant, for example, said that they learned to "bounce back faster and react less . . . less in a way that shows my weaknesses and more in a way that shows my strengths." Others stated that therapy helped them change their mindset to look toward the future more positively.

(F) Remoralization and Increased Motivation

Four participants indicated that they experienced increased motivation and hope. Some stated directly that they had felt more hopeful, and others used other words to describe the change, such as "empowered" or "inspired." One participant stated that, through therapy, they could "see a light at the end of the tunnel." Others reported feeling inspired to change due to therapy. For example, one participant stated that they "came out of every session feeling motivated rather than overwhelmed."

(G) Improved Self-Image/Concept

Four participants stated that they felt better about themselves by the end of therapy. All of the participants in this category stated that they felt more confident in themselves. Here's how one participant conveyed their experience of improving their self-image:

> I just felt like how my therapist listened to me was something that I just didn't have enough of and it was just very, very helpful. It made me feel important in what I have to say. It is not something I am used to having. So, it was just very helpful.

Domain 9: Barriers to Improvement

The majority of responses in this domain arose from the question: *How, if at all, did therapy fail to meet your needs?* Three categories emerged: (A) Clinic Protocol Limitations, (B) Personal and Logistical Barriers, and (C) Problems with Therapist and Therapist Fit.

Table 11
Domain 9: Barriers to Improvement

Category Name	Frequency	Examples
A. Clinic Protocol Limitations	T (10)	Session limits presented a challenge to improvement
B. Personal and Logistical Barriers	V (6)	Didn't know how to implement skills outside of therapy, didn't know how to find a physician
C. Problems with Therapist and Therapist Fit	V (5)	Felt insignificant to therapist, therapy felt awkward

Note. N=13. G=General (12-13 participants), T=Typical (7-11 participants), V=Variant (1-6 participants).

(A) Clinic Protocol Limitations

The majority of clients reported that their experience was impacted by clinic-level policies. Within this category, most participants reported that session limits represented a barrier to their improvement, explaining that they had to end therapy or switch therapists before they felt ready. For example, one participant stated:

> If anything, I feel like it was kind of hard because it was only like 7 session or something that we could meet. And so, it—we did cover a lot. I feel like we could have covered even more because I just—there was more to talk about.

A few reported that waiting as long as they needed to receive services represented a similar barrier, preventing them from receiving services at the times when they needed most. Others reported that changes to clinic procedures due to the COVID-19 pandemic (e.g., switching to telehealth) represented a barrier to improvement. These students moved to states where their therapists were not licensed to see them, so they were forced to terminate prematurely. One participant reported that transferring therapists in the middle of treatment made it more challenging to build therapeutic momentum.

(B) Personal and Logistical Barriers

Six participants indicated that personal and logistical difficulties represented a barrier to treatment. Within this category, some reported that they did not have the time for or "didn't know how to implement the tools" they had learned in therapy. Others stated that therapy felt slow because they were too nervous to tell the therapist about themselves. Some believed their lack of belief in therapy initially played a role in slowing their progress, while others stated that, despite believing their therapists gave good advice, did not make the time to implement their therapists' suggestions. One excerpt captured well how personal and logistical barriers interacted to stymie improvement: "There was a time probably toward the end of therapy where I thought I was deeply depressed, and [my therapist] told me I should see a doctor, but I never did, because I didn't really have a doctor."

(C) Problems with Therapist and Therapist Fit

Five participants explained that they had issues with their therapists' fit or behavior. Some felt that their therapist did not prioritize their primary presenting concerns. Others stated that their therapists' seemed to forget information about them between sessions:

> Sometimes I felt like I had to repeat myself a lot or she was asking the same questions in the therapy sessions because, like, CAPS was just so overwhelmed and, like, they couldn't keep everyone straight and everyone's stories straight.

Other clients remarked that their therapists did not seem like a good fit for them on a personality-level. Some felt either insignificant to or even insulted by their therapists at some point in treatment. For example, one participant noted that their therapist implied that they should have anticipated their parents' divorce.

