

Sudden Gains and Sudden Losses in the Clients of a "Supershrink": 10 Case Studies

BRIAN P. HANSEN,^{a,c} MICHAEL J. LAMBERT,^{a,c} & ERIGONI N. VLASS^b

^a Department of Psychology, Brigham Young University, Provo, Utah

^b Private Practice, Sydney, Australia

^c Correspondence regarding this article should be addressed to Michael J. Lambert, 272 Taylor Building, Provo, UT.

Email: Michael.lambert@byu.edu

ABSTRACT

Sudden gain or sudden loss in psychotherapy is a statistically exceptional decrease or increase, respectively, in a client's symptoms and distress between two treatment sessions. In psychotherapy research, such sudden gains have been found to be strong predictors of outcome at termination and follow-up. To obtain further in-depth knowledge of the nature and process of sudden gains, this article presents qualitative and quantitative case studies of the clients of a clinical psychologist who is a private practitioner, Erigoni Vlass (the third author). Vlass's caseload presented numerous examples of this phenomenon—she had a sudden-gain base rate over five times higher than the established rate for similar types of clients (and a sudden-loss rate one third less than expected)—classifying her as a "supershrink" (Okiishi, Lambert, Nielsen, & Ogles, 2003). Specifically, a randomized sample of five of Vlass's sudden-gain clients and five of her sudden-loss clients were selected and their results compared with quantitative and qualitative data collected at two-year-plus follow-up. The quantitative results indicated, consistent with previous research, that the sudden-gains clients made dramatic improvements in reducing distress and increasing functioning, while the sudden-loss clients showed little such improvement. Also, a statistically significant higher overall working alliance was found in the sudden-gain as compared to the sudden-loss clients. The qualitative results supported the quantitative results, providing rich, narrative details of how the clients experienced the process and impact of the therapy. The article concludes with a discussion of the distinctive aspects of the results, including the role of the therapist as an outcome variable; the uneven rate of change reflected in the sudden gain/sudden loss phenomena; and the ability of a supershrink therapist like Vlass to achieve dramatically positive results—as measured over two years after the end of therapy—in an average of little more than four therapy sessions.

Key words: sudden gains, rapid response; rapid responders; therapy outcome; working alliance; off-track; sudden loss; deteriorators; therapist factors; satisfaction; interpretative phenomenological analysis; mixed methods; supershrink; outcome questionnaire (OQ-45); phenomenology; measuring change; case studies; clinical case studies

1. CASE CONTEXT AND METHOD

Introduction

The current study used pluralistic case-based methods to explore a phenomenon that was discovered through large-scale psychotherapy outcome studies, that of dramatic and sudden treatment response. Specifically, a sudden gain or sudden setback in psychotherapy is defined as a statistically exceptional decrease or increase, respectively, in a client's symptoms between two treatment sessions. During the last twenty years, a subset of researchers began focusing on the timing and sequencing of patient changes in psychotherapy instead of merely measuring pre- to post-therapy outcomes. Some have observed that an individual's recovery path in therapy is likely to differ significantly from the mean change trajectory (Ilardi & Craighead, 1994; Tang & DeRubeis, 1999a). In other words, similar disorders, similar clients, and similar psychotherapies can all produce vastly different patterns of change from one client to another. An often observed phenomenon that takes place within this wide variation of uniquely individual responses to therapy is that of sudden and rapid improvement. This pattern of change is profoundly different when compared to the small, incremental, session-by-session changes traditionally assumed to take place in psychotherapy.

Clarification of Terminology

Despite the presence of this frequently observed phenomenon, there is currently a significant lack of agreement within the discipline when it comes to operationally defining this type of treatment response. Various terms to describe the phenomenon have been used synonymously, such as "sudden gains," "early gains," and "rapid response." Fennel and Teasdale (1987) were two of the first researchers to study this pattern of change while observing different change responses to psychoactive medications, and they utilized a median split to determine dramatic early response. Guy (2000) measured progress from a single point in therapy in relation to the client's initial distress level. Others, such as Stewart et al. (1998) based their definition of rapid response on a therapist's rating that the client had little or no psychopathology by the first or second session of treatment. Two other studies, headed by Beckham (1989) and Renaud, Axelson, and Birmaher (1999), believed 50% improvement over two sessions to be an adequate measure of rapid response. Other terms have been used to describe similar change trajectories in response to psychotherapy, such as "large sudden improvements" (Gaynor et al., 2003), "rapid early response" (Haas, Hill, Lambert, & Morrell, 2002), and "early sudden gains" (Stiles et al., 2003).

In the current study, we utilized Finch, Lambert, and Schaalje's (2001) statistical definition of sudden gains in terms of the most extreme 10% of client sessions. This method will be described in more detail below.

Frequency and Occurrence of Sudden Gains

Aside from the discipline's use of various terms and definitions of this phenomenon, different studies also report varying frequencies of this occurrence. Tang and DeRubeis (1999b) found that 39% of clients met their criteria for sudden gains by the end of treatment. They also

observed that of those who experienced sudden gains, 79% also displayed sub-clinical symptomology by the completion of treatment, as compared to only 41% in the contrast group. Other researchers, using similar criteria to Tang and DeRubeis (Gaynor et al., 2003; Hardy et al., 2005; Hofmann, Schulz, Meuret, Moscovitch, & Suvak, 2006; Stiles et al., 2003; Tang, DeRubeis, Beberman, & Pham, 2005; Tang, Luborsky, & Andrusyna, 2002; Vittengl, Clark, & Jarrett, 2005) demonstrated similar results. Gaynor and colleagues (2003) found that 50% of treated clients met criteria for having experienced sudden gains. Stiles and colleagues (2003) found that 17% of treated clients had experienced sudden gains. Several studies have discovered the trend that approximately 50% of the total change during the course of therapy takes place during the period of sudden gains (Gaynor et al., 2003; Hardy et al., 2005; Hofmann et al., 2006; Stiles et al., 2003; Tang & DeRubeis, 1999b; Tang et al., 2005; Tang, DeRubeis, Hollon, Amsterdam, & Shelton, 2007; Tang et al., 2002; Vittengl et al., 2005). With the exception of Stiles and colleagues' 2003 study, the amount of change experienced during sudden gain periods was typically between 50% and 65% of total change. Multiple studies also showed that individuals who experienced sudden gains tended to maintain their dramatic treatment responses when measured during follow-up time periods (Gaynor et al., 2003; Hardy et al., 2005; Haas et al., 2002; Stiles et al., 2003; Tang & DeRubeis, 1999b; Tang et al., 2007).

Contrary to the discipline's traditional beliefs regarding the timing, necessary dosage, and response to psychotherapy, the phenomenon of sudden gains challenges many of our assumptions about what happens during just a few sessions of psychotherapy that can bring about such lasting change (see Stiles et al., 2003). The finding of substantial instances in which sudden change takes place challenges the belief of many in the field that clients' responses to psychotherapy are linear, gradual, and similar among themselves. The untested assertions inherent in "evidence-based treatments," which typically have fixed session limits and which assume that the entirety of the protocol must be implemented in order for change to take place, run contrary to the findings that individual clients require vastly different dosages of therapy and often respond to therapy much more quickly than would be expected (Pham, 2005; Stiles et al., 2003).

Hypotheses Regarding Mechanisms of Sudden Gains

Although the current literature contains very few studies that have empirically examined the causes of rapid response or sudden gains, many have hypothesized causative factors (see Pham, 2005). Illardi and Craighead (1999) proposed that rapid and early response to therapy may be best explained by common factors rather than theory-specific interventions, because in these instances change occurs before the bulk of the therapeutic work has been accomplished (see also Rachman, 1999). Tang and DeRubeis (1999a, 1999b), who are strong supporters of CBT, argued the opposite position that specific cognitive techniques could account for rapid decreases in symptomology. Other authors (Orlinsky, Ronnestad, & Willutzski, 2004) suggested that a particularly good fit between the client's and therapist's predilections may lead to rapid response in therapy, while Finch et al. (2001) suggested that rapid response may be due to a "flight into health." Other explanations offered by these authors included the possibility of medications beginning to work, or significant life events resolving for the client outside of the therapeutic encounter.

The "Supershrink" Phenomenon, Highlighting the Role of the Therapist Variable

Forty years ago Ricks (1974) described an exceptional therapist whom the author called a "supershrink," because in working with highly disturbed adolescents, he demonstrated exceptional outcomes when the boys were later examined as adults. In contrast, Bergin and Suinn (1975) labeled another therapist in the same study a "pseudoshrink," because the boys treated by this therapist had adult adjustment that was distressingly poor. While in the decades since there has been much more focus in research on the role of psychotherapy method rather than of the individual psychotherapist, some investigations of the therapist variable have been conducted.

For example, Orlinsky, Grawe, and Parks's (1994) review of 2,000 process-outcome studies found that the following therapist factors were reliably related to positive changes: therapist credibility, skill, empathic understanding, and affirmation of the client. They also found that active engagement with the client's concerns typically resulted in better outcomes. In particular, they noticed that therapists who direct the client's attention to the client's own personal internal experiences are more likely to have successful outcomes.

Dans, Bergin, and Garfield (2004) clarified these findings by noting that technique is not irrelevant. However, these authors noted that a modality's power for change is always limited in comparison to the personal influences of the therapist. They found that better outcomes were associated with a strong therapeutic relationship, creative approaches to a client's problems, as well as giving a credible rationale and ritual that matched her or his symptom presentation. Beutler and colleagues (2004) commented that viewing common factors and specific ingredients as mutually exclusive or distinct may lead to a more limited picture of the actual change mechanisms inherent in therapy.

Wampold, Anh, and Coleman (2001) noted that the average therapist effects can account for between 9 and 49% of variance in change scores. They also noted that the variance between therapists is often greater than the variance between different treatment modalities, a finding that warrants further exploration of therapist variables.

Finally, in a detailed empirical study, Okiishi et al. (2003) analyzed data collected on 1,841 clients seen by 91 therapists over a 2.5 year period in a University Counseling Center. Hierarchical linear modeling was used to compare individual therapists on speed of change and overall outcome, revealing considerable variation, that is, a clear statistical rationale for the supershrink versus pseudoshrink distinction. Specifically, they found that:

the therapists whose clients showed the fastest rate of improvement had an average rate of change 10 times greater than the mean for the sample. The therapists whose clients showed the slowest rate of improvement actually showed an average increase in symptoms among their clients. (p. 361)

Design of the Study

In light of the above, the goal of the present study was to simultaneously investigate the nature and process of two important phenomena in psychotherapy research: sudden gains versus sudden losses between sessions and the role of the therapist variable, specifically the process by which one supershrink achieved her results.

Method

Defining, Identifying, and Contacting "Blue" and "Red" Cases

Following a professional presentation on the Outcome Questionnaire (OQ-45; Lambert, Kahler, Harmon, Schimokawa, & White, 2011), the second author (MJL) came into contact with Erigoni Vlass (the third author), a psychotherapist from a clinic in Sydney, Australia who is a registered clinical psychologist. (Vlass will hereafter be referred to as "Eri," since that is the name she has her clients call her.) Eri questioned him about the typical treatment response curves as captured by the OQ-45 since she administered this questionnaire before every therapy session. MJL described a study by Finch et al. (2001) in which over 11,000 outpatient cases with OQ-45s collected at the beginning of every session were analyzed, and then recovery was modeled at every beginning level of disturbance at each session of therapy, identifying the 10% of clients who were responding most positively and the 10% who responded most negatively between sequential sessions. After examining Eri's full year of clients from 2009 to 2010 ($N = 248$), 85 were found to have completed three or more sessions of therapy. The Finch et al. (2001) models were applied to the OQ-45 scores of the 85 clients, and 43 (51%) were found to have experienced sudden gains, and 6 (7%) were found to have experienced sudden losses. Thus Eri had over five times the expected rate of sudden gains in her caseload, and about a third less of the expected rate of sudden losses—in sum, her results for sudden gains and sudden losses were statistically exceptional and she could be characterized as a "supershrink."

The first author (B.P.H) gained access to Eri's entire caseload of 85 clients. Five sudden-gain cases (hereafter referred to as "Blue" cases) were randomly selected from the 43 total sudden-gain cases, and 5 sudden-loss cases were randomly selected from the 6 total sudden-loss cases. The end-state at termination was not taken into account; in other words, we selected for study individuals who had either flagged Blue or Red for their sudden gains or sudden losses only.

Every individual who was randomly selected consented, with the exception of one who had moved off of the continent. Clients were approached by Eri roughly two years or so after they terminated treatment (for the specific length of time between the last therapy session and the follow-up session for each client, see Table 1). She called these 10 previous clients to invite them personally to participate in the study. She asked if they would complete some forms and an interview as she was hoping to write-up his/her case for publication. She explained the rationale behind the study in a non-scripted manner, stating that it was her intent to find out what each client's experience was like in relation to how they rated themselves on measures of mental health functioning. In particular, she told them that she would be looking at changes they made in therapy, specifically identifying what was most helpful, and asking the clients to what they

might attribute their changes in distress. The accompanying risks, potential benefits, purposes of the study, as well as confidentiality were carefully outlined before the study began to ensure that clients were protected. Names, places, and other identifying details were changed to maintain confidentiality. After the feasibility of the study was ascertained, the first two authors (BPH and MJL) submitted a prospectus to Brigham Young University's institutional review board (IRB).

Eri sent consenting participants two documents in addition to the battery of questionnaires: the first was the formal Consent for Research Participation document. Each client was assigned a pseudonym to replace his or her actual name in order to protect confidentiality. The second form contained directions on how to fill out the battery of questionnaires, indicating which assessments were to be filled out first. The patients received these measures in a postage prepaid envelope addressed to Erigoni Vlass. After Eri compiled the assessments, she sent the material to the first two authors for data analysis.

