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Honors Thesis

A QUALITATIVE CASE STUDY EXAMINING DISCREPANCY BETWEEN
PROSPECTIVE OUTCOME USING ROM AND NARRATIVE CLIENT
RETROSPECTIVE VIEW

by
Jarom Hickenlooper

Submitted to Brigham Young University in partial fulfillment
of graduation requirements for University Honors

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Brigham Young University
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ABSTRACT

A QUALITATIVE CASE STUDY EXAMINING DISCREPANCY BETWEEN PROSPECTIVE OUTCOME USING ROM AND NARRATIVE CLIENT RETROSPECTIVE VIEW

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Bachelor of Science

This thesis is a qualitative case study which examines an observed discrepancy in psychotherapy outcomes between prospective routine outcome measurements (ROM) and narrative retrospective assessment by two clients. Although ROM has proven to be effective in improving therapy efficiency and effectiveness (De Jong et al., 2021; Lambert et al., 2018), recent research investigates discrepancies between ROM categorizations of improvement and deterioration and the lived experience of the client. Researchers have found that the narratives delivered through client structured interviews can provide additional and more nuanced insight into therapy outcomes, which can complement and enhance ROM (Roubal et al., 2018; De Smet et al., 2019; Desmet et al., 2021). A recent case study used qualitative analysis of a post-treatment interview to examine the client's perspective of discordant outcome when ROM indicated that the client deteriorated during treatment and the client reported retrospective improvement (Ogles, Goates-Jones, & Erekson, 2022). This thesis builds upon this research. A retrospective survey was sent to 67 former clients at a university counseling center who's

prospective OQ-45 results showed reliable improvement. 25 completed the survey and 7 indicated they felt “about the same” after treatment, presenting a discrepancy with the prospective ROM. Two of these participants were interviewed and interview transcripts were analyzed using the Consensual Qualitative Research (CQR) method (Hill & Knox, 2021). Qualitative themes include motivation, social support, life events and context, therapeutic alliance, and the client’s own view on the observed discrepancy. Findings are discussed with implications for researchers and practitioners.

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Introduction

Today, outcome measures are commonly used in evidence-based psychotherapy, allowing practitioners to track the improvement or deterioration of their clients. An increased interest in patient focused research has helped pave the way for this development in the field by bridging the gap between research and practice (Howard et al., 1996; Castonguay et al., 2013). Researchers like Jacobson & Truax (1991) enabled reliable measurement of clinical progress through developing practical definitions for clinically meaningful change. These definitions have been used alongside statistical research to develop outcome measurements that are used to collect feedback on a client's status and progress in routine outcome monitoring (ROM).

The collection and use of client feedback has been shown to improve client outcomes. One panel of experts concluded that the collecting of client feedback is one of the elements of the therapeutic relationship that is “demonstrably effective” (Norcross & Wampold, 2011, p. 99). Meta-analyses have found that psychotherapy with ROM to be superior to psychotherapy without it and that using progress feedback improves outcomes and reduces drop-out, treatment duration, and deterioration (De Jong, 2021; Lambert et al., 2018). Lutz et al. (2021) go as far to say that “the implementation of outcome measures as part of routine clinical practice and training can be seen as one of the most successful developments in psychotherapy research over the last two decades” (p. 111).

However, like all research tools, ROM has its limitations and shortcomings. ROM can be difficult to implement, for both clinicians and clients (Mellor-Clark et al., 2016; Solstad et al., 2016). And ROM may not always tell the most complete or accurate story of a client's progress and experience in psychotherapy. While the Jacobson-Truax or JT

method of comparing pre-to-post treatment results has been instrumental in determining clinical significance, it does not take into account whether the measured outcome is significant to the client. Further, outcomes as experienced by the patient are multidimensional and include some nuances which cannot be captured by outcome categories specified by ROM (De Smet et al., 2020). Likewise, researchers Desmet et al. (2021) challenge the interpretations of the JT method and present detailed analyses of six cases in which pre-to-post comparisons of outcome measures proved misleading. They conclude that "too much systematization, that is: too strict a method, sometimes can obscure rather than reveal the crucial information on the validity of questionnaires" (p. 9). To curb the shortcomings of ROM, several researchers have implemented a mixed methods approach by supplementing additional and broader measures of outcome (Chui et al., 2021).

A significant focus of mixed methods approaches has been incorporation of narrative through client structured interviews and has yielded interesting findings. For example, Roubal et al. (2018) showed how client structured interviews could enhance and complement ROM, by explaining psychotherapy success or failure and by providing longitudinal and multi-level insight into the nature of clients' changes. It was through client interviews that De Smet et al. (2020) discovered that clients had a more complex and multifaceted perspective on change than the story that the pre-post prospective measurement of the ROM (the Beck Depression Inventory-II) was able to tell. Another study found moderate to low agreement between pre-post assessments of client outcome and qualitative analysis through client interviews (Desmet et al., 2021).

Other recent studies have highlighted discrepancies between client self-reports of outcome and OQ-45 reports (Ghelfi, 2021; Leibert et al., 2020; Ogles, et al., 2022; Top et al., 2018). Granted, discrepancies emerging between different methods of measuring outcomes may not be presenting a paradox or inaccuracy so much as highlighting important but diverse faces of the complex notion that is the outcome of psychotherapy, with its “different meanings for the various agents implicated in it” (Georgaca, 2021, p. 237). In this sense, narrative interviewing is seen as a tool that fleshes out the gaps between bare bones structure that ROM provides and helps us see more of the complexity and humanity in research of the clinical experience and its outcomes. Regardless of its interpretation, this discrepancy has been a special interest of several researchers in recent years.

One such example is a recent case study which demonstrated how semi-structured client interviewing can provide a helpful narrative perspective which supplements ROM (Ogles et al., 2022). This specific study focused on a client who individually reported clinical improvement during treatment, contrary to the prospectively collected results of ROM data using the OQ-45 which showed client symptom deterioration. The current case study builds upon this and other mixed method research in which clients reported improvement despite deterioration according to ROM. But instead, this study focuses on the reverse, in which ROM indicated clients improved significantly, but where those same clients retrospectively reported little improvement in client narrative interviews.

Methods

Participants

The present case study explores the experiences of two former clients and their assessment of the outcomes of their treatment. Participant 1, whom we will refer to as Ashley, is a married, 22-year-old female university student who attended four sessions of therapy at the university Counseling and Psychological Services (CAPS) over six weeks. Ashley started attending therapy because of anxiety and feeling overwhelmed. She reported that she ended treatment because she ran out of the number of sessions allotted per student by CAPS.

Participant 2, whom we will refer to as Breanna, is a married, 23-year-old, female university student who attended therapy at CAPS multiple times over several years. In the most recent episode, Breanna attended six individual therapy sessions over the course of five weeks. Breanna started attending therapy at CAPS this last round due to concerns with depression and anxiety and some obsessive compulsive disorder (OCD) symptoms. She also reported that she ended treatment because she also ran out of the number of sessions allotted by CAPS.¹

Both participants took the Outcome Questionnaire-45 (OQ-45) as part of ROM prior to each session of therapy they attended at CAPS and a comparison between their initial OQ-45 to their final OQ-45 indicated a significant symptom improvement (see Figure 1). It is important to note that Ashley did not complete the OQ-45 prior to her fourth session, so the last outcome measurement used in this research was from her third session. Breanna also did not complete the OQ-45 prior to her fifth session but did prior

¹ Due to the demand for services, the University Counseling Center limited students to a total of 7 sessions per year (including the intake session).

to her sixth and final session. As shown in Table 1, Ashley's OQ-45 total score dropped from 107 to 82, well beyond the necessary 14 points to be considered reliable improvement. Breanna's scores dropped from 103 to 60, as shown in Table 2.

Ashley and Breanna were selected for interviews because of a discrepancy in outcome reporting between the significant improvement indicated on the OQ-45 and their own retrospective assessments of their experience in therapy in a survey² they completed a few months after their treatment. The retrospective survey was sent to 67 former clients from the university CAPS whose OQ-45 data indicated they improved significantly in their time receiving treatment. Participants (N = 25) assessed their overall perspective on the outcomes of their treatment by answering the question "how did you feel after receiving therapy at CAPS?" In response to this question, both Ashley and Breanna selected "about the same" rather than "worse" or "better." Examining this discrepancy is the primary focus of the present multiple case study.

Measures

In addition to answering the question described above, respondents to the survey also completed three measures: The OQ-45, the Working Alliance Inventory (WAI), and the Assessment for Signal Cases (ASC).

Outcome Questionnaire-45

In many ways, the Outcome Questionnaire is the gold standard in ROM. The OQ is designed to measure client wellbeing through self-report items that address various possible types of distress in a client's life, such as interpersonal conflict and functionality at work or school (Lambert, 2015, p. 382). Based on responses on the OQ, the measure

² This survey will be referred to as the "retrospective survey" throughout this paper.

categorizes clients as “recovered, improved, unchanged, or deteriorated” (p. 382). Many studies have been conducted that confirm the reliability of the measure (p. 382).