Domain 10: Evaluations

The majority of responses in this domain arose from the questions: *Could you describe how your therapist did therapy?* and *Could you describe your relationship with your therapist?* Six categories emerged: (A) Positive Evaluations of Therapist, (B) Positive Evaluations of Therapy, (C) Positive Evaluations of the Therapeutic Relationship, (D) Negative Evaluations of Therapist, (E) Negative Evaluations of Therapy, and (F) Negative Evaluations of Therapeutic Relationship.

Table 12
Domain 10: Evaluations

Category Name	Frequency	Examples
A. Positive Evaluations of Therapist	G (12)	"My therapist was my favorite. I really liked him"
B. Positive Evaluations of Therapy	G (12)	"Therapy helped me understand what I should do and what I should be feeling"
C. Positive Evaluations of Therapeutic Relationship	T (10)	"I feel like my therapist was someone I could be friends with"
D. Negative Evaluations of Therapist	V (3)	"I don't think [my therapist] really saw things from my perspective"
E. Negative Evaluations of Therapy	V (3)	"I didn't really like [therapy]"
F. Negative Evaluations of Therapeutic Relationship	V (3)	"I definitely felt judged by my therapist"

Note. N=13. G=General (12-13 participants), T=Typical (7-11 participants), V=Variant (1-6 participants).

(A) Positive Evaluations of Therapist

Nearly all participants offered at least some positive evaluations of their therapist. Most within this category shared positive feelings toward their therapist. These participants reported appreciating their therapists' interventions, their therapeutic style, and their ability to listen. One participant stated appreciating their therapists' ability to intuit what topics were important to talk about:

> I think it was just something that just ended up working really well that she was such a good listener. But I feel like she probably was in tune with the fact that I had a lot of issues with my parents.

Participants also stated that they liked their therapists' ability to express compassion, stressing that they felt heard and comfortable with their therapists. Several participants who had had multiple therapists in the past stated that their therapist from this course was their favorite. One even stated that their therapist "exceeded my expectations."

(B) Positive Evaluations of Therapy

Almost all participants described therapy in positive terms at some point during the interview. The majority of clients stated that they felt therapy was helpful, overall, stating, for example, that it met their needs. Others appreciated having a space to talk with a professional about their concerns. Many liked that they could discuss their issues without straining or burdening their friends and family. A quote from a participant illustrates these positive evaluations toward therapy:

> I loved therapy . . . And I've seen the help it's provided to my mental health because . . . I don't want to be a burden on others. And sometimes I don't tell people everything that I'm feeling, or don't tell people the thoughts that I'm having. Just because I don't want to scare them or bother them. With counseling, you don't, you have a relationship with them, a personal relationship, because they're the counselor, they're the psychologist, and you are their patient, and you can tell them anything.

A few reported liking therapy because it helped them feel less alone.

(C) Positive Evaluations of Therapeutic Relationship

The majority of clients described their relationships with their therapists positively. Most within this category felt that their therapist was a good fit for them. Others characterized their relationship with their therapist as rooted in genuine concern, compassion, or respect. Others said that they felt they had a friendly relationship with their therapist, and others hinted at a strong working alliance. For example, one participant stated that they "felt like we were in this together and there was hope."

(D) Negative Evaluations of Therapist

Three participants negatively evaluated their therapists. Some reported that their therapist made them feel uncomfortable, and others described their therapists as awkward. Finally, some stated that they felt invalidated or insulted by their therapists.

(E) Negative Evaluations of Therapy

Three participants shared negative evaluations toward therapy itself. Some felt that the therapy process felt unclear. A participant reported disliking therapy generally, stating that "it felt like a chore to go to therapy. It didn't feel like something that was helpful."

(F) Negative Evaluations of Therapeutic Relationship

Three participants noted some negative aspects of the therapeutic relationship. Within this category, participants either characterized their relationship with their therapist as awkward, disrespectful, or "judgmental."

Domain 11: Potential Reasons for OQ–Self-Report Discrepancy

The majority of responses in this domain arose from the question: *The distress measure you took before each session indicated that your score increased during your time in therapy, but when we asked you, you said you had gotten better. Why do you think that's the case?* Four categories emerged: (A) Extratherapeutic Factors, (B) Interacted with Questionnaire Differently, (C) Questionnaire Failed to Measure Element of Progress, and (D) Hindsight Bias.