Eri as a Supershrink in Terms of Her Overall Caseload

It should be noted that Eri can also be defined as a supershrink in terms of her overall caseload. Table 2 presents the pre and post OQ-45 scores of her entire yearly caseload of 85 clients, divided into three categories of outcome based on Lambert, Hansen, and Finch's (2001) analysis of a national sample of 10,000 outpatient clients who completed the OQ-45 throughout therapy. Specifically, Lambert et al. (2001) divided the clients into groups as follows: those with outcomes in the top 10% of treatment response; those in the middle 80% of treatment response; and those in the bottom 10% of treatment response. As can be seen, 43 (51%) of Eri's clients were in the top 10% of treatment response, showing statistically significant improvement and crossing the clinical cutoff point at termination; 36 (42%) were in the middle 80% of treatment response, showing statistically significant improvement and ending up just above the clinical cutoff point; and 6 (7%) were in the bottom 10% of treatment response, showing some deterioration at termination, although this was not significant. In sum, Eri's supershrink status is reflected by the fact that her caseload had over 4.3 times the number of clients expected in the top 10% of response, and only 0.70 times the number of clients expected in the bottom 10% of response.

Assessment Measures Administered at Two-Year-Plus Follow-Up

The outcome of treatment was quantitatively assessed through scores on two measures: the OQ-45 and the Consumer Report Satisfaction Survey (CRSS-4), to obtain different perspectives on the measurement of change. (Note that the OQ-45 was administered at the beginning of every therapy session, so change from pre to follow-up could be calculated.) The CRSS-4 asks for a retrospective view of change during therapy.

The outcome of treatment was qualitatively assessed through personal narratives by clients on a semi-structured Client Change Interview Protocol (CCIP).

In light of previous research (e.g., Wampold, 2001) showing that the therapeutic alliance is correlated positively with outcome, each client completed a retrospective view on the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989).

Details on the Specific Measures

Outcome Questionnaire 45 (OQ-45). The OQ-45 is a measure of mental health functioning, which has been found to have adequate psychometric properties (Lambert et al., 2011). For example, the summary score has shown a three-week test-retest reliability of .84, with an internal consistency of .93. The OQ-45 has also demonstrated adequate concurrent validity. The measure correlates at .63 with the Inventory of Interpersonal Problems, .62 with the Beck Depression Inventory, .64 with the State Anxiety Scale of State Trait Anxiety Inventory (STAI), .72 with the General Severity Index of the Symptom Checklist-90, .88 with the Zung Self-Rating Depression Scale, and .80 with the Trait Anxiety scale of the STAI (Lambert et al., 2011). The OQ-45 is able to detect true changes in psychopathology, in that multiple items change when individuals receive treatment, and these items tend to remain constant without treatment (Vermeersch, Lambert, & Burlingame, 2000).

Consumer Reports Satisfaction Survey (CRSS-4). *Consumer Reports* magazine sent out the CRSS-4, a self-report outcome and satisfaction questionnaire, in their 1994 review of psychotherapy outcomes in order to measure their readers' satisfaction with therapy and also pre-therapy and post-therapy functioning in relation to psychotherapy (Seligman, 1995). The questions of the CRSS-4 are presented in Table 3.

Nielsen et al. (2004) administered the CRSS-4 in combination with the OQ-45 in a follow-up study of counseling center clients. They found that the CRSS-4's rating of pre-therapy distress, rating of emotion at follow up, and rating of perceived changes were correlated significantly with OQ-45 scores. The CRSS-4 scores did tend to overestimate the amount of change compared with the OQ-45. The scores on students' CRSS-4 correlated with first OQ-45 at .52, follow-up OQ-45 at .65, and total change scores at .57, respectively. CRSS-4 ratings of distress and symptomatic change were also correlated with changes measured by the Beck Depression Inventory with the same strength as the OQ-45.

Working Alliance Inventory (WAI). The Working Alliance Inventory (WAI; Horvath & Greenberg, 1989) is a self-report instrument that is used in measuring the strength and quality of the relationship between client and therapist. It has 36 items scored on a 7-point Likert scale, divided between three subscales: Goals, measuring how well the therapist and client agree on the therapeutic goals; Tasks, measuring the degree of agreement between therapist and client on the tasks of therapy; and Bond, measuring the strength of a client and therapist's mutual trust and acceptance of one another. Horvath (1994) reports the subscales' internal consistency estimates as ranging between .87 to .93. A meta-analysis (Horvath, Del Re, Flückiger, & Symonds, 2011) found that the WAI demonstrated a clinically significant, albeit moderate ($r = .28$), association with various measures of therapeutic outcome.

Client Change Interview Protocol (CCIP). The CCIP is a structured interview protocol. The measure entails open-ended questions that prompt patients to describe in writing those elements of therapy that were helpful while also commenting on aspects of therapy that were painful, unhelpful, or confusing (Elliott, 1999). Elliott, Slatick, and Urman (2001) argue that interview schedules such as the CCIP can complement large-scale quantitative studies by

capturing the real-life human details and contexts associated with an individual's experience of therapy. The questions were arranged as follows:

1. What changes, if any, did you notice in yourself after therapy started?
2. In general, what do you think has caused any rapid or sudden changes you have experienced? In other words, what do you think might have brought them about?
3. Are you doing, feeling, or thinking differently from the way you did before?
4. What specific ideas, if any, did you get from therapy, including ideas about yourself or other people?
5. Did any changes in how you felt throughout therapy happen as a result of outside events, or would you attribute the changes to things that happened in therapy? Please elaborate.
6. What kinds of things about the therapy have been hindering, unhelpful, negative or disappointing for you?
7. Were there things in the therapy which were difficult or painful but still OK or eventually helpful?

For an example of another CCIP analysis, see Israel, Gorcheva, Walther, Sulzner, and Cohen (2008). Elliott (2010) noted that a retrospective account can have the unforeseen benefit of allowing participants to reflect on and examine their past experiences, possibly leading to a more accurate and full account of the phenomenon (see also Clarke, Rees, & Hardy, 2004). These authors also noted that at the end of the analysis, there is a hierarchy of themes and sub-themes that are based on the grouping of certain frequently appearing patterns within the responses. The current study used interpretative phenomenological analysis (IPA; Smith & Osborn, 2003) as its means of systematically analyzing the qualitative, semi-structured CCIP interviews in an attempt to coalesce themes regarding helpful and unhelpful aspects of therapy.

The first phase of IPA seeks to preserve the original intent of the interview transcripts. Each successive combing through of the data contextualizes the comments within broader psychological theories or serves to challenge such long-held beliefs, with a particular attention to *why* certain words and phrases were used by the participants (Larkin, Watts, & Clifton, 2008). The final product is designed to be a coherent narrative that prizes participants' inner experiences while attempting to aggregate themes that either fit in or disagree with current psychological theories.

2. THE CLIENTS

The Blue Cases

- "Brent," a 52-year-old man who was a trade union official with a very demanding and frustrating job, presented with a diagnosis of major depressive disorder.

- "Bailey," a 36-year-old woman who was referred by her general medical practitioner with acute anxiety.
- "Barbara," a 30-year-old woman who presented to treatment diagnosed with major depression, co-morbid sleep disorders, and alcohol abuse disorder.
- "Beatrice," a 37-year-old woman who presented with extremely high levels of anxiety associated with a relationship break-up.
- "Brenda," a 41-year-old woman who was experiencing extremely high levels of distress on all domains of the OQ-45. She reported that she had been living in a drug-dealer-infested public housing building that had been causing great stress.

The Red Cases

- "Robert," a 39-year-old man who had been diagnosed with bipolar disorder six months prior and who had been on medication for four and a half months. He had been doing well and then he reverted back to previous coping strategies, which were destructive to his relationship with his significant other.
- "Rachelle," a 29-year-old Caucasian woman who presented for treatment with severe symptoms of depression related to interpersonal difficulties, particularly with her mother.
- "Rebecca," a 23-year-old woman who presented for treatment with insomnia and a prolonged, complicated grief reaction, which had led to depressive symptoms.
- "Reilly," a 28-year-old female client who was referred by her general medical practitioner following an accident in the workplace (an industrial warehouse), which was associated with the onset of severe migraines as well as anxiety, due to attendant financial and interpersonal problems.
- "Ruby," a 45-year-old woman who presented for treatment with severe symptoms of depression, which seemed to result from issues of being a single mother and experiencing a relationship breakdown.

Table 1 lists, for each client, initial diagnosis, total number of treatment sessions, the session during which a sudden gain or a sudden setback occurred, and the length of time between each client's last session and follow-up.

Table 4 indicates the actual numerical changes associated with the sudden gains and sudden losses by each session. In this regard, note that Rebecca's sudden loss, which occurred in her third session, only involved a change from 78 to 80. Even though this change does not intuitively appear to be a significant loss per se, Rebecca is still in the bottom 10% of responders and therefore qualifies as a Red case. In other words, a Red case is determined by how much the client deviates statistically from the average expected recovery curve of the particular client when compared to others in the cohort who entered therapy at the same level of distress.

3. GUIDING CONCEPTION AND TREATMENT MODEL

Eri is a master's level, registered clinical psychologist with a background in language and education. She shares a practice in Sydney, Australia with a small group of general practitioner physicians from whom she receives referrals for individual and couples counseling.

A description of Eri's guiding conception and treatment model was written up below by the first author (BPH) based on an interview with Eri in May of 2009. (The descriptions of the Blue and Red clients were written by Eri after the feasibility of the study had been established and the research participants selected.)

Eri assesses each client prior to the first session with the following assessments: the OQ-45; a Sleep for Health Questionnaire, which collects information about the client's sleep patterns; and a clinical interview. (She continues to give the OQ-45 at the beginning of every subsequent session.) She then spends a major portion of the first session educating patients on several different aspects of mental health. The following steps take place in every first session of therapy:

1. Eri allows the client to tell his or her story, as she begins from session one to develop an ever-evolving narrative of the patient's holistic complaints and feelings as they emerge within the greater context of the patient's life history and experience.
2. Eri provides many of her clients a handout on her brain-based therapy approach. The graphical handout highlights the stress response cycle, the function of the amygdala and hippocampus in storing emotional memories, and the body's ability to acquire new information, thereby reducing high stress responses.
3. Every client is then educated regarding the cognitive-behavioral model of emotions. Eri explains how physiological arousal is linked with cognitive patterns, which then culminate in a behavioral response and associated emotional reaction.
4. Clients are next educated on the allostasis stress response in the hypothalamic–pituitary–adrenal axis. Eri discusses how there is a feedback loop starting with the hypothalamus, which interprets stressors and which in turn sends information to the anterior pituitary, which then culminates in the release of stress hormones in the adrenal cortex. Eri elaborates on the role of the hypothalamus and amygdala, and the role that each neuroanatomical structure plays in memory, stress, and emotional regulation. She reviews how traumatic experiences and stressors affect these structures, and how exposure to feared stimuli can result in habituation as well as the acquiring of new information.
5. Eri also educates her clients regarding sleep hygiene, and she provides principles for increasing quality and quantity of sleep. In addition, she also explains the relationship between poor sleep and mood problems/lack of motivation.

6. She finishes the psychoeducation portion of treatment by explaining the role of nutrition, counseling her patients about the effects of alcohol, coffee, and other drugs. She also stresses proper bedtime nutrition and its effects on restful sleep.
7. An important aspect of Eri's initial approach to therapy is an individual tailoring of the treatment plan to the particular client's needs. For example, she often suggests medical treatments, such as chiropractic work for somatic and neurological problems, or recommends certain nutritional supplements for sleep and mood disorders. If sleep problems, anxiety, or depressive symptoms could possibly be better explained by medical factors, she refers the patients to physicians who specialize in thyroid, anxiety, or sleep disorders. She also begins the process of identifying themes that are important for the particular client's improvement, and notes these factors in order to add them to a consolidated, mindfulness CD. This CD includes elements of the client's history, an explanation for the client's suffering, and a believable ritual for alleviating the distress. All of these factors are driven by Eri's ongoing assessment (both qualitative and quantitative) of the client's response or non-response to treatment.

Instead of passively waiting for therapy to take effect, Eri is an active problem solver, always open to new possibilities to improve patient outcome while gathering data on the client's response to treatment. This dynamic, frequent feedback loop between the client's responses and Eri's interventions serves to rapidly adjust therapeutic techniques to meet the current needs of the client. In sum, Eri takes an eclectic, holistic, and highly individualistic approach to the client and the therapy process that begins in the first session. Moreover, she holds at the forefront of her mind the principle that clients are largely in control of their own change processes, and she values this autonomy and independence.

Eri combines two different, but complementary theories in her approach to therapy, cognitive behavioral therapy (CBT; Beck, 1993) and compassionate mind training (CMT; Gilbert & Procter, 2006). The overall purpose of CBT lies in identifying and challenging irrational beliefs. As a result, a client develops a new schema with a resultant change in affect, mood, and behavior. Practitioners of CBT view assessment, psychoeducation, cognitive restructuring, exposure, relaxation, and modeling as six of the most important domains in this approach (e.g., Beck, 1993; Kendall, 1993). CBT has been shown to be effective in the treatment of a variety of mood and affective disorders, eating disorders, psychosis, chronic pain, and substance abuse (Southam-Gerow & Chorpita, 2007).

Compassionate mind training (CMT) is an intervention aimed at alleviating high levels of shame and self-criticism (Gilbert & Procter, 2006). The founders of this modality postulate that early childhood experiences with primary caregivers potentiate a disposition towards guilt, shame, and poor self-images of oneself. Thus CMT claims to borrow from both cognitive and dynamic approaches, in that it emphasizes the importance of early childhood experiences while helping the client become aware of ineffective protective mechanisms that have been erected to help him or her cope with the emotional pain (Mayhew & Gilbert, 2008). Cognitive approaches include helping the patient become aware of the thoughts and beliefs they are holding on to that lead to shame and guilt, and cognitive restructuring takes place as one is able to recognize the

genesis of such beliefs and work towards a more compassionate view of the self. Gilbert and Procter (2006) argued that self-condemning approaches to one's perceived weaknesses can actually be unlearned. CMT has been shown to reduce stress, increase self-esteem, and reduce distress in individuals with psychosis (Lee, 2005; Mayhew & Gilbert, 2008).