The OQ-45 has 45 items which are into three subscales: symptom distress, interpersonal relations, and social role functioning. Each of these items are rated on a 5-point scale from 0 to 4, which makes for a total score ranging from 0 to 180. Level of distress is described as follows: high is anything above 105, moderately high is between 83 and 105, moderate is between 64 and 82, low is anything below 64. Thus, any total score above 63 is considered to be in the clinical range. For a change to be considered reliable there must be an increase or decrease of at least 14 points.

Working Alliance Inventory

The WAI has 36 items which assess three categories of therapeutic alliance: bond between the therapist and client, agreement on tasks, agreement on goals. The 36 items are scored on a seven-point Likert scale. The WAI is not a standardized measure but has been validated and has shown to have robust reliability (Hanson et al., 2002; Horvath & Greenberg, 1989). The WAI is significant because multiple meta-analyses have found a positive correlation between therapeutic alliance and treatment outcome (Flückinger et al., 2018; Horvath et al., 2011; Martin et al., 2000).

Assessment for Signal Cases

The ASC assesses problems that could impede treatment progress, focusing on the following scales: motivation, social support, stressful life events, and therapeutic alliance. It includes 40 items on a 5-point Likert scale ranging from strongly disagree to strongly agree. Scores for each of the four scales are calculated, but no total score. The ASC

identifies problematic scale or item scores through comparison against normative data (White et al., 2015).

Analysis

After being selected out of the 25 respondents who completed the survey, Ashley and Breanna each participated in an individual, semi-structured interview over zoom. Questions for the semi-structured interview were prepared by the researchers with the goal of understanding how participants perceived their therapy and therapy outcomes, with a particular focus on some known predictors of increasing symptoms during therapy measured prospectively including client motivation, social support, life events, and therapeutic alliance. Each hour-long interview was transcribed using the transcription program Otter.ai. The transcriptions were vetted against the video recordings of the interviews by the primary researcher to correct transcription errors. These transcriptions were used for analysis.

Interviews were analyzed using a modified version of the Consensual Qualitative Research (CQR) method for analyzing qualitative data (Hill & Knox, 2021). In the CQR method, each researcher reads through the transcribed interviews and develops their own list of domains or themes from the data. Then the researchers engage in discussion until a consensus is reached on a common, final list of domains, which are then used to qualitatively analyze the data and present results.

This case study involved two researchers focused on the question: “How do the clients, who when asked retrospectively believe they did not improve in therapy despite improving on the OQ (measures prospectively), perceive their therapy and therapy outcomes?” An emphasis was placed on understanding how the participants perceived

some known predictors of increasing symptoms during therapy measured prospectively (such as those measured by the ASC) and researchers sought to understand in a more deep way the perspective of a client on the factors that contributed to their view of non-successful therapy that is discrepant from prospectively measured decrease in symptoms. Five themes emerged: Motivation, Social Support, Life Context and Events, Therapeutic Alliance, and Understanding of Discrepancy. Results and sub-themes are discussed below.

Results

Motivation

Retrospective Survey

The retrospective survey administered to participants asked them to retrospectively reflect back on their experience in therapy as they completed the ASC and WAI measures. The motivation scale of the ASC indicated that Ashley's scores dropped just below the signal client cut-off, indicating potentially some problematic motivation. On a scale of 9 to 45, Ashley scored 28. Breanna scored 43, well above the signal cut-off of 32 (see Table 3).

Retrospective Interview

In their interviews both Ashley and Breanna reported high motivation to engage in therapy. Ashley said she was "pretty motivated," though admitted she probably could have read the materials her therapist gave her in more detail and "really soak it in." But, according to her, that had more to do with how busy she was with work and school than her desire to engage. Ashley also would apply techniques from therapy but found herself

slipping despite her initial motivation. In her words, “it was just...easier for me to go back to my normal ways.”³

Breanna said she was “very motivated,” and explained she had done a lot of personal research in psychology and is “a big believer in therapy.” Learning about herself was a major source of motivation. “It was learning about myself, and how my mind worked really intrigued me a lot.”

Role of Motivation in Discrepancy

In the interviews of these two case studies, motivation did not seem to play a critical role in the discrepancy between results of the OQ-45 and the retrospective interview. Both clients reported that they were highly motivated to engage and interested in improving through the therapeutic process.

Social Support

Retrospective Survey

The social support scale items on the ASC administered in the retrospective survey asked participants to “describe the support [they] felt outside of therapy since your last session,” so results of the scale reflect more the social support since their treatment rather than during their treatment. Ashley and Breanna’s scores on the social support scale of the ASC indicate that their social support since treatment was less than optimal, but still above the cut-off to receive a signal to consider interventions to facilitate external informal networks of care. On a scale of 11 to 55, Ashley scored 37 and Breanna scored 39, as shown in Table 3. The cut-off for signal clients is 31 or less.

Retrospective Interview

³ Some client quotes have been edited for writing clarity.

Coincidentally, both Ashley and Breanna got married shortly before beginning therapy. Both found their husbands to be a good source of support, however they also reported that they experienced rather sudden and significant changes in the dynamics of their friendships and support groups, some of which they attributed to the transition to married life. Outside of their marriage, both expressed some deficits in their social support networks as they were starting therapy.

Ashley initially noted, “my network at the time [of beginning therapy] was great. Like, I felt really supported.” But she qualified that support by explaining, “I had a solid group of friends, but I didn’t feel like I had anyone who ... would sit down with me and ... talk to me and ... understand me... I didn’t feel like I was ... truly, ... being understood or ... connecting with people.” While Ashley had friends that she “would hang out with,” she did not have a support group that could help her with her emotional and psychological needs.

Breanna reported a similar deficit. She talked about how her relationships changed with her own marriage and some of her best friends getting married. “I felt like I was losing my friends and people didn’t know how to talk to me, you know, I was ... married and stuff. So, I just kind of felt really socially isolated. And that was really hard.” And not only did she feel isolation but also abandonment. She explained that “with friendships and stuff, I felt kind of forgotten, and that no one really cared...I kind of felt abandoned, particularly by ... my best friend, which was a huge reason why I kind of started up [therapy] anyway.”

In Breanna’s case, her spouse was a constant positive support. When asked about her social support network she readily commented, “I felt my husband was wonderful.”

At least at first, Ashley did not have the support she needed from her husband, who tended to just try to fix things rather than “listen and be there” like she needed. But as she attended therapy and told him about it, he would mimic the therapist in some ways and became a better social support. She explained that when first starting therapy, “I felt like my husband wasn’t much of ... an emotional support, because we were still understanding each other, and I was ... really stressed and busy all the time. But now he definitely is.”

In Ashley and Breanna’s perspectives, there was a shift in each of their social support systems by the end of their time in therapy, albeit in different ways. For Breanna the change was in her family relationships. She said that she had good relationships with her family when beginning sessions, but none of them were geographically close. However, by the end, her sister, who she considers to be one of her best friends, moved back close by and they could be together again. Additionally, Breanna talked about getting closer to her younger brother as she became a support to him. She explained that he reached out to her for help applying for college and that “really touched my heart and that he was ... coming to me and asking me for help and advice...I think it brought me a lot more excitement and a lot more hope.” Beyond her family relationships, over the course of her time in therapy Breanna also experienced an improvement in her friendships. She explained, “I think I was able to adjust better to ... the change of my relationship, my friends...I was able to feel more supported by people other than my husband.”

In Ashley’s case, the change in her friend relationships was more anticipatory than actual. Like Breanna, she also felt hope and excitement toward the end of her time in

therapy, but it was because she had “so many things to look forward to,” particularly a group of her close friends coming back to the university from being abroad for a few years. Because of that, at the time of ending therapy she felt she “was in a good state.” Unfortunately, those anticipated changes never came to fruition. Shortly after she was no longer seeing her therapist, her friends returned but “it just kind of flopped the complete 180 and they all, we just ... are not friends anymore.” Despite repeated efforts from herself, Ashley explained her friends “didn’t put any effort into our friendship.”

Role of Social Support in Discrepancy

At the time of taking her final OQ-45 in therapy, Ashley was in a relatively good place in her social support, at least anticipating that her friend support would soon improve significantly. However, at the time of completing the retrospective survey and the interview, retrospectively she understood that those positive shifts in her friend group did not take place as she had hoped. This may be part of the reason why six months later she would assess she felt “about the same” at the end of therapy.

For Breanna, her support group improved over the time she was in therapy, and she seems to attribute some of that change to her own growth, as she explains, “I was able to adjust better to...the change of my relationship.” So, these outcomes would surely show in the OQ-45 she took at the end of therapy. However, as we will see in the following sections, this did not constitute as much improvement as she was hoping for.

Life Events and Context

Retrospective Survey

The life events scale items of the ASC administered in the retrospective survey to participants asked them to answer for the past week, so scores reflected the time that they

took the retrospective survey, not events during their therapy experience. Ashley scored much lower than Breanna on the retrospective ASC life events scale, indicating Ashley reported more problematic life events, but neither scored low enough on the overall scale to be flagged as a signal case. On a scale of 9 to 45 Ashley scored 22 and Breanna scored 39, as shown in Table 3. The cut off for signal clients is 19.