Table 13
Domain 11: Potential Reasons for OQ–Self-Report Discrepancy

Category	Frequency	Examples
A. Extratherapeutic Factors	T (7)	Intense family situation is the reason for increase in OQ scores
B. Interacted with Questionnaire Differently	V (6)	Felt more aware of feelings and, therefore, more forthright with questionnaire
C. Questionnaire Failed to Measure Element of Progress	V (4)	Felt they had learned coping skills, but OQ didn't measure ability to cope
D. Hindsight Bias	V (2)	Felt that they might have deceived themselves in retrospect, wishing that they had improved

Note. N=13. G=General (12-13 participants), T=Typical (7-11 participants), V=Variant (1-6 participants).

(A) Extratherapeutic Factors

Most participants cited extratherapeutic factors as the primary reasons their OQ-45 scores and their self-report differed. Generally, participants reported that outside events at the end of therapy likely accounted for the discrepancy. As one participant put it, "Things in my life fell apart at the end of therapy." Common events included family problems, a mental health episode (e.g., mania, depression), and school stress (e.g., finals week coinciding with the participant's final session). Others pointed to physical health difficulties accounting for their increased OQ-45 scores later in therapy.

(B) Interacted with Questionnaire Differently

Six participants indicated that the way they completed the questionnaire changed. Some participants guessed that they had misinterpreted OQ-45 questions at the beginning of therapy and later filled out the questionnaire differently. Several others stated that their response style had changed over the course of therapy. For example, one participant said:

> I remember when I first started, I was very kind of middle-of-the-road for any survey that I took. When I was like, "Well, it could be worse, could be better." And so I always put kind of in the middle. Whereas, nowadays, I'm like, "Well, the middle answers aren't

> helping me, and they aren't helping anyone else with these surveys." So I guess I'm just more willing to put more extreme answers.

Others reported increased willingness to report their symptoms more authentically. For instance, some reported learning from their therapist about the importance of taking the questionnaire honestly, and others became more forthright with the questionnaire as their confidence increased. Two reported that their mood was lower than normal before their last session and that this likely impacted the way they answered questions.

(C) Questionnaire Failed to Measure Element of Progress

Four participants suggested that the OQ-45 did not measure an element of progress that mattered to them. Some stated that while their symptoms increased, their ability to cope with their symptoms also increased, representing an improvement without direct distress reduction. For example, one participant said:

> I feel like I was only able to cope with it as well as I have been—or really to cope with it at all—because I was able to talk through things. So it's like, yes, the problems themselves weren't fixed, and I still had this stress in my life. But I was coping with it . . .
>
> Due to increasing awareness of my experience, combined with increasing life stresses—I guess 'cause of life changes or whatever—my overall stress level may have been higher, although my ability to cope with that stress level also improved.

Others reported that the benefits of therapy felt delayed, taking time to take root in their lives, so the questionnaire did not pick up those changes at the time of their last session. Finally, one felt that the nature of trauma treatment increased their distress temporarily but ultimately helped them overcome symptoms associated with trauma, so that when they took their last questionnaire, they were feeling distressed, even though they were taking steps toward healing.

(D) Hindsight Bias

Two participants guessed that hindsight bias might account for the discrepancy between their report and their OQ-45 scores. For example, one of these participants speculated:

> Maybe now my perspective is different, and like, that I am out of that, like, low place, that I felt like I was improving over time. But maybe when you are actually in it, it's a lot worse and, like, you feel a lot lower.

Domain 12: Perceived Wellbeing at the End of Therapy

The majority of responses in this domain arose from the question: *What was going on in your life when you ended therapy?* Two categories emerged: (A) Feeling Bad at End of Therapy and (B) Feeling Good at End of Therapy.

Table 14
Domain 12: Perceived Wellbeing at the End of Therapy

Category Name	Frequency	Examples
A. Feeling Bad at End of Therapy	T (8)	Felt upset not having processed "everything" about father
B. Feeling Good at End of Therapy	T (7)	"I felt strong enough to end therapy"

Note. N=13. G=General (12-13 participants), T=Typical (7-11 participants), V=Variant (1-6 participants).