4-6. CASE DETAILS ABOUT THE 10 CLIENTS ¹

Eri reviewed her files for the cases under study and produced the following descriptions of her clients and their therapy. The descriptions are in the words of Eri herself in order to preserve the authentic quality of her observations. She wrote these descriptions before she sent out the follow-up measures to her clients, and thus the descriptions are formally independent of these measures. Naturally, Eri's insights are influenced by hindsight bias and can be viewed only as her current conception of these cases. The validity of such recollections is thus limited, and her descriptions may be influenced by the clients' responses to therapy. Her descriptions were based on a review of the clients' clinical files two years after termination.

As context for the descriptions below, see Tables 1 and 4 for the session during which a sudden gain (for the Blue clients) or sudden loss (for the Red clients) occurred.

Blue Case 1, Brent

Brent was a 52-year-old trade union official with a very stressful, time-consuming, and thankless job. He had a tendency to take his stress out on his family. He reported that he lost it when he had a fight with his wife and he checked into a hotel close to work. Brent presented with a diagnosis of major depressive disorder. His father reportedly had a very strong work ethic, and Brent left home at 18 and became financially independent. Brent was highly motivated and eager to change, as he had a fear of repeating history. Brent came into therapy with a high degree of subjective distress and an urgent need to decrease this emotional distress.

Client Variables

- He was initially hesitant about leaving his job, as he feared that it might not change the relationship issues.
- He was prepared to do what it would take to bring about change.
- Appeared to have the ability to sustain and maintain change. Brent was resilient, although he reported experiencing a great deal of stress in his life.
- The rationale for treatment made sense to him; hence, he immediately commenced to make lifestyle changes—namely, taking natural supplements to assist with anxiety symptoms and sleep deprivation and also following the sleep routine.
- He also implemented the compassionate mind training (CMT) into his daily routine.

¹ This section is numbered “4-6” to indicate its parallel to sections 4-6 of a typical PCSP case study—specifically: 4) Assessment of the Client's Problems, Goals, Strengths, and History; 5) Formulation and Treatment Plan; and 6) Course of Therapy

Blue Case 2, Bailey

Bailey was a 36-year-old woman who was referred by her general medical practitioner with acute anxiety. She was of moderate socioeconomic status. Clearly the distress was work related, looking at the OQ-45 scores. The client reported that she had always been ambitious and driven. Her mother had a history of bipolar disorder and the client and her brother were financially responsible for their mother, which had gradually become a burden over time. The goal of treatment was to reduce the high levels of distress. The treatment approach involved psychoeducation regarding allostasis/allostatic load memory systems, behavioral changes, CMT, identifying fears, and recording of the mindfulness training on a CD for daily repetition of the treatment strategies. Interpersonal relationships as assessed on the OQ-45 showed that family relationships were strained, particularly the client's relationship with her mother, which had always been difficult.

Client Variables

- She reported a history of high levels of stress.
- However, she had the capacity to manage negative emotions (albeit her current situation seemed unmanageable).
- She was willing to implement strategies to improve the way in which she related to her mother.
- She was able to implement treatment strategies and sustain treatment gains.
- Temperamentally, she was very resilient

Blue Case 3, Barbara

Barbara is a 30-year-old woman. She is intelligent, with good communication skills. She presented to treatment diagnosed with major depression with co-morbid sleep disorders of initiating sleep, circadian rhythm, maintaining sleep (REM), and somnolence. She was also diagnosed with alcohol abuse disorder. She reported feeling depressed with no motivation to study, which was her primary concern seeing as she was a student. Psychoeducation regarding allostasis and the role of alcohol and sleep deprivation in development of depression and anxiety was given in the first session. The role of nutrition in reducing levels of anxiety was also explained, as was the role of protein in the production of amino acids and subsequent conversion to neurotransmitters. Initially, I took a practical common sense approach and the client was motivated enough to put the sleep routine plan into action, which included taking natural supplements such as 5HTP, Pre Gaba, Co Enzyme Q10, and magnesium. The second session involved CMT and CBT. The third session involved more intensive CMT and encouraging subsequent daily repetition of the treatment strategies.

Client Variables

- She presented with a high degree of subjective distress.
- However, she was motivated to change due to the urgency of her distress.

- She had a strong work ethic.
- She was very motivated and following the first session she was able to dramatically reduce alcohol consumption (which is often a cause of sleep deprivation), and she was committed to taking the natural supplements and subsequently felt less depressed and anxious and more confident.

Blue Case 4, Beatrice

Beatrice is a 37-year-old woman presenting with extremely high levels of anxiety. Clearly, the symptom distress score was the result of the relationship break-up. Treatment involved psychoeducation regarding allostasis and homeostasis, relaxation and breathing techniques, nutrition, sleep hygiene, and schema-focused therapy, once again the focus being on the emotions and fears. The client's greatest reported fear was not being loved.

Client Variables

- She was highly motivated to change and eager to accept help offered.
- She demonstrated a strong commitment to change.
- She was flexible in her character.
- She was intelligent.
- Overall, she showed a history of a calm and resilient temperament.
- Evidence that she had the capacity to manage negative emotions.

Blue Case 5, Brenda

Brenda was a 41-year-old woman referred by her general medical practitioner for acute anxiety. She was experiencing extremely high levels of distress on all domains of the OQ-45. She reported that she had been living in a public housing commission flat for the past three years and a drug dealer/user moved into the unit next door. She consequently became exposed to drug-addicted people moving about the corridor and buying drugs from the drug dealer and heard loud music that continued throughout the night. She reported making a complaint nine months ago, but she had received no response.

She reported that she had never experienced such high levels of distress and that normally she would be able to manage. She had developed fears of being attacked, of becoming seriously ill, and of not being heard or understood by the department of housing. Treatment was initially focused on psychoeducation, i.e., giving Brenda an understanding of why she was feeling so anxious and explaining that she was experiencing an acute phase of allostasis, which is normal given that she had not slept for the past nine months and was constantly in a state of preparedness. Scores on the OQ-45 dropped when she was told that she would be transferred to another housing commission unit. The treatment approach involved psychoeducation regarding allostasis/allostatic load, memory systems, arousal reduction techniques, behavioral changes, CMT, identifying fears, recording of the mindfulness exercises on the CD for daily repetition of

the treatment strategies, and problem solving (finding ways to ensure that she was able to move to another location).

Client Variables

- She presented with a high degree of emotional distress.
- She was ready for change, prepared to do whatever it took.
- She was able to change current circumstances through psychoeducation, managing her fears and relocating.
- She was able to implement treatment strategies and to sustain treatment gains.
- While of modest socioeconomic status, she was able to manage on less rather than more.
- She was highly intelligent.
- She was temperamentally resilient.

Red Case 1, Robert

A 39-year-old man, Robert reported having been diagnosed with bipolar disorder six months prior and had been on medication for four and a half months and was doing well; then he reverted back to previous coping strategies, which were destructive to his relationship with his significant other. Prior to his diagnosis, he self-medicated with drugs and alcohol, and clearly it would take time for him to train himself to change his behavior. He was motivated to change and realized that maintaining a state of homeostasis in the body would ultimately lead to milder manic episodes. It was during severe manic episodes that he would binge drink, use drugs, and visit sex workers.

He reported feeling very ashamed of his behavior; however, he was unable to stop the addictive cycle, hence the reason for therapy. Scores on the OQ-45 showed the erratic initial stages of treatment, and at the second session a "red alert status" signaled a more manic mood state and a reliably worse condition. The third and fourth sessions showed a drop in scores. On the fifth session there was another elevation, though not as severe as the second session. Each time there was an elevation in scores, items always reported frequent substance abuse, suicidal thoughts, and thoughts of violence at work. The feedback was very helpful to the client, as he was able to view his erratic mood swings and reflect on their causes and effects. Once again, the OQ-45 identified the interpersonal domain as the most common problematic client variable for Robert, as for the other non-responders. Treatment focused primarily on stress management and more behavioral strategies in the initial stages, and then schema-focused work looking at core beliefs and fears.

Client Variables

- He has managed to abstain from alcohol and drugs for the past two years and is aware of the mood swings and manages them in more functional and less destructive ways.

- He was motivated to change; however, he was unable to sustain behavioral changes as a consequence of prior problems in procedural memory.
- He was extremely flexible
- He had a loyal partner.
- He was temperamentally unstable.
- He had difficulty managing emotions.

Red Case 2, Rachelle.

A 29-year-old woman, Rachelle was referred by her treating general medical practitioner for severe symptoms of depression. Initial assessment clearly indicated an extremely high level of depression on the OQ-45. The OQ-45 was also able to give a clearer assessment of which domains were causing distress, and the scores on the interpersonal domain were very high. As she began to talk about her distress, it was evident that her interpersonal relationships had always been problematic, particularly her relationship with her mother. Overall, my clinical view was that she manifested borderline personality disorder characteristics. She described her mother as emotionally and verbally abusive and had experienced physical abuse from her father, who was deceased. The first session involved history taking and psychoeducation regarding allostasis, allostatic load, and the benefits of healthy nutrition and fitness in maintaining a healthy balance in the body.

She was encouraged to make changes to her sleep routine. She reported going off to sleep at 3 a.m. and waking at 11 a.m. Unfortunately, she was inflexible with regards to making changes in lifestyle. Schema therapy helped identify core beliefs, which were often related to fears of abandonment by her loved ones. Her expectation of others was that her emotions would not be validated, which invariably had been her experience; hence, she had a more negative view of her emotions. However, she had difficulty disciplining herself to keep rules and to complete behavioral homework. She had never had a love relationship, and she had been unemployed for some time.

Client Variables

- Her interpersonal domain was poor, which is the strongest client variable in the Red clients, i.e., those with sudden losses.
- She had an inability to self soothe.
- She showed a high level of subjective distress.
- Her expectation of treatment was as a kind of magical fix without putting strategies into practice.
- She was not prepared to do what it takes to change.
- She had an anxious, unstable temperament.
- She showed rigidity of character.

- She was unable to change current financial hence unable to change home situation.
- She showed an inability to manage negative emotions.
- She was resistant to making lifestyle changes such as sleep routine.
- She showed a high level of functional impairment.
- She was intelligent.

Red Case 3, Rebecca

A 23-year-old woman presented for treatment as a result of prolonged complicated grief reaction. She was referred by her treating general medical practitioner for insomnia and unresolved grief. Initial scores on the OQ-45 indicated moderate levels of distress with elevations on symptoms distress and social role. The elevations on social role appeared to be the result of the client taking on more work than she could actually manage. The client reported working at a day job as well as working night shifts at a bar while she was studying full-time.

She reported some difficulties in interpersonal relationships, as she had fears relating to the loss of loved ones. This was understandable, given that her mother died when she was six years old and her grandmother had recently suffered a catastrophic stroke, which had left her unable to care for herself. My treatment approach included psychoeducation regarding allostasis and allostatic load, sleep hygiene, and CBT strategies focusing on the core beliefs underlying Rebecca's cognitive responses to triggered events. She displayed an avoidant style of attachment in relationships. When her OQ-45 scores showed sudden loss, the client realized that her allostatic load was the primary cause, and when she lessened the load her scores improved. Scores prior to the commencement of the third session were elevated with a yellow alert status indicating deterioration in all three domains, particularly the social role score. Scores prior to the commencement of the sixth session were very elevated in all domains.

Client Variables

- She was in the contemplative stage of change and was not quite ready to move to the action stage.
- She was resistant to change in terms of her strategy of keeping very active as the way in which she was coping with her mother's death.
- Her degree of subjective distress fluctuated and was therefore not much of a motivating factor.
- She was of moderate socio-economic status, although she did not want to depend on her father financially.
- She was highly intelligent.
- It was difficult to change her current circumstances as she was studying full time and she felt compelled to work to support herself

- She manifested insecurity, hence inflexibility in interpersonal relationships as a result of fear of loss.

Red Case 4, Reilly

This 28-year-old woman client was referred by her general medical practitioner following an accident in the workplace (an industrial warehouse). She was a partner in a family business. A handrail fell from the staircase and landed on the client's head. It was the first accident to occur on the premises since she had been working there. The client suspected that it was not an accident. The client reported experiencing severe migraines since the accident, although she also reported a history of migraines. In this case, the client deteriorated rather than improved. She had no trust in her coworkers, and her business partner decided to sell his share of the business, leaving the client to run the business on her own. He was planning on taking all of the customers with him, as he had set up a new business in another location. The client reported she had no support from her husband or family.

Client Variables

- She showed an inability to change her current circumstances.
- She showed a high level of functional impairment.
- She expressed a desire to change; however, she was emotionally unable to sustain any changes that she had achieved.
- She experienced a high degree of subjective distress.
- She had a college education.
- She was intelligent.
- She had difficult regulating emotions.

Red Case 5, Ruby

This 45-year-old woman presented for treatment when referred by her general medical practitioners for severe symptoms of depression, which seemed to result from single motherhood issues, relationship breakdown, and parenting issues. Initial assessment according to the OQ-45 showed high levels of symptom distress and a highly elevated interpersonal relationships score. The presenting problem was constant rumination about the past, excessive guilt concerning the impact of her separation with her partner on her two daughters, and excessive self-criticism and feeling overwhelmed by the financial struggle of single motherhood. She reported feeling that way for two years. She reported that her youngest daughter was extremely anxious and had been diagnosed with obsessive compulsive disorder. She reported a historically difficult relationship with mother who was dismissive of the client and disliked her, favoring her three brothers.