Retrospective Interview

Previous Therapy. Both Ashley and Breanna had attended therapy before doing sessions at the university CAPS. For Ashley, CAPS was her second time seeing a therapist. Already feeling overwhelmed and anxious a month before getting married, she saw an online therapist for four sessions, but did not find it helpful at all and stopped once she got married. Breanna had attended therapy multiple times, going back to high school when she first started “working through some ... PTSD.” She was still working on PTSD when she first attended CAPS a few years prior to the current study, along with symptoms of OCD, scrupulosity, social anxiety, depression, and general anxiety. When attending CAPS sessions which are the focus of this study, she was actually meeting again with the same therapist she had worked with in previous years.

Mental Health. Ashley’s primary mental health concern that brought her to therapy was anxiety and feeling overwhelmed. For Breanna, the primary mental health struggle was with depression, to the point of suicidal ideation, and she had also decided to start medication for her depression. Breanna also reported struggling with “social OCD,” but felt that she had largely overcome her struggles with scrupulosity and PTSD by the time she started this last round of therapy sessions at CAPS.

Following ending therapy at CAPS, both participants had continued struggles with mental health. Ashley continued to experience anxiety. Breanna described she had another prolonged depressive episode a month or two after completing her therapy.

School and Work Stressors. As most college students do, Ashley and Breanna experienced stress in their studies, though manifest differently in connection to their therapy attendance. Ashley was doing school year-round and said she felt “like there’s too much to do and not enough time.” Particularly stressing for her was one especially difficult and time-consuming course she talked about. She expressed she wants to do everything perfectly but “never got a perfect score on the test [in that class].” She said that “makes me really frustrated, because I feel like I studied very ... in detail” and she would often then ruminate over those academic outcomes. Those feelings of being overwhelmed brought her to therapy.

Breanna had had a “really hard semester at school” the winter semester prior to therapy, which left her feeling “like a failure” and even questioning if she should change majors. But she did not take any classes in the summertime and by the fall semester when she started therapy, got accommodations from the university and school was no longer a major stressor. While she had some stressful classes, she was “really focused on being disciplined that semester” and through therapy was also able to “adopt a good mindset about [her] grades.”

In addition to being full-time students, both Ashley and Breanna were working part-time jobs. While being time consuming, Ashley’s job was a source of stability for her and kept her “steady” and “in a good spirit.” Breanna, on the other hand, had “a really toxic boss at work” and had an overall “stressful job.”

Transition to Marriage. The transition to marriage was an important factor in both of the participant's experiences. On top of the stresses with school, the new life transition that came with marriage caused Ashley an ample amount of anxiety. She wasn't sure if she was "doing this correctly" and as mentioned in the section on social support, it took some time for her and her husband to learn to understand each other. Reality did not meet her expectations of the beginning of her marriage. Instead of enjoying the summer after marriage and going on a honeymoon, she had to postpone her honeymoon for school and was "just ... cramped up, ... doing homework all day, and then going to work," and then would feel completely drained at night. She regrets that what she remembers from the beginning of her marriage "is me doing homework all day and trying to figure out why I got something wrong."

Breanna also had unmet expectations, as her anxiety interfered with her wedding day. On her wedding day she felt like "an anxious mess" and though everything went according to plan, she had never in her life "ever felt that much anxiety all at once."

Neither reported any serious stressors related to family during therapy, but Ashley did have "family issues" starting just a week after ending therapy. This included her mother needing to travel to care for her grandpa who was not doing well, leaving her two dogs at home to be cared for by her stepdad "who hates dogs and doesn't take them out," which all added to Ashley's stress after ending sessions at CAPS.

Physical Health. During therapy, Ashley experienced a lot of poor health. She was physically active and trying to go on runs regularly but said "I was ... always kind of sick." She reported she had an "infection" shortly after getting married, then got sick,

then had other disruptive sickness. Before her last session at CAPS, she also was infected with COVID and had to self-isolate.

Breanna said she was “not the best about eating” because she did not feel good enough to eat with her depression and medication and was “really prone to ... skipping meals.” She did feel though that she was “really prioritizing sleep” and made sure she got at least hours of sleep a night. But due to her depression, “exercise was not good...I could not get myself to go and exercise.”

Spirituality. In addition to providing stability, Ashley’s job gave her an environment where she could thrive spiritually. And though spirituality had been a major concern in the past, spirituality was also not a concern for Breanna at the time she was attending therapy. She felt disconnected spiritually, and brought it up in therapy, but recognized that it was largely a result of her depression, which left her feeling very little at all. Her spirituality was not a main concern for her when she could see “it was because I was depressed.”

Role of Life Context in Discrepancy

Life contexts of the participants could have played a significant role in the observed discrepancy of assessments. Resurgence of anxiety or depressive episodes in the time following their therapy sessions likely impacted their assessment of effectiveness of therapy treatment they had received. Ashley described that right after she stopped going to therapy “was when [she] had ... a bunch of social issues and family issues” and that “took a big toll on [her] mental health.” Breanna explained that by the time she took the retrospective survey for this study, two and a half months after stopping therapy, her “depression was not good again.” At the time of the retrospective survey, she explained

that she thought “I’ve been struggling with depression still, so I don’t think I improved.” Stress from school decreased over time, which may reflect in their OQ-45 results. Both participants adjusted to marriage over time, which additionally likely decreased stressors and anxiety.

Previous therapy experience may have influenced Ashley’s initial evaluation of her improvement and well-being, because her experience in CAPS was much more positive than her previous therapy experience. Conversely, previous therapy may have filtered the improvement Breanna perceived when evaluating her overall experience in the retrospective survey because she had seen more drastic improvements in the past. While impacting their overall well-being in general, physical health and spirituality are not likely to have played as significant a role in the discrepancy because of their general consistency over the timeframe observed.

Therapeutic Alliance

Retrospective Survey

The retrospective survey completed by each participant included the WAI, which is a measurement of therapeutic alliance. As shown in Table 3, Ashley scored 203 (mean of 5.64) and Breanna scored 171 (mean of 4.75). On the 1 to 7 scale these equate to means of 5.64 and 4.75 respectively. The items on the seven-point Likert scale range between the response anchors “never” and “always,” and the scores of 5.64 and 4.75 correspond to “often” and “sometimes.” On the sub-scales, both participants scored higher on bond than task or goal agreement, though differences were more prominent in the case of Breanna. Ashley scored 72 total on the bond scale (mean of 6), 66 on task agreement (mean of 5.5), and 65 on goal agreement (mean of 6.5). Breanna scored 67 on

the bond scale (mean of 5.58), 52 on task agreement (mean of 4.33), and 47 on goal agreement (mean of 3.92).

On the ASC included in the retrospective survey Ashley and Breanna did not score low enough on the total therapeutic alliance scale to be given a warning signal. On a scale of 11 to 55, Ashley received a score of 51 and Breanna scored 52 out of 55, well above the cut off of 42 to be flagged (see Table 3).

Retrospective Interview

Relationship Bond. Both participants reported having a good relationship with their therapist. Both emphasized the professionalism of their therapist in describing their relationship with them. Ashley explained how effective the “therapist-client relationship” was for her experience, and in describing her therapist said, “she was very composed, she was very calm...She was very logical, which was what I needed.”

Likewise, Breanna expounded on her “really good” relationship with her therapist by saying it was “as professional as [it] can get.” Breanna really appreciated how her therapist was “really straightforward and honest with [her].” She also talked about how her therapist’s use of humor and sympathetic responses helped her feel like she was “chatting with a friend.”

At the same time, Breanna also expressed some strain in her relationship with her therapist, which she attributed to her “plateauing” progress with him. The sessions under examination in this study was not the first time that she had worked with that same therapist; she had met with him for multiple sessions a couple years prior as well. But despite having a good relationship, she said “I think what was hard was that I had been seeing him a long time...We had resolved a lot of things, but I still kept having the same

problems. So, and I felt ... that was kind of ... hard for him.” In contrast to his otherwise engaged and sympathetic responses, she described that there were sometimes that she felt her therapist was disconnected or even “bored.” She thought they “both needed ... a change.” If her allotted sessions had not run out, she said she likely would have stayed with the clinic but have switched therapists.

Role of Relationship Bond in Discrepancy. For Ashley, her relationship with her therapist does not seem to have impacted any less-than-positive evaluations of her experience in therapy, or the discrepancy being examined. In Breanna’s case, her plateauing bond with her therapist seems to play a more significant role in her experience in therapy and assessment of her progress.

Goal Agreement. Both participants described some incongruence of goals in their alliance with their therapist; at least in the sense that their goals for therapy and where their experience in therapy led as directed by the therapist seemed inharmonious. Ashley and Breanna each said they wished their therapist had addressed “broader” and “deeper” issues, rather than being so “situation focused.”

Ashley emphasized a desire to improve her personal capacity to manage feeling overwhelmed when explaining her expectations for therapy. “I was hoping, expecting ... the therapist to tell me what I can do when I do feel really overwhelmed.” She shared how her therapist supplied her with strategies for certain situations but failed to give a “general strategy for anxiety.” For example, Ashley describes a time when she got scared at night, and her therapist assisted her in writing down “step by step” what she could do at night to help her not be scared. While this was helpful, Ashley said, “but I’m not ... scared on a day-to-day basis. And I don’t know what I can ... how I can apply that to ...,”

just anxiety in general.” While it seemed her therapist’s vision of the goal of her therapy was to help her navigate specific situations, Ashley’s goal for her therapy was to develop a more “general strategy for anxiety.”