(A) Feeling Bad at End of Therapy

The majority of participants reported feeling bad, unsettled, or incomplete, in some way, at the end of therapy. Participants noted feeling sad, upset, or stressed. One participant recounted feeling like therapy came to an inorganic end, stating that they "didn't have enough time to process everything." Some of the participants wondered during the interview if they had gotten better in therapy, like they had believed, after considering the pain they were still in at the end.

(B) Feeling Good at End of Therapy

The majority of participants also noted feeling good, in some way, at the end of therapy. Several participants noted simply that they were feeling "strong" or "good" when they finished at the counseling center. One participant said: "Honestly, I was feeling like I was doing a lot better than I ever have before." Others reported feeling exceptionally comfortable with or accepting toward themselves and their situations. One participant explained how they were feeling in regard to their spirituality: "I felt a lot more comfortable with myself and just comfortable in just my situations in lots of different facets of life. And so then I just felt more open to then start exploring spirituality again."

Domain 13: Reasons for Ending Therapy

The majority of responses in this domain arose from the question: *What was going on in your life when you ended therapy?* Three categories emerged: (A) Session Limit, (B) Logistical Reasons, (C) and Poor Fit/Ineffective Treatment.

Table 15
Domain 13: Reasons for Ending Therapy

Category Name	Frequency	Examples
A. Session Limit	V (6)	"I ended therapy because you're only allowed so many visits per school year"
B. Logistical Reasons	V (4)	Ended therapy due to graduating
C. Poor Fit/Ineffective Treatment	V (2)	"I quit therapy because we were going this weird direction that wasn't about what I was dealing with"

Note. N=13. G=General (12-13 participants), T=Typical (7-11 participants), V=Variant (1-6 participants).

(A) Session Limit

Six participants ended therapy due to session limits. At the time, clients at the counseling center where this study took place were allowed seven individual therapy sessions per academic

year. These participants reported that they would have liked to keep attending therapy but that they hit their session limit and, therefore, needed to stop or to start in another setting. Several others expressed either sadness or frustration about the session limit.

(B) Logistical Reasons

Four participants ended therapy due to personal or logistical concerns. Some felt too busy to make time for therapy, while others graduated and, therefore, became ineligible for services. One participant stopped therapy due to changes in response to the COVID-19 pandemic, stating that "I would have continued [in therapy], but we were all sent home."

(C) Poor Fit/Ineffective Treatment

Two participants mentioned feeling like therapy was not going to be helpful for them. One of them reported that they had stopped going to therapy because they did not feel like it was addressing their concerns: "I quit therapy because we were going this weird direction that wasn't about what I was dealing with." The other felt they had had a bad fit with their therapist, so they transferred another provider.

Discussion

The primary goal of this study was to learn more about the experiences in therapy of clients who show signs of deterioration based on the OQ-45 but who believe they got better. It is important to understand their experiences for many reasons. First, they suggest that there are elements of change in therapy that OQ-45 pre-post testing fails to capture. Second, the experiences of deteriorators in therapy have been understudied, since they are often excluded from other study findings (Lazar, 2017). The results of this study might offer some direction in deepening our understanding of what does and does not constitute deterioration. In addition, they

might offer BYU CAPS and other settings that use the OQ-45 information to consider how this measure conceptualizes deterioration and treatment failure.

Overview of Findings

General Findings

Our data on participant agreement with the OQ-45 replicated the findings from the pilot study conducted in 2018 (Top et al.). In fact, the proportion of OQ-45-deteriorators who believed they had gotten better in therapy was higher in the current study than in the pilot (58.5% versus 50%). These findings provide further evidence of the recently coined concept of "paradoxical outcome" (Georgaca, 2021). That is, there is a young but growing body of evidence that discrepancies often arise when assessing outcomes with multiple raters (Krause et al., 2020) and methods (e.g., quantitative and qualitative; De Smet & Meganck, 2018). Although even more data could strengthen our confidence that this trend would remain the case in other contexts—such as community mental health centers, hospitals, and outpatient private practices—our sample suggests that this finding in this context is reasonably stable within BYU CAPS and likely other college counseling centers.