My treatment approach included psychoeducation regarding allostasis/allostatic load, sleep hygiene, and CBT focusing on the core beliefs underlying the negative cognitive responses to triggered events. She had an anxious/ambivalent style of attachment in relationships. It

seemed that she would require long-term treatment in order to begin to develop a stable sense of identity and to be able to self-regulate. When scores showed a sudden-loss deterioration to a red alert status at session seven, the elevations were in the interpersonal domain. It seemed that she would require ongoing support over the next few years in order for her to develop an internal self-regulatory system. Once again, the OQ-45 identified the interpersonal domain as the most common critical client variable in sudden-loss clients such as Ruby who deteriorated.

Client Variables

- She showed an inability to change her current circumstances.
- She manifested a high level of functional impairment.
- As with Case 2, Rachelle, Ruby had an expectation that there would be a kind of magical fix without putting in the necessary effort into changing.
- She expressed a desire to change; however, she was emotionally unable to sustain any changes that she had achieved.
- She showed a high degree of subjective distress.
- She had a college education.
- She was intelligent.
- She manifested a histrionic style of personality.
- She had difficulty regulating emotions.
- She had difficulty setting limits with her children.
- She was of low socioeconomic status.

7. THERAPY MONITORING AND THE USE OF FEEDBACK INFORMATION

As described above, the OQ-45 was administered after each session. Eri used the ongoing results, along with her observation and analysis of the ongoing therapy process, to make changes in the treatment plan if progress was not taking place as intended. Since Eri operates under her own, independent license, there was no formal supervision or monitoring of treatment progress of the cases from a third party.

8. CONCLUDING EVALUATION OF THE THERAPY'S PROCESS AND OUTCOME

Quantitative Data

Outcome Questionnaire-45 (OQ-45)

On the OQ-45 the clinical cut-off point is 63/64, and a change of 14 points or more is statistically significant. As shown in Table 5, the average intake OQ-45 score for Blues was 111.4

(an extremely high score, at the 99.7th percentile), while the average intake score for Reds was lower at 92, although still quite high (at the 98.6th percentile), indicating that Reds actually reported statistically significantly less disturbance at the beginning of therapy. The average post-treatment OQ-45 score was 37.6 (at the 34.5th percentile) for Blues, a remarkable, statistically significant drop of 73.8 points into the non-clinical domain, while the Reds dropped an average, nonsignificant amount of 8.4 points with an average post score of 83.6, still in the clinical domain. These differences indicate that the Blues experienced dramatically greater improvement over the course of therapy.

Table 5 also shows the OQ-45 results at the two-year-plus follow-up. Between the last session of therapy and the follow-up, Blues remained stable with a slight drop of 0.4 points on average. The Reds were similarly unchanged, with an average drop of 1.6 points. In other words, Reds and Blues, on average, remained at a similar level of distress compared to their last session of therapy after a two-year-plus time period.

Table 5 shows that four out of the five Blue cases demonstrated improvement on the OQ-45 between their final session and the two-year follow up. Brenda was the only exception, as she deteriorated from a 36 to a 73 at the two-year-plus follow-up. In the same comparison, two Reds, namely Rachelle and Ruby, deteriorated by 9 and 43 points respectively, while the other three Reds demonstrated some reduction in distress as measured at the two-year follow-up.

Consumer Reports Satisfaction Survey (CRSS-4)

The CRSS-4 was administered at the follow-up time point in order to assess the participants' retrospective beliefs and attitudes about their experience in psychotherapy. The results are shown in Table 3. As can be seen by visual inspection, and consistent with the OQ-45 results discussed above, the Blues, compared with the Reds, thought more that "treatment help[ed] with the specific problem that led you to therapy;" were more satisfied with "this therapist's treatment of your problems;" described their "overall emotional state when you started counseling" as poorer; described their "overall emotional state at the end of treatment" as better; and described their "overall emotional state at this time" as better.

Working Alliance Inventory-Revised (WAI)

The Working Alliance Inventory (WAI) was given to each participant, and each was asked to retrospectively rate their overall perception of the therapeutic alliance from their time in therapy with Eri. With the exception of one Red (Reilly, who also rated her relationship higher than the other non-responders), all Blues rated the quality of the therapeutic working alliance higher than their non-responding counterparts. The overall results are presented in Table 6. As seen, the Blues showed much less variability in their scores than the Reds (e.g., a standard deviation of 7.11 versus 30.91, respectively, for WAI-Total). T-tests comparing the Blues and Reds showed that the Blues had statistically significantly higher scores on the Tasks and Goals subscales and on the Total Scale. They had higher ratings on the Bond subscale, but it was not significant, suggesting that the two groups of clients had similar levels of trust, acceptance, and confidence within the therapeutic relationship with Eri.

Qualitative Data: Overview of Client Self-Descriptions at Follow-Up on the CCIP

Self-Descriptions—Blue

Patients were asked to describe themselves at the time of two-year follow-up as part of the Client Change Interview Protocol (CCIP). Before commenting on the themes related to their therapy, a brief overview of these self-descriptions is provided to give context to their respective experiences in therapy. Blue cases were notably more positive in describing their self-images as compared to Red Cases.

Brent described himself as “introverted, thoughtful, [and] empathic.” He also noted that he might be described as “Possibly shy, insightful. . . . [I] quickly develop a strategy and commit to it.

Bailey described herself as feeling “fabulous” and believes she is “capable.” Yet she did note several areas she would like to improve, as she observed that she was “initially over-worried about being a competent mother” and would “like to be less stressed . . . be a little more relaxed about big changes in life, and [not be] as fearful and not coping because of [my] bipolar mother.”

Barbara said of herself that she has always been “a very strong person.” She described herself endearingly as “loud, caring, obnoxious, and very social. My weakness is my strength. I’m very opinionated, and open about what I think. Don’t know when to hold back, holding my ground . . . in a work environment I tend to be a bit standoffish. I tell them what I think.” Later she noted, “I’m very much an open book. I don’t like to bullshit people. You just know when someone’s genuine, and then you can’t. I just move on, people come and go.” She commented on some areas for self-improvement, such as, “I just I think I am little too giving at most times. I need to learn to hold back with my time and emotions. I tend to put people in front of myself.”

Beatrice was also gentle with herself in describing her personality, stating that she is “stronger emotionally” and generally “friendly, reliable, consistent hard working, affectionate, thorough, loving, kind, generous, well mannered, and private,” later adding “perfectionist.” She said she would like to change her “poor attitude towards exercise” and “be a little less private, and suffer less from anxiety.”

Finally, Brenda described herself as “optimistic, intelligent, funny, anxious, loving,” although she added that she needs to “look after myself better.” She wants to “Not to worry so much.”

Self Descriptions - Red

In general, Red cases appeared to describe themselves with more negative adjectives and noted substantial areas for improvement.

Robert was fairly self-deprecating, stating, “I think generally my opinion of myself is lower than what others think of me. That describes the problem. . . . I’m more nervous. It’s like

low self-esteem.” However, he noted that others see him differently than he sees himself: “People would describe me as fearless, confident, outgoing. I think I’m a good actor. I’ve learned it’s a life-long thing I’ve done.”

Rachelle described herself as “traumatized, anxious, stressed, depressed, lacking confidence, quirky, unconventional.” She also stated that she would like to change her “mental health.”

Rebecca, however, displayed greater ego strength and stronger self-esteem, with a personal description of herself as “reliable, loyal, committed, busy, organized, caring, supportive, approachable, and independent.” However, she did note many changes she would like to make to herself: “Am I just allowed one thing? I would make myself smarter, thinner, more light-hearted. But seriously—just one thing would be smarter—to just know more stuff without the effort of having to learn and remember! My whole job, or all my jobs actually, would be less challenging if I were naturally more intellectual.”

Reilly refused to fill out self-descriptions or complete the change interview protocol, and thus the qualitative results do not reflect her opinions about therapy. Reilly reported to Eri that she was going through a pregnancy and did not feel that she had time to complete the qualitative interview. As stated above, Eri described Reilly as resistant to therapy. Also, it should be noted that Reilly had the biggest deterioration in her OQ-45 scores (27 points) from the beginning to the end of therapy, and thus is it not surprising that she would refuse to complete the follow-up change interview protocol.

Finally, Ruby described herself as “mentally unstable and very tired,” later stating “I used to be a happy-go-lucky, outgoing person—does not feel like that now.” She noted that she would like to “return to mental stability,” and become “slimmer, happier.”

Qualitative Data: Interpretative Phenomenological Analysis at Follow-Up on the CCIP

Table 7 presents the structure of the open-coding, phenomenological analysis of the CCIP. As can be seen, two Themes—“Therapy Experience” and “Changes”—emerged, with two Clusters within each Theme and two to three Categories within each Cluster. The results on the various Categories (Table 7) are provided below.

Therapy Experience: The Therapeutic Encounter

A. Unique Therapist Qualities – Blues. Every Blue case commented on factors related to the therapist’s personality and approach in therapy that they found helpful in making changes. Brent highlighted the importance and ease of connecting with Eri in order to be able to discuss things that needed to be worked on: “I struck an easy rapport with my therapist, which quickly established the trust necessary to identify issues.” Barbara commented on Eri’s personal characteristics, particularly her manner of being in therapy: “She’s lovely. She’s very welcoming,

even her voice, is very soothing. She's very open and welcoming . . . like I said before, she's a really beautiful person. I can't put my finger on it."

Other clients spoke about Eri's ability to help them accept the reality of painful emotions. Barbara commented, "With Eri, she sort of reassured it was okay to be upset. It was okay to feel the way I was feeling. Why am I getting anxious, or annoyed, or crying. It was okay to have emotions, and be sad." Brent emphasized Eri's affinity for validation: "I think that I always suspected that the happiness of others depended more on my psychological well-being; what I needed was someone to confirm this for me."

A. Unique Therapist Qualities – Reds. Red cases were equally appreciative of Eri's way of being with them. Similar to Blues, Robert commented on Eri's spiritual nature: "I live a spiritual life, that's really important. I got a lot of that from Eri, I think she's a spiritual brain, she has this aura about her." He also spoke about the importance of feeling comfortable in order to talk about things that were difficult: "I felt comfortable, so I took the risk. . . . I had a lot to get out once I felt safe and comfortable." He noted Eri's ability to empathize based on her past experiences "Maybe in her life, she has had a lot of pain and struggle. We connect because of the pain. That's my belief, we connected to the pain . . . the suffering, compassion and empathy gets through the head, gets to the heart. I can know it from a hundred miles away."

Ruby said that she "felt understood in therapy." Others spoke to the importance of feeling connected. Robert also noted, "Connecting with a human on a deep level is what it's all about, that's where you get healing," and later noted "I think Eri was the type of person that I needed in my life at that time. It wasn't until I sat on her couch, and sat across from her, and started talking . . . it just felt right for me. I had someone on my side. I didn't feel alone." Rachelle also emphasized Eri's ability to be compassionate and validating, noting that she enjoyed "having someone to understand and not to discriminate and judge." Rebecca also mentioned Eri's ability to understand and advocate for her, and she said "it also made me feel supported, like there was someone on my side no matter what."

B. Potent and Specific Ingredients – Blues. Blues appeared to make stronger comments related to specific, potent ingredients of therapy as compared to their red counterparts. Several patients highlighted change mechanisms related to cognitive restructuring. Barbara noted, "She got me to write things down. I can't remember the specifics: what was important to me, what I enjoyed, and what was doing well in my life, what was bad." Although patients did not use technical terms or phrases, it was apparent that several of them understood the basic concepts of cognitive therapy and compassionate mind training. In particular, several Blue cases indicated the importance of stepping back from the situation and evaluating the cause of their distress. Barbara noted, "She taught me to stop, and think about things. And evaluate what is going on." Beatrice mentioned that Eri was helpful with "understanding why I felt the way I did and the reasons why I got to that point and state of mind."

It appears that linking thoughts with emotions helped patients comprehend why they felt the way they did, and this brought with it relief as they now understood their painful emotions better. Brenda summed her experience in this domain simply with the word "reflection," with Bailey noting that therapy was helpful by "taking a good look at what I experienced." Barbara

was helped by the connection between past experiences and her present reactions, a mechanism of change in line with CBT's assumptions regarding the power of core beliefs: "It was more working on things from my childhood. I didn't consciously recognize that they were bothering me, but she sort of picked up on those things. We went back through stuff that happened in my childhood. I didn't realize it. A lot of things I had to deal with emotionally (I get bad anxiety), came from my childhood."

Others noted techniques that appear to be specific to Eri's particular brand of therapy, which includes making a meditation CD that reminds her patients of the work they do in therapy as an act of consolidation and practice: "She gave me a recording, I still actually have it, sort of like a meditation for me to listen to in the afternoon or before I went to sleep. A reassurance of, I don't know, sort of like a meditation. That really helped" (Barbara).

Bailey noted the importance of the recording: "I used the CD both times I came to therapy, felt a whole lot better." Barbara also commented specifically on the utility of mindfulness-based interventions, mentioning that she was helped by the "breathing techniques, and the meditation." Brent noted he was now "able to plan ahead." Barbara noted an increase in health behaviors, such as, "She helped me get my sleeping patterns back in order. I'm in bed at 10 or 11," later adding "I do yoga quite regularly. I keep quite fit. . . . I eat well, the clean living sort of thing happening."

B. Potent and Specific Ingredients – Reds. Reds also mentioned specific cognitive strategies that they found helpful in therapy. Robert mentioned that "pen and paper are important for me as well. On days, I can see the distortions, and go 'geez, come on mate . . .'" Later he commented, "One of the things Eri did for me was that she challenged my thinking about what I thought about myself . . . she tapped into something and told me: 'this is who you are, you need to look at this.' It didn't happen straight away. I can look back now; it was good for me to be told that my thinking was distorted."

Two mentioned being able to care for themselves better and make their life a priority. Ruby noted that Eri was good at "helping with decision making." Ruby also began to understand where her stress came from as she "realized that [she was] unable to say 'no' to others" and was "never thinking about self." Rebecca also commented on the helpfulness of Eri's problem-solving, writing, "I think I was struggling with Uni[versity] and my decision to do a PhD—something which with time I managed to get my head around anyway. I think therapy helped the process along." Rebecca also saw therapy as symbolic of taking care of her needs, noting, "It always felt great to be in therapy because I felt that I was doing something to help myself."