It is interesting to note that Ashley experienced a shift in her perspective on anxiety in the course of therapy. Though not explicitly taught by the therapist, she attributes this paradigm shift largely to the increased awareness she developed in therapy. She was able to find utility in her stress to motivate her and appreciate that her anxiety is naturally giving her motivation and is part of what makes her engaged and productive. She explained, “I realized that anxiety is not all bad, because anxiety has helped me with ... being hard working...I feel like it does help me.”

Breanna on the other hand stressed that her goal for therapy was symptom reduction and to “feel like [herself]” again. She described, “I just didn’t want to feel depressed anymore...I kind of just wanted to find myself again...I just wanted to enjoy life again and be happy where I was...to feel again and go through normal human processes.” Her therapist helped her achieve some “little outcomes” including being able to better recognize her thought processes, identify patterns and tendencies, and change her high expectations of herself. However, she felt a significant lack of “goal centered type things in [her] therapy experience” or “actual targets.” Consequently, she felt her therapy was “helping [her] understand the situations...and how it’s working with [her] OCD and depression” but failed in “actually targeting the depression and OCD.”

Role of Goal Agreement in Discrepancy. Ashley and Breanna both reported in their interviews that they experienced “small” improvement by the end of their time at CAPS, but in a broader (retro-)perspective not nearly as much as they had hoped. To a

degree this could be attributed to goal disagreement in their therapeutic alliances. Some of the discrepancy between the OQ-45 and the retrospective questionnaire where they described feeling “about the same” at the end of the therapy may be accounted for by the difference in the targeted outcomes of the therapist and OQ-45 and those held by the clients themselves. Further, the lack of goal agreement in therapy likely left them to retrospectively assess their therapy experience as less impactful than the OQ-45 reported. This idea will be considered further in the discussion section following.

Task Agreement. Except for some of the shortcomings mentioned above and the fact that tasks in therapy did not necessarily all lead to agreed goals, both participants expressed satisfaction and agreement with the therapist in how they conducted therapy. In hindsight however, both participants also commented on some of the shortcomings of certain approaches, with which they no longer seem to agree with.

Therapy sessions for both participants were primarily client-led, which they appreciated. Ashley explained, “I felt like I was kind of leading the direction, which every week, I felt like I had a different thing that I needed to vent...I thought it was pretty good that [the therapist] let me kind of just ... say, whatever, what I was thinking.” In these sessions, Ashley said her therapist would listen in a non-judgmental way, and validate her, which worked well for her. At the same time, Ashley commented on how this approach sometimes led to their sessions getting “off track” and how this seemed to be part of the reason that there was not a “big solution” to her anxiety, because so much time was spent addressing specific situations that she brought up in session.

Breanna’s experience of client-led sessions was very similar. She described it as follows: “I would basically come in and then [my therapist] would just be like, ‘okay, tell

me what happened this week.’ And then I would tell him about what happened that week, what were my main concerns and stressors, and then he would [help] me identify what was going on and that was basically it.” While she acknowledges how this approach led to multiple positive outcomes in her case, she explained the problem was it only worked if she had problems that week to discuss. “Sometimes I’d come in and be like, I had a fine week. And then there was ... we had nothing to talk about.” Here, Breanna brought up how the approach of sessions was very “situation focused” and she was concerned that they were not “getting through these deep issues.” So, considering a client-led approach to sessions, Ashley and Breanna each had some points of task agreement and other aspects where they did not agree with the approach, at least in retrospect.

Both Ashley and Breanna positively commented that they felt their therapist was really listening and sincerely trying to understand. Ashley said, “it felt like [my therapist] was internalizing, really listening.” Breanna shared about how her therapist had her bring her husband in for a session once. Reflecting on the intervention, she said, “I really appreciated that. That [my therapist] was willing to try and understand my situation from multiple angles.”

Another point of task agreement for both participants was their therapists helping them to identify, acknowledge, and accept their feelings and experiences and reframing them in psychological terms. Ashley identified the way that her therapist would reframe things in psychological terms as a sign of greater professionalism. Further, Ashley shared how her therapist helped her talk through her experiences and identify what was going on. She said, “I am acknowledging what is happening with my body because of therapy.” Learning to acknowledge and accept her mental illness was the main benefit Ashley

found in her therapy experience. She said what was beneficial about therapy was “being able to acknowledge what is going on... it’s just a mental illness that won’t go away.” She expounded, “I hate [mental illness] ... I want to get rid of it. But after therapy, I was kind of like, understanding more, and being like, ok, well, [anxiety] has helped me in some ways ... it’s pushed me to ... work a lot.”

For Breanna, talking through her weekly experiences as prompted by her therapist provided her understanding and validation. She shared how her therapist would identify phenomena like compulsive thoughts in her anecdotes and validate or normalize her experiences by explaining how they were common for others with the same mental health struggles. For example, after sharing about some “vivid, insane dreams” she had had and how she couldn’t stop thinking about them, her therapist pointed out to her how her hyper fixation on these thoughts from when she was sleeping was a sign of OCD. Additionally, Breanna spoke positively of how her therapist was able to help her overcome some of her perfectionism and develop a more accepting mindset about things like her grades through acknowledging and accepting in sessions, and “humbled” and grounded her in her mindset.

Grounding was another intervention which both participants noticed and concurred with. Ashley said it was helpful how her therapist was there to “ground [her] and be like, ‘Hey, this is okay, and here are some practical things you can do.’” And grounding was the primary reason Breanna assessed her therapy was beneficial at all. She expressed, “[therapy] was beneficial, because it mainly helps me to kind of bring me down ... bring me down to a reality, and then also be able to understand what was going on in my brain.”

In line with Ashley's expectations of receiving practical strategies from therapy, her therapist gave her materials to read, techniques she could practice, and practical suggestions to employ. The only problem for Ashley was those strategies situational, not principle-based, and improved her understanding but did not lastingly change her behavior. Suggestions were tailored for specific situations she was going through at the time, but now after therapy, as mentioned multiple times already, she has no strategy to apply to anxiety in general. Ashley also described how the materials she read didn't "really soak in" and she often went back to her "normal ways" shortly after applying techniques. Without an understanding of how to apply principles and strategies to various situations, now she finds herself doing "the same as [she] used to do," except for the fact she is now acknowledging what is happening in her body.

Role of Task Agreement in Discrepancy. Whereas both clients expressed initial agreement with the approach of their therapists during sessions, such as client-led discussions, both talked about how those tasks in the end did not lead to the goals they had desired. In a retrospective assessment, each participant could view the shortcomings of some of these tasks, which leaves them less satisfied than they may have been immediately following their sessions. This could account for some of the discrepancy in which they retrospectively assessed their therapy experience less positively.

Discrepancy

At the end of their interviews, the observed discrepancy between their OQ-45 results and their answer to the retrospective survey was explained to the participants and they were asked directly why they thought there was a discrepancy. Both participants

acknowledged they experienced some subtle improvement, but not as much as they had hoped. They each also explained some distinction in how they responded to instruments.

Ashley described that when she completed the OQ-45 following every session, she answered focused on “if the last session was ... helpful, or ... the last week has been better because of therapy,” and she would determine the therapy was helpful because she “felt like [she] was listened to” and her therapist gave her suggestions which she was able to apply that last week. She explained that by the time she took the retrospective survey assessing her overall experience retrospectively, she had a larger perspective on her therapy experience. She explained, “Now looking back, I feel like generally, I didn’t improve. ... maybe it was ... a small, little increase that I could see a lot better when it’s on a weekly basis. But now looking back at that month and a half, I’m like, maybe it is still the same.” In a zoomed-out perspective, the improvements she experienced seemed minimal, and insignificant to her in her overall improvement. It is relevant to note that at this time, Ashley’s OQ-45 results indicated that her symptom levels were relatively close to those at the time of her last session. In the retrospective survey Ashley received an OQ-45 total score of 76, slightly lower than her last score during treatment, at 82, as shown in Table 1 and Table 3.

Addressing the discrepancy, Breanna commented on her response to the retrospective survey in which she had indicated she felt “about the same” after therapy. She explained, “When I had taken that survey, my depression was not good again.” She believed that having struggled with depression for the month leading up to taking the retrospective survey, navigating medications and dosages, and experiencing additional “hormonal challenges” as diagnosed by her doctor at the time “was a huge part that was

affecting [her]” at the time of completing the retrospective survey. Results from the OQ-45 completed in the retrospective survey months after treatment however do not indicate a reliable resurgence of symptoms. Breanna’s OQ-45 total score during the retrospective survey was 70, just ten points above her final score at the end of therapy, and well below the 103 she scored at the time of her intake, as shown in Table 2 and Table 3. When taking the retrospective survey, Breanna thought, “No...I’ve been struggling with depression still, so I don’t think I improved.” However, at the time of the interview several weeks later, she admitted, “I think there were ... little, but still improvements. They weren’t drastic. [but] they’re there, the improvements were there.” So, somewhat deviant from the retrospective survey, as well as the significant prospective outcomes measured by the OQ-45, in the interview she acknowledged that she did not experience as much improvement as she had hoped for, but experienced some improvement, nevertheless.