Some clear themes arose in the data. The presenting concerns mirrored what would be expected for a more general sample drawn from a college counseling center. That is, anxiety and depression were the most common presenting concerns, and experiences with trauma, interpersonal problems, and other mental health concerns followed. Most participants reported liking their therapist, gaining something positive from therapy, and experiencing complicated extra-therapy events (e.g., challenging classes, graduation, interpersonal strife) during their therapy course. Still, the majority of participants listed positive and specific outcomes, such as learning new ways to cope with anxiety and depression, finding new ways to approach

interpersonal problems, or improving self-esteem. It would likely not be clear to an unknowing observer that these participants had met criteria for deterioration.

Expectations

A large majority of participants believed that therapy would help them when they had started. Notably, these participants often stated that they did receive the types of help that they had expected, with only a few suggesting that their expectations went unmet. On this positive end, they generally expected to meet with someone who would give them space to talk through their concerns and provide new perspectives or tools. Only occasionally did any express somewhat unrealistic expectations of therapy (e.g., that it would shed light on the participant's neurobiology and work by helping the client change their neurobiology). A few participants felt unsure about what to expect or even pessimistic about the ability of therapy to help with their concerns. Pertinent to the aims of this study, most participants felt optimistic in regard to the efficacy of therapy, and it is possible that this affected their perceptions of change throughout the process.

Of those whose expectations for therapy were absent or negative, most stated that they had been referred to therapy by a friend or relative. Most of them had never been to therapy before. One participant mentioned that they did not think therapy would be helpful but went anyway because they did not know what else to do.

Presenting Concerns

The participants in this study reported presenting concerns that were consistent with broader counseling center populations (Center for Collegiate Mental Health, 2021). With such a small sample, it is not possible to draw any conclusions about the precise nature of the presenting concerns in this population on a broad scale. It is worth noting, however, that as far as they go,

they are unremarkable. Most participants reported feeling depressed or anxious, and many reported interpersonal concerns (e.g., difficulty making friends, familial strife). Some endorsed a history of trauma, and a few endorsed persistent medical problems. It does not appear that presenting concerns themselves account for or explain the discrepancy in OQ-45 scores and qualitative self-reports.

Positive Outcomes

All but one participant reported liking therapy and liking their therapist. Interestingly, all participants reported gaining something positive from therapy (e.g., learning to draw interpersonal boundaries), even when three participants reported some negative experiences in therapy. Most participants stated that their outcomes were positive *and* that they enjoyed or appreciated their experience in therapy sessions.

The outcomes reported in this study looked similar to reported outcomes of therapy in other qualitative research (e.g., De Smet et al., 2020). Participants reported learning new tools and coping strategies, new ways of approaching interpersonal problems, and new ways of understanding and relating to themselves. Many clients reported having fewer of the symptoms for which they started therapy, and several reported feeling more resilient and better able to cope with their symptoms. Even when they did not feel their symptoms had subsided, several participants noted feeling more hopeful and moralized through the therapeutic process.

Although there was substantial overlap among the types of outcomes and improvements participants recognized, they were also highly varied. This fact might help account for the difficulty of tracking outcomes with a single measure. Some of these outcomes (e.g., flashback reduction) are straightforward to track, and others are more challenging to capture with formal questionnaires (e.g., insight and interpersonal skills), at least with one formal questionnaire that

is short enough to reasonably administer at every session. The OQ-45, for example, does not include items about resilience or detailed interpersonal changes, which several participants cited as meaningful outcomes.

Negative Outcomes

Not all participants felt wholly positive about their experience in therapy. Two participants particularly noted mixed reactions to treatment. One suggested that they had quit therapy because it had begun to feel like they were not addressing the right problems. Another felt insulted and disrespected by their therapist and stated at the time of the interview that they were not sure if they had gotten better in treatment or not, despite marking that they had gotten better in the survey. Within this sample, reactions like these were rare but noteworthy.