Interestingly enough, the only Red who mentioned the OQ-45 actually had a positive experience with it. Robert noted, "I tell you one thing that stands out was that she made me do a questionnaire on a computer each time I got there. And it would show me in a color of where I was. What it did was, it showed me I was improving. This was one of the places I got hope from. Eri would say 'that's really good.'"

Reds also mentioned skills that they acquired through therapy that did not have to do with specific therapeutic techniques. Robert noted, "I follow the disciplines of yoga, and a spiritual

faith, some prayer. . . I live a spiritual life, that's really important," later adding, "I find that when I relax and meditate and breathe properly, things slow down, the answers come." Ruby noted that therapy "help[ed] with decision making."

C. What Didn't Work (Negative Factors) – Blues. Blue cases were, in general, very sparse in commenting on negative aspects of therapy. However, Beatrice did voice disappointment from certain techniques: "hypnotism was disappointing for me," while Barbara commented on the OQ-45: "The computer score meant nothing to me, you don't remember the things you didn't talk about." Barbara's other negative comments could actually be seen as a strength of therapy, stating that there was "Not enough time." The other patients did not make any negative comments.

C. What Didn't Work (Negative Factors) – Reds. Red cases were much more likely to make negative comments about their experience in therapy. Some of the complaints centered on Eri's techniques. For example, two mentioned specific aspects of therapy that they found unhelpful or even repugnant. Rebecca wrote, "Disappointing would probably be when my behavior was justified, e.g., 'no wonder you have been taking drugs when you have all this going on,' when really I felt there was no excuse and I was probably looking for the slap on the wrist that I wasn't getting at home." Rebecca mentioned, "I really hated the meditation and relaxation techniques. I'm sure it's very helpful to many people but it honestly drives me crazy! If I am going to lie down and be that still – I would just rather go to sleep!"

Although several patients had noted that mindfulness and relaxation techniques were positive experiences in therapy that led to greater self-compassion and awareness, Red cases did not seem to glean the same benefit from such interventions. Rachelle noted the ineffectiveness of trying "to 'stay with the feeling,' which I find a little hard to understand and implement."

Several Reds also commented on their lack of hope in the future, such as Rachelle mentioning that she had made "seemingly little or no progress. Sometimes it seems pointless." Rachelle commented in a similar vein, noting, "I am progressively less and less hopeful." Reds were also more likely to note regression in their symptoms, such as Rachelle: "If any changes, they were very briefly lived," later noting that she was "better than two years ago, but starting to deteriorate again." Ruby also commented that she was "feeling more depressed." Rebecca added: "Since then I have probably reverted back to old ways a little." Rachelle noted that therapy was "only rarely helpful." Rachelle replied, when asked whether she was doing, feeling, or thinking differently than she had before, with "hardly."

Therapy Experience: Attitude Towards Therapy

A. Resistance to Therapy – Blues. Several patients noted having initial resistance to disclosing information. Brent noted his difficulty in being fully open initially: "At first I avoided some issues but gradually developed the confidence and trust to expose and examine these issues in a healthy way." Barbara mentioned being unsure at first, but eventually understood the general purpose behind therapy: "I was very skeptical, like 'this isn't going to help.' All in all it was quite positive, nothing bad about it."

A. Resistance to Therapy – Reds. One Red case (Robert) commented on several occasions regarding the apprehension he felt in being completely transparent in therapy. Robert noted, "I didn't tell her everything." Robert also highlighted the impotence he felt when trying to make changes initially, saying, "I tried to change, move everything outside yourself. All you get is frustration, anger and guilt. Lots of negativity." However, he was able to transcend his initial apprehension at the therapeutic experience, stating that therapy "seems sort of a bit, weird stuff, but it works."

B. Personal Responsibility for Change Process – Blues. Blue patients were surprisingly realistic in their realization that they had to take responsibility for any changes they would make in life. Bailey noted: "You can tell someone how to do things, but if you do not take them on board and practice, you're never going to change." Some commented on their pre-therapy realization that they were in charge of their lives.

Brent stated, "I made a firm decision at the outset that I wanted to resolve my problems—without this commitment I really believe that CBT is a waste of time for all parties." Brent also noted, "For most people there is a stigma attached to seeking help; however I reached a point whereby self-treatment was no longer an option or effective."

Blues tended to be more aggressive in searching out help for their problems, with Bailey noting she was "always proactive about getting help." Two commented on the nonmystical aspect of therapy, reaffirming their beliefs that therapy involves a high level of personal responsibility: "It would be easy to take a pill everybody would like that, everything would be better," said Bailey, while Brent stated: "I believe no matter how good the therapist is, magic does not happen." Brenda noted she is "trying to stay positive."

B. Personal Responsibility for Change Process – Reds. Red Cases also mentioned the need to take responsibility in therapy, although their comments were generally less realistic, and tended towards ambiguity or ambivalence. Again, Robert was the most positive, and made comments related to the need for responsibility, stating, "The only thing I can change is me, my behavior, my attitude." He also noted, "A positive way is to change myself, not the world. I don't do it perfectly." The rest of the Red cases made less enthusiastic statements regarding the need for responsibility, with Rebecca noting without much assurance: "Perhaps the situations changed or I learned to cope with them better." She also questioned, "I guess the reasons I was in therapy in the first place were due to my coping with situations in my life."

C. Painful But Worth It – Blues. Although all blue cases made substantial improvements through the course of therapy, several commented on the inherent difficulty of making changes in their life. Barbara noted that she had to work through the initial pain of therapy in order to see her self-worth: "It was a hard time, it was a learning curve for me, mentally and emotionally, to realize that I am a strong person."

Others spoke specifically to painful aspects of therapy, but recognized that the pain was a necessary element in change. Bailey said: "Actually being in therapy is painful—if therapy is not painful, there is no point in going." Bailey also noted that it was "painful when talking about my mother and my PTSD, kind of a journey."

Interestingly, Blue cases also shared that while therapy can be a painful process, they wanted to highlight that they had appropriate attitudes towards therapy. Bailey commented that “everybody wanted like a quick fix—therapy is not a quick fix, not a realistic expectation.” Although one might assume that individuals who experience sudden gains in therapy would find the process immediately enjoyable, it was surprising to find a running theme throughout the interviews that therapy is painful, although worth the effort. Brenda had a realistic attitude towards change, noting, “One day at a time, [I am] hopeful things will improve.”

C. Painful But Worth It – Reds. Although Red cases also mentioned aspects of therapy that were painful but worth it, they generally appeared to be less certain about the necessity of struggle during their change processes. Robert noted that he had come to a place where the pain finally pushed him over the edge to receive treatment, stating: “I was dying. I cry out to something outside of myself, 'fuck I can't do this anymore.' From that point on, things change.” He also noted the benefits of finally disclosing painful emotions: “There was a lot of stuff that was painful . . . it was just painful for me to talk about it to someone anywhere, stuff that I haven't spoken to anyone about—guilt and shame, and things I'd done. Stuff you'd take to the grave, those secrets make you sick. Getting them out is really good. I didn't tell her everything, but for the first time I was really honest. I learned how to be honest.”

Another commented on painful events. Rebecca, stating that she could not remember, recalling, “I'm sure there were things that were painful or difficult, but I honestly cannot really remember—it was years ago!”

Changes: Personal Changes

A. Putting Things in Perspective – Blues. Blue patients tended to place substantial emphasis on the helpfulness of gaining a new perspective through therapy. Brent noted, “I am far more detached from previous issues and this distance has enabled me to put a range of issues in perspective.” Later he noted, “Basically my new philosophy is that I can make no one happy unless I am happy.”

Two spoke to the necessity of recognizing the need to take time for themselves. Brent wrote: “My priorities have changed and I now place greater importance on myself without feeling guilty,” and Bailey stated she learned to “not to place too many pressures on self.” Others spoke to the importance of thinking in a more rational manner. Beatrice noted that she was “less confused,” while Barbara noted that therapy was helpful by “putting things in perspective.” Bailey made changes in her ability at “being rational . . . scientific and rational.”

Others spoke to the calming effect of understanding why they were having certain reactions, and this new learning changed their outlook on life. Brent noted that he “developed a clarity of purpose,” while Bailey had a “more positive outlook.” Barbara attributed changes, saying she “put that down to a right frame of mind, a better frame of mind. It was a domino effect,” later stating, “I learned to understand myself and thoughts better, and to be accepting of this.” Beatrice mentioned that one of the most helpful aspects of therapy was “understanding why I felt the way I did and the reasons why I got to that point and state of mind. . . . I'm more aware of the physical reactions of my body to the stress as it's happening.”

A. Putting Things in Perspective – Reds. For Red cases, the adoption of a new perspective was also one of the most frequently mentioned changes that resulted from therapy. Several patients articulated an increased understanding and awareness of problematic behaviors: Rebecca noted, “I have a problem saying no to many things, to over-committing, and I think this is because I know how easily I get depressed/lonely.” Rebecca later mentioned, “I think I became better at recognizing the emotions that were behind certain behaviors, and hence became better at dealing with emotions and improving behaviors, e.g., recognizing that if I was using (rarely) recreational drugs it was because I needed an outlet.”

Ruby noted that she gained “the realization that putting my needs on hold, going into enormous debt for the sake of others” was problematic. Others mentioned the importance of understanding the true cause of their symptoms: “I look at the situation, and realize I’ve been wounded. I look at it from the other side,” said Robert.

Rebecca stated: “I learned that I am in control of what I do—it’s my responsibility to examine my thoughts, feelings, behaviors and to address them if I need to make changes.” Rebecca also asserted that “therapy helped make me aware to the connections between my emotions and behaviors.”

Robert focused on the instillation of a more optimistic future, noting, “I was able to get hope. It was very important to have hope in my life. They’ll tell you it’s all gone to shit. The reality is, only your thinking and feelings have changed. Your situation hasn’t changed that much.” He later noted that his ability to see his improvement has helped him gain a new perspective: “I still suffer from some depression, but I also see where I’ve come from. It’s a miracle where I’ve come from.” Rebecca drew connections between her behavior and her emotional state, noting, “I was having trouble getting out of bed; it was not because I was tired but rather because I was avoiding things.”

B. I am Just Doing Better (Mood and Affective Changes) – Blues. Blue patients made several references to general relief of symptoms. Several patients addressed non-specific affective changes, such as Brent being “calmer,” and “less overwhelmed.” Beatrice described herself by saying, “I was calmer” and “clearer thinking once therapy started.” Others spoke to an increase in resiliency and coping abilities: Brenda said it was “a little easier to handle extremely anxious times.” Beatrice described herself as being “stronger emotionally,” while Bailey noted that therapy “helped PTSD, get over it more quickly.” Some directly addressed the issue of feeling happier, with comments such as Brent’s: “[I] found myself happy for the first time in many years,” and Bailey’s: “[feeling] fabulous.” Barbara summarized her experience by stating “I think I’m a happier being.”

B. I am Just Doing Better (Mood and Affective Changes) – Reds. Reds also commented on changes in their mood and affect. Two mentioned a newfound ability to relax, with Robert noting how others “saw a calmer, slower, somewhat more relaxed me. Not relaxed, it’s like I’d slowed down a bit,” and he later mentioned, “I felt calmer, I felt safe.”

Rebecca noted an increase in her psychological robustness: “I am better equipped at dealing with the stress/anxiety that comes with being very busy than I am at dealing with

depression/anxiety.” However, Rebecca was also ambivalent about her affective changes, commenting, “I guess I started to feel better? I don't really remember, this is a few years ago now.” Robert noted a paradoxical effect of admitting to things he was embarrassed about: “Some of the feelings I felt can give you anxiety, shame, and guilt. But also relief at the same time.”

C. Acceptance of Self and Situation – Blues. Another notable category that emerged was that of accepting oneself and one's experiences. Barbara commented: “It was okay to feel the way I was feeling,” and later hinted at the relief she experienced by realizing that “I'm not a crazy person.” Others noted changes in their ability to confront and accept life's challenges. Beatrice said she developed the perspective that “you are a stronger person, and if you do get faced with a challenge, everything will be okay again,” and later mentioned that she will “take every day as it comes.”

Others noted the importance of an increased ability to accept their own need to be happy, with Brent noting that he makes an effort to “consider my needs,” and later, “My happiness is paramount and I don't need to feel guilty or selfish about this.”

C. Acceptance of Self and Situation – Reds. Only two of the Red cases mentioned changes in therapy that centered on both acceptance of their problems, and acceptance of themselves. Some profited from self-statements regarding their ability to deal with difficult circumstances, such as Robert's maxim: “No matter what's happening, I'm okay,” and later mentioning, “Whatever the way life is today, I accept it. . . . I just let it go.” Ruby realized that it was okay to take care of herself, noting that she was “never thinking about [her]self.” Robert also noted that accepting the inevitability of pain can help one see their problems from a new perspective: “Everything serves a purpose. . . . It opened up those parts that are blocked off. That's what it's all about.”

Changes: Changes to Life

A. Interpersonal Effectiveness – Blues. Brent spoke to an increased awareness of the needs of others, specifically stating that therapy helped him “take the time to listen” and “. . . [consider needs] of others.” He also spoke to a newfound fulfillment in their relationships, namely, “I am able to discuss things more easily with others,” later noting, “I also live in the moment more and enjoy the people I'm with and what I am doing. . . . This has enabled me to extract a lot more joy from life and the people close to me.”

A. Interpersonal Effectiveness – Reds. Red cases also asserted that therapy had changed the way they relate to others. Robert mentioned how therapy helped him to “not think about myself as much, to think about others . . . to put others first.”