Discussion

Several themes and impacting factors were observed in the results which complement and inform the literature regarding the discrepancy between ROM and retrospective outcome assessments. These include social support, response shift, frame of reference, the utility of retrospective assessments, goal agreement, and how narrative interviewing can supplement ROM. Each of these will be discussed, followed by a discussion of the implications of the findings of this study for researchers and clinicians.

Social Support

According to interview responses from Ashley and Breanna, social support seemed to play a consequential role in their overall well-being and psychological distress.

The distress they reported to have had towards the beginning of treatment correlated with periods of difficulties in social support, such as transitioning to married life and changing friendship dynamics or adjusting to their marital partner. Symptom reduction later in treatment, as reported by OQ-45 results, correlates with periods in which participants reported to have experienced some improvements in social support, or at least (in the case of Ashley), hopeful expectations for coming improvements to social support.

The hopeful expectations Ashley harbored at the end of her treatment, close to the time she was completing her last OQ-45, were never fulfilled. Ashley reported that when her anticipated social support group crumbled shortly after ending treatment, she experienced a correlated decline in her mental health. Her decline shortly after treatment, largely impacted by her poor social support, likely influenced her retrospective assessment of her treatment outcomes in the retrospective survey sent to her for this study. It should be noted, however, that by the time of taking the retrospective survey, Ashley's scores on the social support scale of the ASC did not warrant a warning signal.

This demonstrates the necessity to consider factors outside of therapy itself when assessing treatment outcomes. Examining these factors and their effect is in essence the purpose of measurements like the ASC (White et al., 2015). As far as the authors of this paper are aware, unfortunately the ASC was not administered to Ashley or Breanna during their treatment and because their ROM was indicating progress, it would not be usual to administer the ASC which is typically given to signal cases. The narrative interviews in this case study augment this measurement and allow for details specific to each client to emerge that may not be directly assessed by the ASC. And studies on the ASC as a feedback tool have found that clients whose "progress goes off-track while in

psychotherapy,” (White et al., 2015, p. 724) or experience “extremely negative deviations in psychological distress and functioning” (Probst et al., 2020, p. 564) seem to have their greatest difficulty with social support and adverse life events, followed by motivation and then therapeutic alliance. As different assessments were administered at different times in the clients’ treatment, as well as months later for retrospective assessments for the current study, social support likely played a critical role in the discrepancy observed.

Response Shift

In addition to the discrepancy between the OQ-45 and the retrospective self-report from the two participants, there is evidence of some response shift for each of the participants. Response shift is not a new or obscure concept (Howard, 1980; Schwartz et al., 2006). Response shift refers to a change in self-report outcomes over time, usually influenced by a change in the insight a client has in perceiving themselves, often as a result of the intervention (Howard, 1980). Response shift could even be considered a subset of placebo effects in that it “describes a specific psychological mechanism by which patients' self-assessed health can change in the absence of known biological and physiological effects” (Wilson, 1999). The mechanism that changes the self-assessment can be a change of self-knowledge (Howard, 1980; Sibthorp et al., 2007). This was evident in the case study done by Ogles et al. (2022), where the client suggested that therapy helped him to be more aware and may have thus increased his self-reporting of symptoms, contributing to a higher OQ-45 score after therapy.

The manifestation of response shift in the present case study carries similarities as well as some nuances with the existing literature. In the case of Ashley and Breanna, their OQ-45 results show a reported drop in symptoms rather than an increase through

heightened self-awareness or self-knowledge. Ashley describes an increase in knowledge or perspective from the time of therapy to her interview months later. Having a broader view in retrospective reflection, she could see a bigger picture to assess that overall she did not feel she improved very much after all.

One response shift for Breanna actually takes place between her initial response to the retrospective survey in which she reported she felt “about the same” after therapy, and her interview, in which she acknowledged some notable improvement over her time in therapy. Breanna admitted her lower assessment during the retrospective survey was impacted by feeling depressed at the time while she was navigating medications.

Frame of Reference

Variability in the clients’ responses may also reflect differences in frame of reference. In his presidential address, Gordon Allport, president of the American Psychological Association (APA) in 1939, talked about frame of reference as any sort of context that significantly influences a person’s perceptions, judgments, feelings, or actions (Allport, 1940). The APA dictionary of psychology defines frame of reference as “the set of assumptions or criteria by which a person or group judges ideas, actions, and experiences” and warns that “frame of reference can often limit or distort perception” (APA, 2023). When completing self-reports and measures, clients have their own frames of references, which may or may not be consistent with the frame of reference of the researchers or developers of the measure. This is why many personality measures provide contexts in their items (e.g., “I pay attention to details *at work*”) which have been shown to improve validity (Lievens et al., 2008; Schmit et al., 1995).

In this case study, Ashley and Breanna had their own criteria by which they judged their experiences in therapy, and how they assessed improvement. For example, Ashley emphasized a desire to increase her self-efficacy to “get [her anxiety] under control” and know what to do when she feels “really overwhelmed.” In fact, she reported that her ability to “apply the things that [her] therapist told [her]” each week, along with feeling “listened to” was her primary frame of reference to “interpret...[herself] getting better” when completing ROM. Breanna talked about symptom reduction, but also a desire to “feel like [her]self” and “enjoy life again.” She reported that experiencing another depressive episode during the time she completed the retrospective survey and retrospectively assessed her improvement created a context that significantly influenced her judgment of the experience and outcomes.

In the case study conducted by Ogles et al. (2022), the client retrospectively reported improvement from therapy because they were able to gain greater self-awareness and insight into issues leading to their distress. However, while Ashley and Breanna likewise reported increased self-awareness and insight, in their frames of reference, that did not consist of an improvement, at very least not to the degree which they had expected or hoped. Whereas a different frame of reference in the study by Ogles et al. (2022) resulted in a discrepancy where the client reported improvement contrary to the deterioration assessed by the OQ-45, this case study presents a reversed example.

The frames of reference of Ashley and Breanna are not entirely consistent with the frame of reference by which the OQ-45 determines improvement in clients, that is symptom reduction. Breanna did focus on symptom reduction in assessment of her improvement, but against the backdrop of past improvements she reported the symptom

reduction she experienced felt “little.” And her frame of reference for improvement was more encompassing than reduction of depressive symptoms. The inconsistency of criteria defining improvement between the measure and the clients’ interviews accounts for some of the discrepancy observed in the respective outcomes, where the participants reported little or no significant improvement despite significant improvement reported by the prospective OQ-45 during treatment.

Retrospective versus Prospective Assessments

Some researchers have raised criticisms of the use of retrospective assessments to determine the effectiveness of psychotherapy. Some of this critique includes the concern that various biases, ranging from demand characteristics to memory distortion, could “contaminate” participants’ responses (Jacobson & Christensen, 1996, p. 1033). Other researchers have found that the presence of psychopathology can further influence recall bias (Ebner-Priemer et al., 2006). Additionally, critics raise the argument that there is often no way to verify the accuracy of retrospective responses (Jacobson & Christensen, 1996). Granted, this multiple case study did demonstrate some inaccuracy or memory distortion of participants’ responses in the retrospective interviews when compared to data received from the counseling center, such as specific factual information including the dates of when the participant started and ended therapy, the exact number of weeks the participant attended sessions, or even the exact number of sessions they attended. However, assessment of overall improvement during psychotherapy is another matter entirely. And one cannot claim that prospective assessments are immune to bias either. In fact, Ashley admitted that when she was completing the OQ-45 during psychotherapy, she determined by her own frame of reference if she had improved or not, and then

answered items on the questionnaire already with the subjective notion that she had improved, potentially contaminating her responses.

Contrary to these critics who posit that prospective assessment is much more reliable than retrospective, some defenders of retrospective measures have found general consistency between prospective and retrospective results when asking clients about their experience in psychotherapy (Howard et al., 2001). And a lack of consistency does not necessarily mean a lack of validity. Several researchers have argued that the personal change clients experience over the course of psychotherapy also changes the way they see themselves--their frame of reference--which will result in a change in the way that clients answer outcome questionnaires, potentially rendering pre- and post-therapy scores incomparable (Sandell & Wilczek, 2016; Roubal et al., 2018). A symptom-based questionnaire (such as the OQ-45) would detect a change in symptoms, but not a change in attitude, which would mean that a pre- and post-therapy measure could be measuring qualitatively different phenomenon, comparing apples to oranges (Roubal et al., 2018). Similarly, a detailed analysis of six cases in a study by Desmet et al. (2021) found pre-to-post comparisons of outcome measures to be misleading.

Conversely, these and other authors have proposed using subjective retrospective assessments measuring the amount of change over psychotherapy as a “direct” measurement of change (see Sandell & Wilczek, 2016; Roubal et al., 2018). This presents multiple advantages, including the client (rather than the researcher) interpreting their own feelings of change, which ensures that the change being measured is what is actually meaningful to the client. Roubal et al. (2018) explain further that “asking clients to assess their change retrospectively can reflect how the psychotherapy achievements have been

integrated into their daily lives (in contrast to a mere comparison of two measurement points).”