Evaluations

Participants offered their opinions on their therapists and on the therapeutic process. Many of these opinions, both positive and negative, consisted of evaluative statements. The overwhelming majority of these evaluations were positive. Most stated that therapy was helpful, and some who had had multiple therapists mentioned that their most recent therapist had been their favorite, the one with whom they felt they had had the best fit. The few negative evaluations of therapy tended to center on feeling confused about the process or misunderstood by the therapist. Many participants did, however, convey frustrations about the procedures and policies involved in the counseling center. That is, many were frustrated with long wait times and session limits. Still, even when given reassurance that their responses would be confidential, the majority of these deteriorators provided mostly positive feedback about their experiences in therapy.

The Role of Extratherapeutic Factors

The students in this sample endorsed complex academic, professional, and interpersonal lives outside of therapy. As the next section covers in greater detail, extratherapeutic factors were the top participant theory as to why there was a difference between their OQ-45 scores and their report at the time of the survey. Many participants were either starting or finishing school, starting or ending relationships, or undergoing another major life change or difficulty. In some cases, these factors contributed to distress beyond the participants' ability to control (e.g., parents announcing divorce, chronic pain due to a medical problem). It is not possible to say whether the types of circumstances these participants described would be unique in some way to this population. They do, however, serve as a reminder of why factors outside of the therapeutic context can account for such a large portion of change (Wampold & Imel, 2015).

OQ-45-Self-Report Discrepancy

Answers to the question concerning why their scores differed from their perceptions clustered around several themes. Participants typically expressed surprise during the interview that they had gotten worse according to the measure. Despite this surprise, no participants denied the claim or argued with the interviewer. One participant even stated that they must have been wrong about getting better.

Most believed that stressors outside of therapy likely influenced their scores at the end of treatment, elevating their scores when they would otherwise consider therapy successful. That is, they typically identified extratherapeutic factors as the most likely explanation of the discrepancy. This suggestion is consistent with prior findings that factors outside of therapy account for a substantial proportion of change that occurs during therapy (Lambert, 1992; Lambert & Barley, 2002; Wampold & Imel, 2015). It also helps to explain why these participants

failed to intuit that they had gotten worse in therapy—therapy felt helpful on the whole and generally offered them tools they did not have before. To determine whether or not therapy had worked well for them, they seemed to consider their immediate distress less than their ability to cope with life and behave differently. As a result, they seemed to grasp at difficult events in their lives (e.g., finals, family trouble) to explain their OQ-45 scores.

Some participants suggested that, as they changed, the way they interacted with the questionnaire changed. For example, participants noticed that their response styles had changed from the beginning of therapy (when they had "sugar coated everything") to the end of therapy, after they had learned to be more direct about their feelings. Paradoxically, in such cases, an increase in OQ-45 scores might actually indicate overall improvement in presenting concerns. The phenomenon of "faking good," for example, is well documented (e.g., Griffin et al., 2004). Some participants reported that they became more willing to acknowledge to themselves and to others by the end of therapy that they were struggling. Consequently, they were more likely to score higher on scales of distress but not because their distress had itself increased.

Others suggested that although their distress did increase, their ability to cope with and manage their distress also increased, making therapy successful. They suggested, in other words, that the OQ-45 did not capture important changes in symptom management skills but only the symptoms themselves. It is worth considering that some theoretical orientations explicitly aim to increase coping skills without making overt attempts to control symptoms. Although we did not track the theoretical orientations used by therapists in this study, it might be the case that these clients were receiving therapy that was, at least in part, designed with these intentions and around this kind of language. It would be expected, then, that their clients might notice progress that would go undetected by the OQ-45.

Also included in this dataset were two respondents who believed they had improved in therapy until the interviewer told them their OQ-45 scores suggested they had deteriorated, after which they stated that they must have only convinced themselves that they had improved when they really had not. While one of these participants quickly agreed that therapy had not been helpful, the other agreed with qualifications. The latter noted that, overall, they might have gotten worse but did appreciate some of the coping skills and interpersonal tools they learned in therapy.

In the next sections, implications and limitations of these results are discussed.

Theoretical Implications for Outcome Measurement

This study bears implications for routine outcome measurement. First, and in line with others' thoughts on this topic (Georgaca, 2021; Wahlström, 2021), it points to potential limitations of routine outcome monitoring. The process of therapy is unquestionably complex, involving a series of expectations and interactions that therapists and clients often interpret differently (Tzur Bitan & Abayed, 2020). Capturing the complexity of the changes that take place in a course of therapy is, doubtless, a challenging task. To do so with a measure that therapists can administer briefly and regularly is even more challenging. This study shows that some important elements of therapy outcomes—for example, coping skills, acceptance, some interpersonal changes—for clients might fall through the cracks of the OQ-45 and other measures with which the OQ-45 strongly correlates.