Others seemed to emphasize boundaries, with Ruby stating she “realized that [she] was unable to say no to others.” Rebecca mentioned her understanding that she was needed by her loved ones, stating, “I got the idea that people around me (both family and friends) rely on me a lot.” Rebecca also suggested that therapy helped to quell fears about relationships, saying, “I

have much more of an open heart now to relationships, whereas before I was petrified of getting hurt, of loss.”

B. Life Skills – Blues. Several comments were made in reference to general life changes the Blues experienced through therapy. Although they had previously commented on specific affective and cognitive changes, it appears that therapy was also helpful in making basic lifestyle changes. Brent stated that he “developed a plan for the future which involved leaving a very stressful job and undertaking full-time study.” He later commented similarly on the domino effect of therapy in making life changes: “The reduction in stress has allowed me to take stock on my life and set priorities.”

Barbara recognized similar life changes, namely relating to her career path: “I’m working on a bachelors in business management,” while later noting a newfound comfort with her current situation: “Now I’m really good, settled, in work and home.” Some commented on the relationship between therapy and outside events changing in their life, such as Beatrice mentioning, “Outside events improved because of confidence gained through therapy,” while later noting, “Outside events also improved on their own over time.” Barbara mentioned she “also graduated, and got an amazing job which I am loving.”

B. Life Skills – Reds. Red cases were more likely to make ambivalent or negative comments regarding their general changes in quality of life. For example, Rebecca expressed her doubt that she had even made any changes, “It’s hard to say as I don’t really remember what I was feeling/thinking before.” Rebecca also noted, as mentioned above, “Perhaps the situations changed or I learned to cope with them better,” which seems to emphasize the lack of self-efficacy that she experienced.

Ruby was similarly ambivalent, saying that she has made “positive and negative changes.” Again, Robert was very positive about certain life changes, with statements such as, “I don’t even have the obsessions about drinking anymore!” while stating that he was working on “gratitude, humility, being open-minded.”

Rebecca mentioned some regression in her improvements, stating that “therapy really helped me to recognize this and work towards maintaining balance—although since then I have probably reverted back to old ways a little.” Rachele noted that she had since received a new job. Robert also mentioned life changes such as, “I’m trying to be that person that I wanted to be,” clarifying, “I’ve been able to remove a lot of it to be more giving, not be as selfish. Not think about myself as much, to think about others. To put others first. . . . to make amends, to forgive you. Make amends for my behavior in the past. That’s a pretty humbling experience.”

Discussion

Summary

In this study a small, randomly chosen sample of patients was selected from the larger case-load of an independent practitioner in order to better understand the phenomenon of a "sudden gain" (in five "Blue" cases) versus a "sudden loss" (in five "Red" cases) between two

consecutive therapy sessions. These phenomena were identified by Finch et al.'s (2001) method in which "sudden gains" and "sudden losses" are defined as the 10% of clients who respond most positively or most negatively, respectively, between sequential sessions, as controlled by beginning level of disturbance. The clients were contacted between two and two and a half years following their therapy experience and asked to complete a measure of their mental health functioning (the OQ-45), a post-therapy satisfaction survey (the CRSS-4), a therapeutic alliance measure (the WAI), and a set of open-ended questions that were meant to explore hypotheses from the literature that could account for dramatic change (such as the strength of the therapeutic relationship, flight into health, and/or cognitive changes in line with CBT theory). Two important contexts for this study included the established finding that a substantial subset of clients benefit from treatment well before it has been completed and that the client sample was drawn from the caseload of a supershrink, a practitioner with statistically exceptional rates of sudden-gain clients.

Different Patterns Between the Blue and Red Cases

Since the clients in this study were given the OQ-45 prior to treatment and throughout the course of therapy, it was possible to make a quantitative evaluation of their change from pre-therapy levels to post-therapy functioning as well as at follow-up. In addition, the session at which the dramatic change occurred could be tracked by changes in OQ-45 scores. On average, Blue cases started treatment with levels of disturbance about three standard deviation units above the mean of normal functioning, showed dramatic positive change following their first session of treatment, and ended therapy with levels of disturbance well below the mean of normal functioning. These clients, as a group and as individuals, showed an impressive degree of change, which was maintained at follow-up. These findings are in harmony with previous work examining the long-term outcomes of rapid-responders, in that they tend to maintain their gains (Haas, Hill, Lambert, & Morrell, 2002).

The five Red cases showed a different pattern of change on the OQ-45. At intake they were less disturbed than the Blue cases, although they still manifested a degree of disturbance characteristic of outpatients at about two standard deviations above the normative sample mean. As a group they improved by the end of treatment, albeit to a much smaller degree than the Blue cases, and remained in the clinical range as a group. Only 1 out of the 5 individuals met criteria for recovery with the remaining 4 categorized as manifesting no reliable change. At follow-up two years post-therapy, two patients showed reliable improvement, one showed reliable worsening, and two did not change.

Sudden Gains Appearing After the First Session, the Brief Nature of the Therapy, and Eri's Distinctive Role as a Supershrink

Four of the five Blues achieved their sudden gain in the second session, with the fifth achieving it in session 4. This dramatic, early response of the Blues was quite short compared to other studies, which have typically found that an average of five sessions were required to produce such gains (Hardy et al., 2005; Stiles et al., 2003; Tang & DeRubeis, 1999b; Tang et al., 2005). In two other studies, the median occurrence was session eight (Tang et al., 2005; Vittengl et al., 2005). Importantly, clients tend to make their most substantial gains before the bulk of the

therapeutic work has been undertaken. In this small sample, changes appeared to happen within a very quick period of time, certainly before the majority of specific cognitive or behavioral interventions were implemented. In contrast, the session in which the Red clients experienced sudden loss was generally later in treatment than for the Blue clients, with two of the Red clients experiencing it the second session, one in the third session, and the others in sessions 6 and 7 (Table 1).

We propose two tentative hypotheses about why the sudden gains in Eri's Blue clients occurred so rapidly and why their overall therapy was so short. One is based on the particular setting in which Eri practices. She is a psychologist who receives referrals exclusively from primary care doctors in a managed care setting, where session lengths are restricted and many patients present with problems unique to a primary care setting (such as chronic health and substance abuse issues). Thus, Eri's case load might not have been representative of the typical client seeking services in an outpatient mental health clinic—although it should be noted that the diagnoses of the Blue and Red clients as listed in Table 1 were primarily major depression disorder and generalized anxiety disorder, both quite typical in an outpatient mental health clinic.

The second hypothesis for the quick sudden gains and the brief duration of therapy in the Blue clients relates to Eri's qualities as a supershrink, and particularly to the highly efficient nature of her therapy approach. The client descriptions of their therapeutic relationship with Eri portray a therapist with charisma, with the ability to make a strong, immediate connection, with a clear and persuasive plan for change based on both medical and psychological principles, and with an expectation of quick change. In line with this, her techniques are designed to empower clients to find their own solutions, and her pragmatic approach does not require lengthy treatment. Thus Eri provides her clients a holistic, top-down view of their psychopathology within the first session, so that they have a working rubric to organize their symptoms and seek to find solutions in a timely period. This first session can raise hope, which has been found to be a powerful facilitator of change (e.g., Howard, Moras, Brill, Martinovich, & Lutz, 1996). The qualitative data from this study indicate that two years and more after therapy, Eri's clients were able to clearly articulate their understanding and use of certain of Eri's therapeutic techniques.

Overall, the picture of Eri's therapeutic relationship and intervention approach with her clients is quite consistent with the characteristics mentioned above that have been identified in previous studies of supershrinks (Orlinsky et al., 1994; Dans et al., 2004). These include "a strong therapeutic relationship" based on the "therapist's credibility, skill, empathic understanding, and affirmation of the client;" the therapist's "creative approaches to a client's problems, as well as giving a credible rationale and ritual that matched her or his symptom presentation;" the therapist's "active engagement with the client's' concerns;" and a focus on directing "the client's attention to the client's own personal internal experiences."

It should be noted that the Red clients had more therapy sessions (an average of 6.8 compared to an average of 4 for the Blue clients), and also a longer time before their sudden loss session: two of the Red clients experienced it in the second session, one in the third session, and the others in sessions 6 and 7 (Table 1). It should also be noted that in Eri's total caseload, the

average number of sessions was a little over 4, and thus the Red and Blue clients are not that different for her in this regard.

Eri's Special Way of Being

Interrelated with the factors just mentioned, the way in which clients described Eri's distinctive presence in the therapy seems another important component in her effectiveness as a supershrink. Specifically, both Blues and Reds stressed the helpfulness of therapeutic factors related directly to Eri's way of being. In particular, both mentioned Eri's ability to validate, her ability to relate to their pain, her kindness, her personal nature, her acceptance of them as people, and a degree of spirituality. For example, Kim and Kim (2013) found that in particular, validating a patient's concerns, so that the therapist articulates accurate empathy for what a patient is feeling and is able to express this to the client, has been connected with increases in self-esteem. Validation was also found to be more effective than reflection in improving mood and lowering aggression.

The way Eri handled pain is also very valuable in understanding what clients perceived to be helpful. Some of the clients in the sample noted that Eri had a particularly effective way to communicate her understanding of pain, which also tended to communicate to patients that facing and learning to handle pain may be an important aspect of therapeutic change. Also, the importance of Eri's spiritual qualities appeared several times in the interview transcripts.

Other Themes in the Phenomenological Analysis

The therapeutic encounter. Clients made comments regarding the importance of the therapeutic relationship, specific potent ingredients of therapy, and aspects of therapy that were disappointing or unhelpful. Many patients in our sample highlighted the importance of taking personal responsibility, emphasized acceptance of self and situation, and recognized that the change process is often necessarily painful but worth it. Participants also commented on how the adoption of a new perspective that shifted their worldviews ameliorated their pain. Boscaglia and Clarke (2007) referred to this factor as an increase in a "pervasive and enduring sense of meaningfulness, manageability, and comprehensibility" (p. 192).

The subjects in our sample, speaking from their own experiential expertise, did not separate the helpful aspects into categories according to therapeutic modalities. It was only after aggregating the meaning units that the first author noticed that both specific (i.e., CBT or CMT) ingredients were viewed as being just as helpful as common factors such as validation and acceptance, while also valuing specific characteristics of their therapist. Clarke and colleagues (2004) noted that while some authors believe patients only benefit from common factors (see Paulson, Camp, & Robinson, 1991; Wampold, 2001), clients also found elements of specific models of therapy, such as challenging distorted thinking, accepting oneself regardless of performance, and mindfulness approaches were equally valued (see Beck, 1993; Gilbert & Procter, 2006; Hanh, 1996).

Transparency with the therapist. Consistent with the findings of Clarke and colleagues (2004), there did not appear to be a strong trend favoring Reds or Blues when it came to the need

for being open and honest, and self-disclosing. Indeed, members from both groups endorsed difficulty with sharing their innermost thoughts and feelings and tended to censor some of their innermost insecurities. However, this finding is not surprising; patients are occasionally prone to mislead their therapists through exaggerating their pain or incompetence, distorting their experience, deceiving the therapist, omitting important details, or even fictionalizing aspects of their life (Hill, 2012). This finding can serve as a potent reminder for therapists to check in with their patients frequently on their level of comfort with disclosure, and seek to maintain a strong therapeutic bond that encourages honesty and openness instead of secrecy and shame. Clarke et al.'s (2004) studies are consistent with our findings, in that complete disclosure does not appear to be a necessary ingredient of change as both groups made significant changes without being completely transparent.

Client changes both outside and within. Although Red and Blue patients demonstrated dramatically different treatment trajectories, there was a surprising degree of common experiences shared among Red and Blue cases. Patients from both groups made comments about changes outside of themselves as well as changes within themselves. These results are similar to Klein and Elliott's (2006) review of client changes. These authors also found that patients tend to make change comments regarding their own self-improvement, which is separate from change experiences brought about in their interpersonal relationships and general life functioning. Klein and Elliott (2006) also noted personal changes in the domains of experiential processing, self-improvement, and affective changes. Our sample reported similar changes, as the participants highlighted mood and affective changes, improvements in perspective/understanding, as well as increases in self and life situation acceptance.

Blues' match to the therapy culture. The Blue cases' tendency to engage with therapy better, utilize certain interventions, and eventually speak the "language" of therapy may highlight that Blue cases were a better fit for the broader "therapy culture." As individuals come in to therapy with different backgrounds, values, and cultural identities, they may clash with the prevailing vogues and assumptions of current psychological theories and techniques. As the sudden-gains clients appeared more likely to buy into certain therapeutic values, such as "acceptance" or "vulnerability," it is possible that therapy is merely more effective with people who share similar values and goals with the therapist. Future studies could examine how the prevailing zeitgeist of psychotherapy interacts with certain demographics of patients who may hold different values than clinical psychology in general about what it means to live the good life.

Red clients' negative attitudes towards the therapy. In line with above point on Blues resonating more with the therapy culture, the sudden-loss, Red clients tended to make more ambivalent statements regarding their improvement in therapy, reflecting a stronger tendency to endorse negative aspects of therapy. In particular, areas that were helpful for other clients (empathy and affirmation and meditation, for example) seemed to elicit negative reactions with Red cases. Their sudden-loss status could thus possibly be due to their inability to utilize specific skills taught within the therapeutic encounter.

Flexibility. Our results also suggest that there are no one-size-fits-all interventions in psychotherapy as some patients find certain therapeutic techniques more helpful than others. Frank and Frank (1991) believed that patient attributes actually interact dynamically with therapeutic interventions. Thus, no one intervention is suited for all clients. They summarized their view by noting that the closer interventions align and harmonize with the “predilections” of the patient, the more successful the outcome is likely to be. This conclusion was supported by the findings of our study, given that clients who improved quickly were more likely to comment on the helpfulness of certain aspects of the therapy/therapist, while others found the same methods to be unhelpful.