The interview responses of the participants in this case study reflect some of the conclusions drawn by these authors. A large reason for the discrepancy between the OQ-45 objective results and the subjective assessments of outcomes by the participants themselves was that the outcome questionnaire did encompass all of what Ashley and Breanna personally considered to be meaningful change. And whereas the prospective OQ-45 results reported a few data points that demonstrated symptom reduction, in retrospect Ashley and Breanna were able to assess with a larger perspective on their overall change and how their “achievements have been [or have not been] integrated into their daily lives.” As the idiom advises, you cannot see the forest for the trees. With an awareness of not only their change of symptoms, but also carrying a change in attitude, the participants were able to assess their overall improvement from psychotherapy on a broader and more integrated scale than prospective assessments. In this way, evidence from this case study confirms existing literature on the advantages of subjective retrospective assessment.

Goal Agreement

Therapeutic alliance, particularly goal and task agreement, play a significant role in the current case study. This is consistent with literature on therapeutic alliance. Meta-analyses on therapeutic alliance show that client-therapist goal consensus and collaboration, or client preference accommodation, are associated with higher psychotherapy outcomes and lower dropout rates (Lingiardi et al., 2005; Swift et al., 2018; Tyron et al., 2019). Unfortunately, multiple studies have found low levels of

convergence of client-therapist goals and tasks (Clemence et al., 2005; Fitzpatrick et al., 2005; Swift & Callahan, 2009; Tryon et al., 2007).

Unfortunately, this study did not inquire therapists of their perspectives on goals and tasks for the treatment of the participants of the study, so it is not possible to determine the actual congruence or incongruence of goals and tasks. However, WAI results from the participants and their own reports in interviews indicate they perceived at least some lack of goal and task agreement with their therapist. Incomplete agreement on tasks was an item both participants addressed when expressing their less-than-full satisfaction with their experience and outcomes from therapy. While neither participant dropped out of therapy, Breanna did indicate that if she had continued at the university counseling services, she would have found a new therapist to work with. It seems much of the lower assessment of outcomes from the retrospective survey and interviews can be attributed to the therapeutic alliance.

Narrative Interviews to Supplement ROM

This study contributes to the pool of research that shows the utility of supplementing ROM with other measures, such as narrative interviews. As demonstrated by several other studies, this multiple case study shows how narrative interviews can provide additional insight, explain successes and failures of psychotherapy, and provide nuances and more complex understanding of clients' experiences in psychotherapy (De Smet et al., 2020; Desmet et al., 2021; Ghelfi, 2021; Hardy et al., 2019; Ogles et al., 2022; Roubal et al., 2018). As stated by Desmet et al. (2021), "the more data one analyses, the more one realizes that outcome and subjectivity can only be grasped by telling a narrative – a story – which describes the complexity of the patients' subjective

experience of the therapy and its effects. A subject's experience of a psychotherapeutic process is a complex story, and psychotherapy research should make this story explicit by describing it, rather than aiming to reduce it to one or a few figures that eventually are fed into statistic machinery" (p. 9). Narrative interviewing allowed for the full complex story of Ashley and Breanna's experiences to be revealed.

Limitations

As a case study the results of this study naturally lack generalizability. In addition to having a limited number of participants, the sample size carries little heterogeneity, as both of the two participants are female, young adult, married college students in similar stages of life. Due to a limited number of sessions allotted to clients at the university counseling center, the therapy experiences under scrutiny for this study were also relatively brief. Unfortunately, the therapists of the participants did not administer the ASC or WAI to their clients in this case, so the only prospective assessment which can be compared against the retrospective assessments in the survey sent to participants is the OQ-45. This study also lacks any input from the therapist perspective for each of the participants, so congruence or incongruence of goals and tasks between the client and therapist could only be deduced through client reports in the narrative interviews. It is also important to note that Ashley did not complete the OQ-45 assessment prior to her last session, so the final OQ-45 results from her, until the retrospective survey, did not include the last week of her therapy experience. Nevertheless, this case study is able to present meaningful insights and data which correlates and contributes to the existing findings in this area of psychotherapy research.

Implications for Researchers

The findings of this double case study build upon those from Ogles et al. (2022), who also investigated a discrepancy between ROM and subjective assessments from a retrospective narrative interview, but in this case examined two participants who subjectively reported less improvement than ROM rather than more. This study also supports conclusions by researchers that narrative approach to outcome can supplement quantitative ROM measures which are primarily oriented around symptom reduction by providing a multidimensional and client-meaningful perspective on outcomes of psychotherapy (De Smet et al., 2020; Desmet et al., 2021; Ghelfi, 2021; Ogles et al., 2022; Roubal et al., 2018). Responses from the participants in this study provide narrative data which support findings on the importance of therapeutic alliance, specifically goal and task agreement. This study additionally highlights the necessity of acknowledging the potential influence of response shift and variable frames of reference on self-report assessments. And assessments such as the ASC and interview questions focused on factors outside of treatment can be instrumental in gaining a broader picture and understanding of outcomes during and after treatment. Researchers may also consider expanding conceptualizations of “good outcomes” beyond reduction of symptoms and incorporate more client-meaningful indicators of positive outcome when assessing client outcomes (De Smet et al., 2020).

As a retrospective case study, these findings also demonstrate the utility of retrospective assessments and how they can provide additional insight and perspective on client outcome. Despite the practicality of pre- and post-treatment assessments to measure outcome, researchers should practice caution when drawing conclusions from

that approach because of the findings of the present and mentioned studies which demonstrate how those assessments may lack completeness and accuracy in telling the true story of clients' experiences and outcomes in psychotherapy. Implications of these findings also entail the possibility of inaccuracy in current estimates of client improvement and deterioration, which are calculated from these limited ROM measures. More research is needed to investigate a comparison of ROM and narrative interviewing perspective on outcome on a broader scale with larger sample sizes. Future research assessing psychotherapy outcomes should include more nuanced and multidimensional perspectives as those provided by narrative interviewing. Researchers may turn to research child and adolescent psychology which has investigated multi-informant data as well as the relevance and meaningfulness of discrepancies (De Los Reyes et al., 2015; De Los Reyes & Epkins, 2023).

Implications for Clinicians

It should be stressed that this study does not in any way discourage the use of ROM to assess client outcomes, rather that they should be supplemented by narrative approaches as well. Strong evidence shows that psychotherapy employing ROM is more effective than treatment without ROM (De Jong, 2021; Lambert et al., 2018). Clinicians and treatment centers not currently using ROM are recommended to implement them in their practice. Those who are already reaping the benefits of ROM are encouraged to consider supplementing their assessments with additional means including narrative approaches to gain a more comprehensive and increasingly accurate perspective on the treatment outcomes of their clients. Clinicians should also ensure they are aware of the

effects that factors outside of treatment can have on outcomes, as illustrated by findings from the ASC and the narrative interviews of this study.

Qualitative analysis of the client interviews indicates some desired outcomes not captured by the OQ-45. For example, Ashley expressed the meaning she discovered in her experience with anxiety as her perspective shifted and she began to feel her anxiety was “not all that bad” and had some utility such as helping motivate her. Another recent study by De Smet et al. (2020) found that client concepts of good outcomes are multidimensional and include “feeling empowered, finding personal balance and encountering ongoing struggle, indicating an ongoing process and variation in experience” (De Smet et al., 2020). It is recommended that clinicians likewise consider broader definitions of “good outcomes” (De Smet et al., 2020).

Findings from qualitative analysis of the interviews also embody several of the conclusions made by Levitt et al. (2016) in their extensive meta-analysis of qualitative studies analyzing clients’ experiences within adult individual psychotherapy. The authors identified five clusters of themes in the research: 1) therapy is a process of change through structuring curiosity and deep engagement in pattern identification and narrative reconstruction, 2) caring, understanding, and accepting therapists allow clients to internalize positive messages and enter the change process of developing self-awareness, 3) professional structure creates credibility and clarity but casts suspicion on care in the therapeutic relationship, 4) therapy progresses as a collaborative effort with discussion of differences, and 5) recognition of the client’s agency allows for responsive interventions that fit the client’s needs. These categories then contain further subthemes (see Levitt et al., 2016). Authors additionally identified a “core category”: being known and cared for

supports clients' ability to agentically recognize obstructive experiential patterns and address unmet vulnerable needs. It is recommended that clinicians read each of the themes and subthemes in the article by Levitt et al. (2016), but that is beyond the scope of this paper and presently only a few with particular correspondence with the findings of this case study will be highlighted.

For example, both Ashley and Breanna demonstrated aspects of Cluster 2, developing greater self-awareness as they internalized messages and insights from their therapist and entered the change process. With the bond aspect of therapeutic alliance, both participants reported their therapists were caring, understanding, and accepting; this is likely what made progress and self-awareness possible. Likewise, both described how analysis of their thoughts and behaviors helped them gain new insights into themselves (see Levitt et al., 2016, category 1.4). A theme from Levitt et al. (2016) that appears lacking in the cases of Ashley and Breanna is collaborative effort with discussion of differences (cluster 4), such as explicitly negotiating client-therapist roles when setting the therapy agenda (cluster 4.1), or the therapist demonstrating responsiveness by checking on the client's goals, the fit of the process, and the content of the sessions (cluster 5.2). Doing so would have likely increased the task and goal agreement, and thus improved alliance. Likewise, clinicians should bear in mind the themes and findings from this study and other studies such as Levitt et al. (2016) when practicing psychotherapy in order to best address the needs and desires of their clients.