This study's findings make a case to broaden the conceptual reach of outcome monitoring to include items or subscales dedicated to capturing coping skills or psychological flexibility. Participants' stories about therapy validate therapeutic approaches that seek to reduce or alleviate symptoms *and* approaches that primarily aim to increase psychological flexibility. From clients'

perspectives, in other words, symptom reduction and increased capacity for handling challenging situations and emotions both represent worthwhile and achievable goals. In addition, while measures do exist to gauge the latter, many commonly used measures, including the OQ-45, do not.

These results also suggest that it would be worthwhile for the field to develop a clearer definition of deterioration, particularly as it relates to treatment failure. It is important, in other words, for therapists to understand not just that their clients are doing worse but also (1) what role therapy might have played in their doing worse and (2) what role therapy can play in helping them do better. There are measures and procedures already invented with which to accomplish this task, such as the Assessment for Signal Clients (Probst et al., 2015). However, these measures, as useful as they are, become less meaningful without a more fully formed understanding of deterioration. It remains somewhat unclear what signals of deterioration point to and, therefore, how clinicians should interpret those signals.

In sum, a major theoretical takeaway from this study is that our methods of measuring outcomes lack adequate nuance to consistently capture (1) improvements in therapy without symptom reduction or (2) progress from the client's perspective. No single measure or construct can likely capture the full richness or complexity of the therapeutic process or outcomes. These are important gaps in our ability and potentially fruitful areas in which to explore and innovate in clinical practice.

Practical Implications for Outcome Measurement

One potential approach to more accurately assess for deterioration might consist of triangulating outcome monitoring techniques, as is done in rigorous research and in psychological assessment. As is the standard in controlled trials and in psychological

assessments, using multiple means of assessing outcomes could help cover the several facets of improvement and deterioration that clients notice in therapy. It might also be worth exploring with clients which of these facets is most important to them. In this study, for example, participants often noted that they were happy with their progress despite feeling distressed. The OQ-45, valid as it might be as a measure of distress, failed to detect other brands of change—namely, perceived coping skill, remoralization, and some interpersonal changes. The results of this study help form a case to expand how outcomes are conceptualized and measured while taking cues from real clients about how and why therapy is impactful.

In addition, this study points to the importance of considering the authority that quantitative measures can carry for clients who usually do not have enough training to discern the nuances involved in tracking therapy outcomes. For example, several participants expressed doubts concerning their experience of change or progress in therapy after learning about their OQ-45 scores. Some were concerned that they had merely convinced themselves they had gotten better when they had really gotten worse. For example, one said, "I try to think that I got better, but obviously I didn't." In other words, it might be important when sharing outcome data with clients to review carefully what that data can and cannot say about the client, since these numbers can have a strong air of scientific authority or objectivity.

Alternative Outcome Measurement Methods. There are many measures and practices designed to help clinicians track clients' outcomes during therapy. In addition to using standardized routine outcome monitors like the OQ-45, clinicians can also informally check in with clients about their progress toward goals, create more specifically targeted measures with clients (Battle et al., 1966), and select measures more specialized to clients' presenting concerns or clinicians' theoretical orientations. Although there are still many gaps in this research, best

practices for managing paradoxical outcomes in regard to deterioration likely consist of using a combination of these approaches as well as deliberately involving clients in the discussion about their progress or lack thereof. Clinicians should use the tools available to consider their clients' outcomes through varied methods and perspectives.

Clinicians might also consider using measures to focus on the process of therapy, since the process is more within clinicians' control than the outcomes in most cases. Many of the participants in this sample seemed to attribute improvement in therapy to key features of the process (e.g., feeling cared about, feeling listened to). The CCETS (Levitt, 2018), a measure discussed in the introduction, is derived from clients' positive statements about the therapeutic process. Using this or similar measures, especially in conjunction with measures designed to track psychological distress, would help clinicians stay more broadly informed about how their client is feeling *and* how well the process of therapy is unfolding. Employing this strategy might help close some part of the gap left by the OQ-45 at which participants in this study hinted.

