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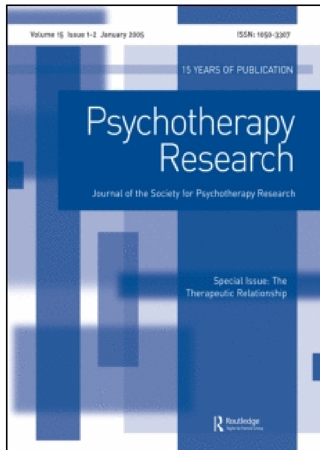

Psychotherapy Research
Publication details, including instructions for authors and subscription information:
http://www.informaworld.com/smpp/title~content=t713663589

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First Published on: 06 March 2007
To cite this Article: , 'Patients' experiences of change in cognitive-behavioral therapy and psychodynamic therapy: a qualitative comparative study', Psychotherapy Research, 1 - 14
xxxx:journal To link to this article: DOI: 10.1080/10503300601139988
URL: http://dx.doi.org/10.1080/10503300601139988

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Patients' experiences of change in cognitive–behavioral therapy and psychodynamic therapy: a qualitative comparative study

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(Received 7 March 2006; revised 22 November 2006; accepted 22 November 2006)

Abstract
Research suggests that different therapeutic approaches produce roughly equivalent outcomes despite their theoretical and technical differences. This study explores whether the quantitative equivalence may conceal differences in patients' experiences of the quality of change. Thirty-two patients who had terminated cognitive–behavioral therapy or psychodynamic therapy were interviewed about their experiences in psychotherapy. The cases were clustered in four groups depending on type of therapy and whether outcome was judged as satisfactory or not. An outcome narrative was reconstructed for each type. Even though the ratio of satisfactory to unsatisfactory cases was roughly equal in the two types of treatments, there were obvious differences in the kinds or quality of outcome that were reported as well as some experiences common to the two groups of patients. The narratives of the dissatisfied patients underscored the importance of matching the approach to the patient.

Since, in 1975, Luborsky et al. revived and revisited Rosenzweig's Dodo bird verdict, it has become increasingly clear that psychotherapy has a significant positive effect in the treatment of psychopathology, while it remains equally clear that no one form of psychotherapy is generally superior to another (Lambert, 2004; Lambert & Ogles, 2004; Luborsky, Singer, & Luborsky, 1975; Wampold, 2001).

A number of hypotheses have been advanced to account for this state of affairs. It may well be that differences do exist in the effect of particular forms of treatment, but research methodology and effect measures have not been sufficiently sensitive to elucidate them (Kazdin & Bass, 1989). Another possible explanation, the common factors hypothesis, suggests that specific or unique ingredients matter less than the ingredients that are common or similar among the different forms (Hubble, Duncan, & Miller, 1999). According to a third hypothesis, the interaction or matching hypothesis, different forms of psychotherapy vary in their degree of suitability for individual patients. A certain treatment may be effective with some patients but unsuitable for others. However, when researchers only test for main effects, ignoring the interaction between patient factors and types of psychotherapy, different treatments will appear to have equal mean effects. Beutler (1979; Beutler & Harwood, 2000) and Blatt (Blatt & Felsen, 1993; Blatt & Ford, 1994; Blatt & Shahar, 2005) are among those who have provided support for this idea.

However, do the quantitative equalities really reflect qualitative similarities? A fourth interpretation of the equality paradox is that different varieties of psychotherapy may be quantitatively equal in their outcomes, although these outcomes (and their mechanisms) may be quite different from a qualitative point of view. Although this may not be unique for psychotherapy, we believe that its relatively free or flexible format and relative open-endedness (compared, e.g., with pharmaceutical or surgical treatment) offer a wider scope for experiences of what happens in therapy and what comes out of it.