Conclusion

Perhaps most importantly, this case study exemplifies the complexity of client outcomes in psychotherapy research and practice. It is because of the multi-faceted and idiosyncratic experiences and outcomes of each client that a narrative approach becomes particularly fruitful in understanding those experiences and outcomes. This study shows how retrospective narrative interviewing can supplement quantitative data from ROM to assess and research treatment outcomes. It further highlights the necessity to consider variables such as response shift and frame of reference when measuring outcomes and how the most practical approaches for assessment may not always be the most accurate or comprehensive. Bearing in mind the findings of this case study--along with the existing research to which its findings contribute--in ongoing research and practice will assist researchers and practitioners in better understanding the whole story of client experiences and outcomes in psychotherapy.

References

- Allport, G. W. (1940). The psychologist's frame of reference. *Psychological Bulletin*, 37(1), 1.
- APA. (2023). *APA Dictionary of Psychology*. American Psychological Association.
<https://dictionary.apa.org/frame-of-reference>
- Castonguay, L., Barkham, M., Lutz, W., & McAleavey, A. (2013). Practice-oriented research: Approaches and applications. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change (6th ed)*, pp. 85–133). Wiley.
- Chui, H., Chong, E. S. K., Atzil-Slonim, D., Sahin, Z., Solomonov, N., Minges, M. V., Kuprian, N., & Barber, J. P. (2021). Beyond symptom reduction: Development and validation of the Complementary Measure of Psychotherapy Outcome (COMPO). *Journal of Counseling Psychology*, 68(5), 550–561.
- Clemence, A.J., Hilsenroth, M.J., Ackerman, S.J., Strassle, C.G., & Handler, L. (2005). Facets of the therapeutic alliance and perceived progress in psychotherapy: Relationship between patient and therapist perspectives. *Clinical Psychology and Psychotherapy*, 12, 443–454.
- De Jong, K., Conjin, J. M., Gallagher, R. A. V., Reshetnikova, A. S., Heij, M., & Lutz, M. C. (2021). Using progress feedback to improve outcomes and reduce drop-out, treatment duration, and deterioration: A multilevel meta-analysis. *Clinical Psychology Review*, 85, 102002.
- De Los Reyes, A., & Epkins, C. C. (2023). Introduction to the special issue. A dozen years of demonstrating that informant discrepancies are more than measurement error:

- Toward guidelines for integrating data from multi-informant assessments of youth mental health. *Journal of Clinical Child & Adolescent Psychology*, 52(1), 1-18.
- De Los Reyes, A., Augenstein, T. M., Wang, M., Thomas, S. A., Drabick, D. A. G., Burgers, D. E., & Rabinowitz, J. (2015). The validity of the multi-informant approach to assessing child and adolescent mental health. *Psychological Bulletin*, 141(4), 858–900. <https://doi.org/10.1037/a0038498>
- De Smet, M. M., Meganck, R., De Geest, R., Norman, U. A., Truijens, F., & Desmet, M. (2020). What “good outcome” means to patients: Understanding recovery and improvement in psychotherapy for major depression from a mixed-methods perspective. *Journal of Counseling Psychology*, 67(1), 25–39.
- Desmet, M., Van Nieuwenhove, K., De Smet, M., Meganck, R., Deeren, B., Van Huele, I., ... & Schiepek, G. (2021). What too strict a method obscures about the validity of outcome measures. *Psychotherapy Research*, 31(7), 882-894.
- Ebner-Priemer, U. W., Kuo, J., Welch, S. S., Thielgen, T., Witte, S., Bohus, M., & Linehan, M. M. (2006). A valence-dependent group-specific recall bias of retrospective self-reports: A study of borderline personality disorder in everyday life. *The Journal of nervous and mental disease*, 194(10), 774-779.
- Fitzpatrick, M.R., Iwakabe, S., & Stalikas, A. (2005). Perspective divergence in the working alliance. *Psychotherapy Research*, 15, 69–79.
- Flückiger, C., Del Re, A. C., Wampold, B. E., & Horvath, A. O. (2018). The alliance in adult psychotherapy: A meta-analytic synthesis. *Psychotherapy*, 55(4), 316-340.

- Georgaca, E. (2021). Is divergence in outcome evaluation paradoxical? Towards validating multiple perspectives on psychotherapy practice. *European Journal of Psychotherapy & Counselling*, 23(2), 237-248.
- Ghelfi, E. A. (2021). *When Clients Who Got Worse Believe They Got Better: A Qualitative Analysis of OQ-Deteriorators Reporting Improvement In Therapy* (Doctoral dissertation, Brigham Young University).
- Hanson, W. E., Curry, K. T., & Bandalos, D. L. (2002). Reliability generalization of working alliance inventory scale scores. *Educational and Psychological measurement*, 62(4), 659-673.
- Hardy, G. E., Bishop-Edwards, L., Chambers, E., Connell, J., Dent-Brown, K., Kothari, G., ... & Parry, G. D. (2019). Risk factors for negative experiences during psychotherapy. *Psychotherapy Research*, 29(3), 403-414.
- Hill, C. E., & Knox, S. (2021). *Essentials of Consensual Qualitative Research*. American Psychological Association.
- Horvath, A. O., Del Re, A. C., Flückiger, C., & Symonds, D. (2011). Alliance in individual psychotherapy. *Psychotherapy*, 48(1), 9-16.
- Horvath, A. O., & Greenberg, L. S. (1989). Development and validation of the Working Alliance Inventory. *Journal of counseling psychology*, 36(2), 223-233.
- Howard, G. S. (1980). Response-shift bias: A problem in evaluating interventions with pre/post self-reports. *Evaluation review*, 4(1), 93-106.
- Howard, K. I., Moras, K., Brill, P. L., Martinovich, Z., & Lutz, W. (1996). Evaluation of psychotherapy: Efficacy, effectiveness, and patient progress. *American psychologist*, 51(10), 1059.

- Howard, K. I., Krause, M. S., Caburnay, C. A., Noel, S. B., & Saunders, S. M. (2001). Syzygy, science, and psychotherapy: The Consumer Reports study. *Journal of Clinical Psychology, 57*(7), 865-874.
- Jacobson, N. S., & Christensen, A. (1996). Studying the effectiveness of psychotherapy: How well can clinical trials do the job?. *American Psychologist, 51*(10), 1031-1039.
- Jacobson, N. S., & Truax, P. (1991). Clinical significance: A statistical approach to defining meaningful change in psychotherapy research. *Journal of Consulting and Clinical Psychology, 59*, 12–19.
- Lambert, M. J. (2015). Progress feedback and the OQ-system: The past and the future. *Psychotherapy, 52*(4), 381.
- Lambert, M. J., Whipple, J. L., & Kleinstäuber, M. (2018). Collecting and delivering progress feedback: A meta-analysis of routine outcome monitoring. *Psychotherapy, 55*(4), 520–537.
- Leibert, T. W., Powell, R. N., & Fonseca, F. D. (2020). Client descriptions of outcomes compared with quantitative data: A mixed-methods investigation of a quantitative outcome measure. *Counselling and Psychotherapy Research, 20*(1), 9-18.
- Levitt, H. M., Pomerville, A., & Surace, F. I. (2016). A qualitative meta-analysis examining clients' experiences of psychotherapy: a new agenda. *Psychological bulletin, 142*(8), 801-830.
- Lievens, F., De Corte, W., & Schollaert, E. (2008). A closer look at the frame-of-reference effect in personality scale scores and validity. *Journal of Applied Psychology, 93*(2), 268.

- Lingiardi, V., Filippucci, L., & Baiocco, R. (2005). Therapeutic alliance evaluation in personality disorders psychotherapy. *Psychotherapy Research*, 15(1-2), 45-53.
- Lutz, W., de Jong, K., Rubel, J. A., & Delgadillo, J. (2021). Measuring, predicting, and tracking change in psychotherapy. In M. Barkham, W. Lutz, & L. G. Castonguay (Eds.), *Bergin and Garfield's Handbook of Psychotherapy and Behavior Change* (7th ed., pp. 89-134). Wiley.
- Martin, D. J., Garske, J. P., & Davis, M. K. (2000). Relation of the therapeutic alliance with outcome and other variables: a meta-analytic review. *Journal of consulting and clinical psychology*, 68(3), 438-450.
- Mellor-Clark, J., Cross, S., Macdonald, J., & Skjulsvik, T. (2016). Leading horses to water: Lessons from a decade of helping psychological therapy services use routine outcome measurement to improve practice. *Administration and Policy in Mental Health*, 43(3), 279–285.
- Norcross, J. C., & Wampold, B. E. (2011). Evidence-based therapy relationships: research conclusions and clinical practices. *Psychotherapy*, 48, 98–102.
- Ogles, B. M., Goates-Jones, M. K., & Erekson, D. M. (2022). Treatment success or failure? Using a narrative interview to supplement ROM. *Journal of Clinical Psychology*, 78(10), 1986-2001.
- Probst, T., Kleinstäuber, M., Lambert, M. J., Tritt, K., Pieh, C., Loew, T. H., ... & Delgadillo, J. (2020). Why are some cases not on track? An item analysis of the Assessment for Signal Cases during inpatient psychotherapy. *Clinical psychology & psychotherapy*, 27(4), 559-566.