Therapist and therapy characteristics were both helpful. Our findings were somewhat reminiscent of Clarke et al.'s (2004) own review of therapeutic experiences, which included characteristics of the therapist (safety, resistance/fear, and excited/absorbed), as well as specific ingredients of therapy (cognitive change, practice, the CBT model, and understanding core beliefs). In our sample, however, patients highlighted helpful therapist factors that were unique to Eri's own personality and style as well as specific potent ingredients of therapy, unhelpful aspects, and general attitudes towards therapy of taking responsibility for their healing and the necessity of pain in the change process. This finding somewhat echoes Clarke and colleagues' 2004 findings that taking personal responsibility is often a positive outcome that is derived from therapy, although in our sample it appeared to be an actual mechanism of change as well as a natural outcome.

"Difficult but worth it." Blue cases emphasized the importance of “difficult but worth it,” highlighting the necessity of active engagement with the therapy and realistic expectations of inevitable pain in order to produce results. Blues had a tendency to realize that changes in therapy would only occur if they invested themselves in the treatment. They were more likely to comment on their realization that therapy was not magic and that changes would only occur if they exercised their will in the process. Reds, on the other hand, were less likely to comment on the necessity of struggle in therapy and more likely to speak to their lack of hope in the future. One interpretation of these findings, in combination with the Reds' self-descriptions, is that Red cases may be naturally more vulnerable to stress and that Blue cases may be generally more resilient. This hypothesis would have to be tested in the future by measuring participants with characterological and personality measures before and after therapy.

Expectations of therapy. On a related topic, Red clients made more negative statements about therapy and displayed a lesser degree of hope in the therapeutic process in general. Frank and Frank (1991) believed that “mobilization of hope” and the engendering of positive expectations in therapy are a foundational part of the therapeutic success. Studies (e.g., Joyce, Ogrodniczuk, Piper, & McCallum, 2003) have found a strong relationship between patient expectations of therapy and their final therapeutic outcome. When a patient gives up hope in a better future, they may be more likely to continue to be distressed and symptomatic (Clarke & Kissane, 2002). These authors also noted that “For patients adjusting to a life . . . [problem], a re-appraisal of life's goals in a way that gives coherence with global meanings, hopes and

beliefs, and empowerment through attainment of these objectives will increase morale” (p. 739). Thus, deterioration in therapy may be due, in some degree, to the expectations patients hold regarding the responsibility they have in making therapy work for them, and the belief that therapy will help them improve. Future studies could measure incremental improvements in patients whose therapists place a greater emphasis on “selling” the viability and helpfulness of psychotherapy.

Acute distress versus characterological issues as presenting problems. A surprising finding was that the Blue cases were substantially more distressed than their Red peers at intake, yet the Blues improved more quickly in therapy. This was contrary to previous studies (e.g., Ward, Wood, & Awal, 2013; Miklowitz & Johnson, 2006), which found that more severe symptomology at the onset of therapy led to poorer outcomes and longer treatment. This supports a tentative conclusion that the phenomenon of sudden gains in therapy is unique when compared to a typical positive response in therapy.

One possible explanation is that sudden-loss clients suffered more from characterological, personality-disordered symptoms, whereas the clients who witnessed sudden gains were more likely to be in a crisis situation that could be resolved in a shorter period of time. Indeed, Red cases were much more derogatory in their self-descriptions. This possibility may account for the consistency of the longitudinal data that indicated that Reds were generally more symptomatic over a two-year period, while Blues were able to maintain their symptomatic improvements over time. Thus, the Blues' impressive response to treatment may underscore the possibility that their improvements occurred in a time of acute crisis, whereas the Reds' distress was due more to long-standing personality factors that remain consistent over time.

Limitations

Like many case studies, the greatest limitation of our current study remains the small size of the sample. We hope that the promising results of this project encourage others to replicate and expand this type of research with larger samples.

Another limitation was that one of the Red cases (Reilly) did not complete the Client Change Interview Protocol; thus, the qualitative results do not reflect her responses to therapy, and the investigators may have missed out on key aspects of her experience.

Another weakness of this study is the obvious issue of conflating causation with correlation (Ankuta & Abeles, 1993; Klein & Elliott, 2006). Two variables in particular are subject to skepticism in this regard, namely the satisfaction and working alliance constructs. It is unclear at this time whether a better outcome in therapy leads to better satisfaction and stronger sense of working alliance, or vice versa. The alliance and satisfaction would need to be measured throughout therapy to draw more certain conclusions. When asking clients to retrospectively evaluate their experiences in therapy, we may be measuring some degree of artifact given that patient's perspectives of therapy can be affected by the lapse of time and by other experiences during the interim (Clarke et al., 2004; Nielsen et al., 2004). In other words, the direction of change is unknown.

The patients also presented with a multitude of differing diagnoses, thus limiting the possible generalizability of the findings (Klein & Elliott, 2006). We agree with these authors in proposing that future studies examine patients according to diagnoses in order to observe whether different presenting problems are more or less amenable to sudden gains.

The strength of this study's conclusions, as well as its generalizability, is limited given that the study was retrospective in nature (Clarke et al., 2004). The results could be quite different in a prospective study. This would require a researcher to examine client traits such as resilience prior to entering treatment. The psychotherapy itself could be tape-recorded and the process of therapy examined in real time. Special emphasis could be placed on therapeutic events that preceded dramatic gains, which could also be examined in a prospective study.

Because the clients were assessed by a woman that they potentially had a unique and powerful relationship with, they may have had a tendency to underreport poor experiences in therapy and overreport good experiences so as to protect the relationship. The candidness of participants' recollection of therapy, including statements about what they didn't like, lends support to the belief that the qualitative portions were by and large authentic and representative of participants' experiences, but the possibility of hindsight bias cannot be controlled for. Future research could also examine whether sudden gains or sudden losses are additionally explained by acute symptoms versus characterological issues. Patients could be evaluated for personality disorders prior to therapy, and researchers could examine whether the presence of a personality disorder prohibits the likelihood of sudden gains and tends to lead to sudden losses, causing these patients to fall off track in treatment and, eventually, to become a *treatment failure*.

Conclusion.

In spite of the design limitations just listed above, we believe our study, using a naturalistic, pluralistic research design, contributes to our understanding of two important phenomena in psychotherapy research: (a) the occurrence of sudden-gain and sudden-loss sessions and the connection of these with good and poor overall outcomes, respectively, and (b) the types of therapist qualities and therapeutic processes associated with supershrinks. This latter topic highlights the importance of researching the therapist variable, adding to the investigation of empirically supported therapies the study of empirically supported therapists.

REFERENCES

- Ankuta, G. Y., & Abeles, N. (1993). Client satisfaction, clinical significance, and meaningful change in psychotherapy. *Professional Psychology: Research and Practice*, 24(1), 70.
- Beck, A. T. (1993). *Cognitive therapy and the emotional disorders*. NY: Penguin.
- Beckham, E. E. (1989). Improvement after evaluation in psychotherapy of depression: Evidence of a placebo effect? *Journal of Clinical Psychology*, 45(6), 945-950.
- Bergin, A. E., & Suinn, R. M. (1975). Individual psychotherapy and behavior therapy. *Annual Review of Psychology*, 26(1), 509-556.
- Beutler, L. E., Malik, M., Alimohamed, S., Harwood, M. T., Talebi, H., Noble, S., & Wong, E. (2004). Therapist Variables. In M. J. Lambert (Ed.), *Bergin and Garfield's Handbook of Psychotherapy and Behaviour Change* (5th ed., pp. 227-306). Chicago, IL: John Wiley and Sons.
- Boscaglia, N., & Clarke, D. M. (2007). Sense of coherence as a protective factor for demoralization in women with a recent diagnosis of gynecological cancer. *Psycho-Oncology*, 16(3), 189-195.
- Clarke, D., & Kissane, D. (2002). Demoralization: its phenomenology and importance. *Australian and New Zealand Journal of Psychiatry*, 36(6), 733-742.
- Clarke, D., Rees, A., & Hardy, G. E. (2004). The big idea: Clients' perspectives of change processes in cognitive therapy. *Psychology and Psychotherapy: Theory, Research, & Practice*, 77(1), 67-89.
- Dans, A., Bergin, A., & Garfield, S. (2004), *Handbook of psychotherapy and behavior change* (4th ed., pp. 72-113). New York : John Wiley and Sons.
- Elliott, R. (1999). Client Change Interview protocol. *Network for Research on Experiential Therapies*. Website: <http://experientialresearchers.org/instruments/elliott/changei.html>. Accessed on September 12, 2011.
- Elliott, R. (2010) Psychotherapy change process research: Realizing the promise. *Psychotherapy Research*, 20(2), 123-135.
- Elliott, R., Slatick, E., & Urman, M. (2001). Qualitative change process research on psychotherapy: Alternative strategies. In J. Frommer and D.L. Rennie (Eds.), *Qualitative psychotherapy research: Methods and methodology* (pp. 69-111). Lengerich, Germany: Pabst Science Publishers.
- Fennell, M., & Teasdale, J. D. (1987). Cognitive therapy for depression: Individual differences and the process of change. *Cognitive Therapy and Research*, 11(2), 253-271.
- Finch, A., Lambert, M., & Schaalje, S. (2001). Psychotherapy quality control: The statistical generation of expected recovery curves for integration into an early warning system. *Clinical Psychology and Psychotherapy*, 8(4), 231-234.
- Frank, J. D., & Frank, J. B. (1991). *Persuasion and Healing: A comparative study of psychotherapy* (3rd ed.). Baltimore: Johns Hopkins University Press.
- Gaynor, S. T., Weersing, V. R., Kolko, D. J., Birmaher, B., Heo, J., & Brent, D. A. (2003). The prevalence and impact of large sudden improvements during adolescent therapy for depression: A comparison across cognitive-behavioral, family, and supportive therapy. *Journal of Consulting and Clinical Psychology*, 71(2), 386. doi: 10.1037/0022-006X.71.2.386.

B.P. Hansen, M.J. Lambert, & E.N. Vlass

Pragmatic Case Studies in Psychotherapy, <http://pcsp.libraries.rutgers.edu>

Volume 11, Module 3, Article 1, pp. 154-201, 09-12-15 [copyright by authors]

- Gilbert, P., & Procter, S. (2006). Compassionate mind training for people with high shame and self-criticism: Overview and pilot study of a group therapy approach. *Clinical Psychology & Psychotherapy*, *13*(6), 3-7; 353-379.
- Guy, W. (2000). Clinical Global Impressions Scale. Modified from: Rush J, et al.: *Psychiatric Measures*, APA, Washington, DC.
- Haas, E., Hill, R. D., Lambert, M. J., & Morrell, B. (2002). Do early responders to psychotherapy maintain treatment gains. *Journal of Clinical Psychology*, *58*(9), 1157-1172.
- Hanh, T. (1996). *The Miracle of Mindfulness: A Manual on Meditation*. Boston, MA: Beacon Press.
- Hardy, G. E., Cahill, J., Stiles, W. B., Ispan, C., Macaskill, N., & Barkham, M. (2005). Sudden Gains in Cognitive Therapy for Depression: A Replication and Extension. *Journal of Consulting and Clinical Psychology*, *73*(1), 59-67.
- Hill, C. E. (Ed.) (2012). *Consensual qualitative research: A practical resource for investigating social science phenomena*. Washington, DC: American Psychological Association.
- Hofmann, S. G., Schulz, S. M., Meuret, A. E., Moscovitch, D. A., & Suvak, M. (2006). Sudden gains during therapy of social phobia. *Journal of Consulting and Clinical Psychology*, *74*(4), 687-697.
- Horvath, A. O. (1994). Empirical research on the alliance. In A. O. Horvath and L. S. Greenberg (Eds.), *The working alliance: Theory, research and practice* (pp. 259-286). New York: Wiley.
- Horvath, A. O., Del Re, A. C., Flückiger, C., & Symonds, D. (2011). The alliance. In J. C. Norcross (Ed.), *Relationships that work* (pp. 25-69). New York, NY: Oxford University Press.
- Horvath, A. O., & Greenberg, L. S. (1989). Development and validation of the Working Alliance Inventory. *Journal of Counseling Psychology*, *36*(2), 223-233.
- 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), 1059-1064.
- Ilardi, S. S., & Craighead, W. E. (1994). The Role of Nonspecific Factors in Cognitive- Behavior Therapy for Depression. *Clinical Psychology: Science and Practice*, *1*(2), 138-155.
- Israel, T., Gorcheva, R., Walther, W. A., Sulzner, J. M., & Cohen, J. (2008). Therapist's helpful and unhelpful situations with LGBT clients: An exploratory study. *Professional Psychology: Research and Practice*, *39*(3), 361-368.
- Joyce, A. S., Ogrodniczuk, J. S., Piper, W. E., McCallum, M. (2003). The alliance as mediator of expectancy effects in short-term individual therapy. *Journal of Consulting and Clinical Psychology* *71*(4): 672-679.
- Kendall, P. (1993). Cognitive-behavioral therapies with youth: Guiding theory, current status, and emerging developments. *Journal of Consulting and Clinical Psychology*, *61*(2), 235-247.
- Kim, E., & Kim, C. (2013). Comparative effects of empathic verbal responses: Reflection versus validation. *Journal of Counseling Psychology*; *60*(3), 439-444.
- Klein, M. J., & Elliott, R. (2006). Client accounts of personal change in process-experiential psychotherapy: A methodologically pluralistic approach. *Psychotherapy Research*. *16*(1), 91-105.