Finally, although their inventions might be unready for widespread dissemination, Imel and colleagues (2019) have begun developing technology using machine learning to provide immediate feedback to therapists about their relative fidelity to a treatment approach (in this case, motivational interviewing). This represents another, albeit nascent, tool therapists might consider using when tracking their therapeutic process. Fully acknowledging the youth of this line of research, these recommendations are tentative. However, they might provide a starting point for researchers and clinicians to begin the difficult work of more accurately conceptualizing and tracking what happens in therapy.

Limitations

As in all research—and perhaps especially qualitative research—researcher bias is unavoidable and potentially impactful on study results. Although we took measures to control for this bias (controlling for bias is at the heart of the CQR process), it remains important to acknowledge the possibility that researcher bias has skewed our findings. The primary analysis team disclosed their assumptions about therapy, which we include on the Open Science Framework page for this study: https://osf.io/ns9eu/. In addition, the method section of this dissertation includes information about the theories of change of the primary author and interviewer.

Limitations of Setting

Limitations also sprang from the setting in which this study took place. A large majority of the sample was female, Caucasian, and religious. Although it is not an aim in CQR to select representative samples of the entire population, it nevertheless seems important to acknowledge the narrowness of the sample in this case. Conclusions drawn from this study, then, should take into account that participants in other demographic groups might have generated markedly different results. BYU CAPS is also housed in a unique, religiously sponsored university. The sample was largely homogenous in regard to race, religion, and, to some extent, gender. It is impossible to say precisely how this affected the results of the study, but it merits mentioning, and the reader will do well to interpret the results bearing these facts in mind.

The counseling center also uses a brief treatment model with, generally, hard session limits. This led, per some participant reports, to premature or inorganic termination. Therapists and clients in this center are often left to negotiate and collaborate about how long treatment will last, which concerns to prioritize, and whether to transition to another provider in the community

when they have reached their limit. While no setting provides perfectly smooth procedures for clients, many enjoy freedom from these specific limitations, and it is possible that other settings would yield different results.

Directions for Future Studies

It will be important to replicate these findings using other outcome measures. These results, for example, might be a product of features of the OQ-45 that would not replicate in studies using other outcome measures. Given the high convergent validity between the OQ-45 and other outcome measures, this seems unlikely. Nevertheless, others might consider exploring the agreement between different outcome measures and qualitative client reports in regard to deterioration.

It will also be important to collect data from other universities and other settings. University counseling centers constitute an effective resource for collecting data, but they do not fully represent the experience of most people who seek psychological treatment. Beyond offering a restricted population, the university counseling center's policies led several clients to end therapy when they would otherwise have continued, potentially contributing to their quantitative deterioration. Settings without session limits would better avoid the issue of premature termination in addition to replicating findings in a different population.

Perhaps even more germane to this study's results, future research might aim to explore and flesh out our understanding of deterioration according to clients. For example, although the small population size might complicate recruitment, it would be interesting to study former therapy clients who believe they deteriorated during therapy—particularly if they attribute their deterioration to therapy itself. There is no evidence that therapy systemically *causes* deterioration. However, if there are cases where clients believe therapy contributed to the

worsening of their condition, it would be important for therapists to know what factors that, according to clients, made therapy a harmful experience.

Conclusion

Our results join a growing body of research exploring clients' perspectives regarding psychotherapy outcomes (e.g., Binder et al., 2010; Bowie & McLeod, 2016; De Smet et al., 2020; Paulson et al., 1999). They also join the newer stream of research investigating "paradoxical outcomes" in therapy (e.g., De Smet et al., 2020; Georgaca, 2021), the divergence between different methods of measuring outcomes. We explored the experiences of a specific subset of clients classified as deteriorators on the OQ-45 but who endorsed improving in therapy. Most of these participants noted that, beyond improving in therapy, they had liked many elements of the therapeutic process. This study forms a step toward better understanding the depth and detail of therapeutic outcomes, particularly as they relate to deterioration.

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