- Roubal, J., Rihacek, T., Cevelic, M., Hytych, R., & Holub, D. (2018). Retrospective Client Interviewing Can Inform Clinicians' Practice and Complement Routine Outcome Monitoring/Las Entrevistas Retrospectivas a los Clientes Pueden Informar Acerca de la Práctica de los Clínicos y Complementar el Monitoreo de Rutina de los Resultados. *Revista Argentina de Clinica Psicológica*, 27(II), 294
- Sandell, R., & Wilczek, A. (2016). Another way to think about psychological change: Experiential vs. incremental. *European Journal of Psychotherapy & Counselling*, 18(3), 228-251.
- Schwartz, C.E., Bode, R., Repucci, N., Becker, J., Sprangers, M. A. G., Fayers, P. M. (2006). The clinical significance of adaptation to changing health: A meta-analysis of response shift. *Quality of Life Research*, 15, 1533-1550.
- Schmit, M. J., Ryan, A. M., Stierwalt, S. L., & Powell, A. B. (1995). Frame-of-reference effects on personality scale scores and criterion-related validity. *Journal of Applied Psychology*, 80(5), 607.
- Sibthorp, J., Paisley, K., Gookin, J., & Ward, P. (2007) Addressing Response-shift Bias: Retrospective Pretests in Recreation Research and Evaluation. *Journal of Leisure Research*, 39(2), 295-315.
- Solstad, S. M., Kleiven, G. S., Castonguay, L. G., & Moltu, C. (2021). Clinical dilemmas of routine outcome monitoring and clinical feedback: A qualitative study of patient experiences. *Psychotherapy Research*, 31(2), 200–210.
- Swift, J., & Callahan, J. (2009). Early psychotherapy processes: An examination of client and trainee clinician perspective convergence. *Clinical Psychology & Psychotherapy: An International Journal of Theory & Practice*, 16(3), 228-236.

- Swift, J. K., Callahan, J. L., Cooper, M., & Parkin, S. R. (2018). The impact of accommodating client preference in psychotherapy: A meta-analysis. *Journal of clinical psychology, 74*(11), 1924-1937.
- Top, N. Snell, A., Hansen, P., & Goates-Jones, M. (2018, September). Did I get better? Clients perceptions of psychotherapy outcomes. Paper presented at the meeting of The North American Society for Psychotherapy Research, Snowbird, UT.
- Tryon, G. S., Birch, S. E., & Verkuilen, J. (2019). Goal consensus and collaboration. In J. C. Norcross & M. J. Lambert (Eds.), *Psychotherapy relationships that work: Evidence-based therapist contributions* (pp. 167–204). Oxford University Press.
- Tryon, G.S., Blackwell, S.C., & Hammel, E.F. (2007). A meta-analytic examination of client-therapist perspectives of the working alliance. *Psychotherapy Research, 17*, 629–642.
- White, M. M., Lambert, M. J., Ogles, B. M., Mclaughlin, S. B., Bailey, R. J., & Tingey, K. M. (2015). Using the Assessment for Signal Clients as a feedback tool for reducing treatment failure. *Psychotherapy Research, 25*(6), 724-734.
- Wilson, I. B. (1999). Clinical understanding and clinical implications of response shift. *Social science & medicine, 48*(11), 1577-1588.

APPENDIX A

Table 1

ROM Data for Participant 1 “Ashley” (OQ-45 Total)

Days since intake	OQ-45 Total Score
0	107
13	69
20	82
34	-

Note. Ashley did not complete the OQ-45 prior to her fourth session, so the last outcome measurement used in this research was from her third session.

Table 2

ROM Data for Participant 2 “Breanna” (OQ-45 Total)

Days since intake	OQ-45 Total Score
1	103
6	89
13	75
20	77
27	-
34	60

Note. Breanna did not complete the OQ-45 prior to her fifth session but did prior to her sixth and final session.

Table 3*Retrospective Survey Assessments*

Assessment	Assessment Scores	
	Participant 1 “Ashley”	Participant 2 “Breanna”
OQ-45 Total Score	76	70
ASC		
Motivation	28	43
Social Support	37	39
Live Events	22	39
Therapeutic Alliance	51	52
WAI Total Score	203 (M = 5.64)	171 (M = 4.75)
Goal Agreement	65 (M = 5.42)	47 (M = 3.92)
Task Agreement	66 (M = 5.50)	52 (M = 4.33)
Bond	72 (M = 6.00)	67 (M = 5.58)

Note. The following assessments were administered to participants as part of the retrospective survey: Outcome Questionnaire - 45 (OQ-45), Assessment for Signal Clients (ASC), and Working Alliance Inventory (WAI). Means of items are given for the WAI.

Figure 1

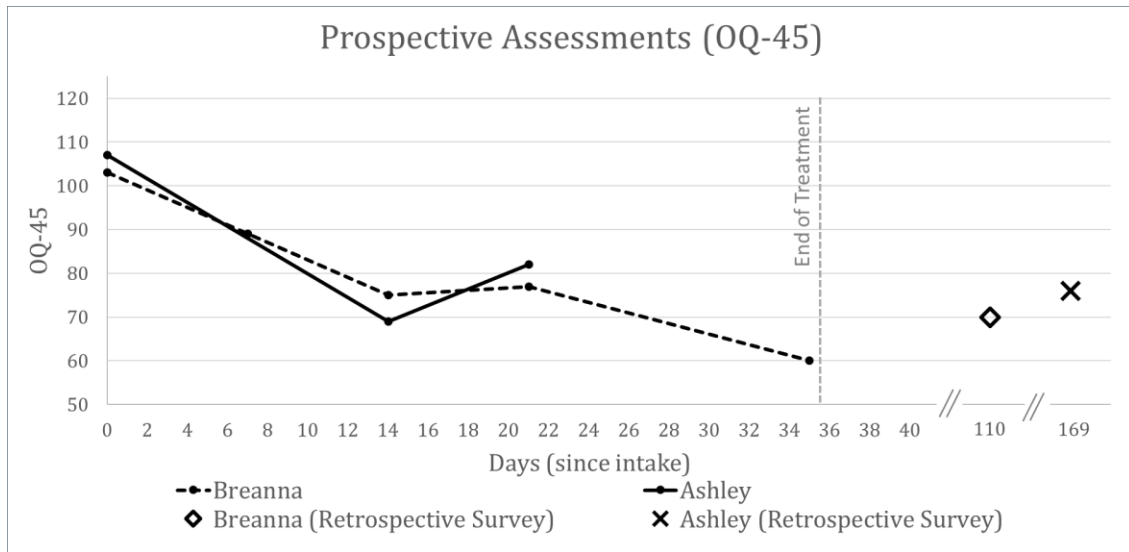


Figure 1. ROM data (OQ-45) from both participants as well as OQ-45 scores at the time of taking the retrospective survey.

APPENDIX B

Semi-Structured Interview Questions

1. What mental health concerns brought you to therapy?
2. Tell me about what was happening in your life when you started therapy. (Make sure to cover each of the following domains.)
 - a. With mental health
 - b. In family relationships
 - c. In social relationships
 - d. With school
 - e. With physical health
 - f. With your spirituality
3. Tell me about your social support network at the time you started therapy.
4. How motivated were you to engage in therapy and make it work?
 - a. What factors influenced your level of motivation?
5. How did you expect therapy to help with your concerns?
6. Describe how your therapist did therapy.
7. Describe your relationship with your therapist.
 - a. Tell me about some specific interactions that stood out to you.
 - b. Was there ever a time where you felt like your relationship with the therapist was strained? If so, tell me more about what happened.
8. Tell me about your experience in therapy.
 - a. What emotions did you experience in therapy?

- b. Did you feel you changed at all in the course of therapy? If so, in what ways?
- 9. Did anything else happen in therapy that was significant?
- 10. Describe any significant life events that occurred while you were in therapy?
 - a. Helpful for progress.
 - b. Made it more difficult to progress.
- 11. Tell me about your social support network during therapy and the degree to which it was helpful or not.
- 12. If it was beneficial, why was therapy beneficial to you?
- 13. What, if anything, did you learn about yourself?
 - a. How did you learn this about yourself?
- 14. How, if at all, did therapy fail to meet your needs?
 - a. How could the therapy have met your needs better?
- 15. What was going on in your life when you ended therapy?
 - a. With mental health
 - b. In family relationships
 - c. In social relationships
 - d. With school
 - e. With physical health
 - f. With your spirituality
- 16. Tell me about your social support network at the time you ended therapy.
- 17. At the beginning of your therapy sessions at CAPS, you took a questionnaire that measured distress. Your scores over time suggested that you got better (had more

distress) during your time in therapy. But when we asked you about your outcome, you said that you stayed the same or got worse in your time in therapy. Why do you think there is a discrepancy?