B.P. Hansen, M.J. Lambert, & E.N. Vlass

Pragmatic Case Studies in Psychotherapy, <http://pcsp.libraries.rutgers.edu>

Volume 11, Module 3, Article 1, pp. 154-201, 09-12-15 [copyright by authors]

- Lambert, M. J., Hansen, N. B., & Finch, A. E. (2001). Patient-focused research: Using patient outcome data to enhance treatment effects. *Journal of Consulting and Clinical Psychology, 69*(2), 159-172.
- Lambert, M. J., Kahler, M., Harmon, C., Shimokowa, K., & Burlingame, G. (2011). Administration and scoring manual for the Outcome Questionnaire-45.2. Orem, UT: American Professional Credentialing Services.
- Larkin, M., & Watts, C., Clifton, E. (2008). Giving voice and making sense in interpretative phenomenological analysis. *Qualitative Research in Psychology, 3*(2), 102-120.
- Lee, D. A. (2005). The perfect nurturer: A model to develop a compassionate mind within the context of cognitive therapy. In P. Gilbert (Ed.), *Compassion: Conceptualisations, research and use in psychotherapy* (pp. 326-351). New York, NY: Routledge.
- Mayhew, S., & Gilbert, P. (2008) Compassionate mind training with people who hear malevolent voices. A case series report. *Clinical Psychology and Psychotherapy, 15*(2): 113–38.
- Miklowitz, D. J., & Johnson, S. L. (2006). The psychopathology and treatment of bipolar disorder. *Annual Review of Clinical Psychology, 2*, 199-235.
- Nielsen, S., Smart, D., Isakson, R., Worthen, V., Gregersen, A., & Lambert, M. (2004). The Consumer Reports effectiveness score: What did consumers report? *Journal of Counseling Psychology, 51*(1), 25–37.
- Okiishi, J., Lambert, M. J., Nielsen, S. L., & Ogles, B. M. (2003). Waiting for supershrink: An empirical analysis of therapist effects. *Clinical Psychology & Psychotherapy, 10*(6), 361-373.
- Orlinsky, D. E., Grawe, K., & Parks, B. K. (1994). Process and outcome in psychotherapy— Noch einmal. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (4th ed., pp. 270–378). New York, NY: Wiley.
- Orlinsky, D. E., Ronnestad, M. H., & Willutzki, U. (2004). Fifty years of psychotherapy process–outcome research: Continuity and change. In M. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (5th ed., pp. 307–389). New York, NY: Wiley.
- Paulson, P. E., Camp, D. M., & Robinson T. E. (1991). Time course of transient behavioral depression and persistent behavioral sensitization in relation to regional brain monoamine concentrations during amphetamine withdrawal in rats. *Psychopharmacology (Berl), 103*(4), 480–492.
- Pham, T. (2005). The specificity and mechanism of sudden gains. *Dissertation Abstracts International: Section B: The Sciences and Engineering*, pp. 6-25.
- Rachman, S. (1999). Rapid and not-so-rapid responses to cognitive behavioral therapy. *Clinical Psychology: Science and Practice, 6*(3), 293-294.
- Renaud, J., Axelson, D., & Birmaher, B. (1999). A risk-benefit assessment of pharmacotherapies for clinical depression in children and adolescents, *Drug Safety, 20*(1), 59-75.
- Ricks, D. F. (1974). Supershrink: methods of a therapist judged successful on the basis of adult outcomes of adolescent patients. In D. F. Ricks, M. Roff, & A. Thomas (Eds.), *Life history research in psychopathology*. Minneapolis, MN: University of Minnesota Press.
- Seligman, M. E. (1995). The effectiveness of psychotherapy: the Consumer Reports study. *American Psychologist, 50*(12), 965-974.

- Smith, J. A. & Osborn, M. (2003) Interpretative phenomenological analysis. In J.A. Smith (Ed.), *Qualitative psychology: A practical guide to methods*. London, England: Sage.
- Southam-Gerow, M., & Chorpita, B. (2007). Anxiety in children and adolescents. In E. Mash & R. Barkley (Eds.), *Assessment of childhood disorders* (4th ed., pp. 347-397). New York, NY: Guilford Press.
- Stewart, J. W., Quitkin, F. M., McGrath, P. J., Amsterdam, J., Fava, M., Fawcett, J., . . . & Roback, P. (1998). Use of pattern analysis to predict differential relapse of remitted patients with major depression during 1 year of treatment with fluoxetine or placebo. *Archives of General Psychiatry*, 55(4), 334-343.
- Stiles, W. B., Leach, C., Barkham, M., Lucock, M., Iveson, S., Shapiro, D. A., & Hardy, G. E. (2003). Early sudden gains in psychotherapy under routine clinic conditions: Practice-based evidence. *Journal of Consulting and Clinical Psychology*, 71(1), 14-21.
- Tang, T. Z., & DeRubeis, R. J. (1999a). Reconsidering rapid early response in cognitive behavioral therapy for depression. *Clinical Psychology: Science and Practice*, 6(3), 283-288.
- Tang, T. Z., & DeRubeis, R. J. (1999b). Sudden gains and critical sessions in cognitive-behavioral therapy for depression. *Journal of Consulting and Clinical Psychology*, 67(6), 894-904.
- Tang, T. Z., DeRubeis, R. J., Beberman, R., & Pham, T. (2005). Cognitive Changes, Critical Sessions, and Sudden Gains in Cognitive-Behavioral Therapy for Depression. *Journal of Consulting and Clinical Psychology*, 73(1), 168-172.
- Tang, T. Z., DeRubeis, R. J., Hollon, S. D., Amsterdam, J., & Shelton, R. (2007). Sudden gains in cognitive therapy of depression and depression relapse/recurrence. *Journal of Consulting and Clinical Psychology*, 75(3), 404-408.
- Tang, T. Z., Luborsky, L., & Andrusyna, T. (2002). Sudden gains in recovering from depression: Are they also found in psychotherapies other than cognitive-behavioral therapy? *Journal of Consulting and Clinical Psychology*, 70(2), 444-447.
- Vermeersch, D. A., Lambert, M. J., & Burlingame, G. M. (2000). Outcome Questionnaire: Item sensitivity to change. *Journal of Personality Assessment*, 74(2), 242-261.
- Vittengl, J. R., Clark, L. A., & Jarrett, R. B. (2005). Validity of Sudden Gains in Acute Phase Treatment of Depression. *Journal of Consulting and Clinical Psychology*, 73(1), 173-182.
- Wampold, B. E. (2001). *The great psychotherapy debate: Models, methods, and findings* (pp. 200-105). Mahwah, NJ: Lawrence Erlbaum Associates.
- Wampold, B. E., Ahn, H., & Coleman, H. K. (2001). Medical model as metaphor: Old habits die hard. *Journal of Counseling Psychology*, 48, 268-273.
- Ward, A., Wood, B., Awal, M. (2013). A naturalistic psychodynamic psychotherapy study: Evaluating outcome with a patient perspective. *British Journal of Psychotherapy*, 29(3), 292-314.

Table 1. Client Initial Diagnoses and Session History

<i>Client</i>	<i>Gender</i>	<i>Age</i>	<i>Initial diagnosis</i>	<i>Total number of therapy sessions</i>	<i>Sessions during which sudden gain occurred</i>	<i>Sessions during which sudden loss occurred</i>	<i>Length of time between last therapy session and follow-up session (months)</i>
BLUES							
Brent	M	52	MDD*	5	2	-	25
Bailey	F	36	GAD*	3	2	-	26
Barbara	F	30	MDD, Alcohol Abuse Disorder	4	2	-	30
Beatrice	F	37	GAD	3	2	-	27
Brenda	F	41	GAD	5	4	-	31
REDS							
Robert	M	39	Bipolar I	9	-	2	30
Rachelle	F	29	MDD	7	-	6	26
Rebecca	F	23	MDD	6	-	3	30
Reilly	F	28	GAD, Pain Disorder	4	-	2	27
Ruby	F	45	MDD	8	-	7	32

*MDD = Major Depressive Disorder; GAD = General Anxiety Disorder

Table 2. Mean Scores on First Session OQ-45, Last Session OQ-45, and
Change OQ-45 for Eri's Caseload Over a Year

Category	N =	Mean Length of Treatment In Sessions	First Session OQ-45	Last Session OQ-45	Average Change OQ-45
Top 10% of Treatment Response*	43	3.9	104.2	54.9	-49.3
Middle 80% of Treatment Response*	36	3.4	93.5	68.6	-24.9
Bottom 10% of Treatment Response*	6	5.5	86.3	94.3	7.0

* Based on statistics from over 10,000 outpatient clients by Lambert, Hansen, and Finch (2001).

Notes:

- 1) The clinical cut off for the OQ-45 is 63/64, with higher scores reflecting higher symptom levels.
- 2) A change equal to or greater than +14 or -14 points on the OQ-45 denotes a reliable change of loss or gain in symptoms, respectively.

-

Table 3. Subjects CRSS-4 Scores

<i>Subject</i>	<i>CRQ1*</i>	<i>CRQ2</i>	<i>CRQ3</i>	<i>CRQ4</i>	<i>CRQ5</i>
Brent	1	1	1	4	5
Bailey	1	1	1	4	5
Barbara	1	1	1	5	5
Beatrice	1	1	1	3	3
Brenda	1	1	1	4	4
Robert	2	3	3	3	3
Rachelle	2	2	1	3	3
Rebecca	2	3	2	4	4
Reilly	1	1	1	3	3
Ruby	2	4	1	3	3

Note. The Consumer Reports Questionnaire 4 (CRSS-4) is from Seligman (1995)

*CRQ1: How much did treatment help with the specific problem that led you to therapy?
1=made things a lot better; 5=made things a lot worse

*CRQ2: Overall how satisfied were you with this therapist's treatment of your problems?
1=completely satisfied; 5=completely dissatisfied

*CRQ3: How would you describe your overall emotional when you started counseling? 1=very poor: I barely managed to deal with things; 5=very good: Life was much the way I liked it to be

*CRQ4: How would you describe you overall emotional state at the end of treatment? 1=very poor: I barely managed to deal with things; 5=very good: Life was much the way I liked it to be

*CRQ5: What is your overall emotional state at this time? 1=very poor: I barely managed to deal with things; very good: Life was much the way I liked it to be

Table 4. Subjects' OQ-45 Scores, by Session and by Change

<i>Subject</i>	<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>5</i>	<i>6</i>	<i>7</i>	<i>8</i>	<i>9</i>	<i>OQ^{Final}</i>	<i>OQ^{Pre-Post}</i>	<i>OQ^{Post-Final}</i>
Brent	110	<u>40</u>	30	21	20	-	-	-	-	19	-89	-1
Bailey	72	<u>32</u>	33	-	-	-	-	-	-	14	-39	-9
Barbara	117	<u>87</u>	65	45	-	-	-	-	-	34	-83	-11
Beatrice	108	<u>84</u>	54	-	-	-	-	-	-	46	-62	-8
Brenda	150	148	130	<u>31</u>	36	-	-	-	-	73	-77	+37
Robert	104	<u>124</u>	110	72	106	76	85	80	72	52	-32	-20
Rachelle	109	101	110	78	75	<u>123</u>	79	-	-	88	-30	+9
Rebecca	69	78	<u>80</u>	69	58	83	-	-	-	62	+14	-21
Reilly	87	<u>102</u>	108	114	-	-	-	-	-	111	+27	-3
Ruby	91	91	91	77	61	65	<u>104</u>	70	-	113	-21	+43

Notes:

OQ^{Pre-Post} measures overall change on OQ-45 between first and last sessions of therapy.

Clinically significant change is indicated by + or - 14 points.

OQ^{Post-Final} measures overall change on OQ-45 between last session of therapy and follow-up at 2-year interval.

Clinically significant change is indicated by + or - 14 points.

An OQ score with an underline () denotes a session in which a client either made either a sudden-gain or a sudden-loss compared to the previous session.

The clinical cut-off for the OQ-45 is 63/64, with higher scores reflecting higher symptom levels.

Table 5. Mean Change Scores on OQ-45

	<i>OQ^{Pre}</i>	<i>OQ^{Post}</i>	<i>OQ^{Follow-up}</i>	<i>OQ^{Pre-Post*}</i>	<i>OQ^{Post-Follow-up*}</i>
Blues	111.4	37.6	37.2	-73.8	-0.4
Reds	92	83.6	85.2	-8.4	+1.6

Notes:

- 1) The clinical cut off for the OQ-45 is 63/64, with higher scores reflecting higher symptom levels.
- 2) A change equal to or greater than +14 or -14 points on the OQ-45 denotes a reliable change of loss or gain in symptoms, respectively.

Table 6. Mean Scores on WAI-Tasks, WAI-Bond, WAI-Goals, and WAI-Total

	<i>WAI-Tasks</i>	<i>WAI-Bond</i>	<i>WAI-Goals</i>	<i>WAI-Total</i>
Blues	81.4 (<i>SD</i> = 3.29)	78.6 (<i>SD</i> = 2.59)	82.2 (<i>SD</i> = 2.49)	242 (<i>SD</i> = 7.11)
Reds	63 (<i>SD</i> = 10.49)	71.4 (<i>SD</i> = 10.21)	76.6 (<i>SD</i> = 11.44)	202 (<i>SD</i> = 30.91)
<i>t</i> -value	3.74 (<i>df</i> = 8)*	1.43 (<i>df</i> = 8)	2.78 (<i>df</i> = 8)*	2.82 (<i>df</i> = 8)*

Notes

The three WAI subscales can range from 12 to 84, and the Total scale, from 36 to 252.

* $p < .05$

Table 7. Open-Coding of Client Change Interview Protocol

<i>Theme I: Therapy Experience</i>
Cluster 1: The Therapeutic Encounter
◦ Category A: Unique Therapist Qualities
◦ Category B: Potent and Specific Ingredients
◦ Category C: What Didn't Work
Cluster 2: Attitude Towards Therapy
◦ Category A: Resistance to Therapy
◦ Category B: Personal Responsibility in Change Process
◦ Category C: Painful but Worth It
<i>Theme II: Changes</i>
Cluster 1: Personal Changes
◦ Category A: Putting Things in Perspective
◦ Category B: I am just doing better (mood and affective changes)
◦ Category C: Acceptance of Self and Situation
Cluster 2: Changes to Life
◦ Category A: Interpersonal Effectiveness
◦ Category B: Life Skills