Jones and Pulos (1993) and Ablon and Jones (1998, 1999), in process comparisons among cognitive–behavior therapy (CBT), psychodynamic therapy (PDT), and interpersonal therapy (IPT), found that therapist stances, activities, and techniques were generally consistent with the different theoretical recommendations for whichever brand of therapy the therapist was practicing, yet the therapies came out very similar from a quantitative point of view. Whereas Jones et al. seemed to favor a variety of the common factors hypothesis, we find it

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ISSN 1050-3307 print/ISSN 1468-4381 online © 2007 Society for Psychotherapy Research
DOI: 10.1080/10503300601139988

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unlikely that the outcomes of such different processes really are equal from a qualitative point of view. Rather, we believe, fixed-format responding, in terms of ratings and scores on standard quantitative scales, will make quality differences in outcomes go unnoticed. Qualities of outcome are the patient's experiences, memories, meanings, fantasies, cognitive and perceptual styles, concepts, values, resources, capacities, interests, or habits. These may change, not primarily by becoming more (or less) on some variable but by becoming different, thereby modifying, replacing, or eliminating prior structures or forming new ones. Such changes may require altogether different, qualitative methods for their detection.

McLeod (2001) is probably the one psychotherapy researcher who has consistently argued that qualitative research methods need to be used as a complement to conventional quantitative outcome studies. If this is not done, the full array of psychotherapy effects will not emerge, including the negative effects, side effects, and so on. According to McLeod, the use of deep interviewing techniques may thus help to give a more balanced impression of therapy.

Quasi-qualitative[1] studies of clients' experiences of psychotherapy seem often to identify common, relational factors as the most helpful (Elliott & James, 1989; Gershefski, Arnkoff, Glass, & Elkin, 1996; Murphy, Cramer, & Lillie, 1984; Norcross, Dryden, & DeMichele, 1992; Sloane, Staples, Cristol, Yorkston, & Whipple, 1975; Strupp, Fox, & Lessler, 1969), such as the therapist's helpfulness, encouragement, and interest. However, also so-called specific factors are important, either helpful or hindering. Gershefski et al. (1996) and Levy, Glass, Arnkoff, and Gershefski (1996) found that the same treatment aspects (e.g., focus on negative cognitions in CBT, interpersonal problems in IPT, both classified as treatment specific by the authors) were felt as helpful to some clients but as hindering to others. Qualitative outcome studies in psychotherapy are rare (McLeod, 2000). Whereas qualitative inquiry seems to come rather naturally to researchers of family therapy (Maione & Chenail, 1999), we have been able to find only two studies on CBT, one by Kühnlein (1999) and the other by Dunn, Morrison, and Bentall (2002). Studies of PDT from a patient perspective are somewhat more common but still not frequent (Elliott & Shapiro, 1992; Haugaard Jacobsen & Thybo, 1994; Llewelyn, Elliott, Shapiro, Hardy, & Firth-Cozens, 1988; Rennie, 1992; Wachholz & Stuhr, 1999). As with the previous set of studies, the focus in most cases has been on what the patients believe has been helpful rather than what they feel has changed about them.

The purpose of the present study was to qualitatively compare two theoretically distinct forms of psychotherapy: PDT and CBT. The study aimed to answer the following question: Do patients in PDT and CBT differ—and if so, how—in the following respects: How do they describe their experiences of being in therapy? In what ways do they feel they have changed as a consequence? How do they believe these changes have come about? How do they describe unhelpful or negative aspects of psychotherapy? The study had a naturalistic retrospective design and used semistructured interviews with former patients at a psychotherapy clinic. As often with ex post facto clinical studies, and beyond our control, the assignment of patients was clinical, not randomized; diagnoses were unknown and the chart files inaccessible to us; pretreatment assessment was lacking; and the treatments were nonmanualized and therapist adherence was unchecked. Nevertheless, because we did not intend to do a comparative efficacy study, we welcomed this opportunity to do an exploratory study addressing an important issue.

Method

Participants

Patients who had previously completed psychotherapy at a subclinic of a publicly funded psychiatric outpatient clinic in an average-size town in south central Sweden were informed by mail about the project and asked to participate. Patients had previously received either CBT or PDT. A team at the clinic had assigned the patients to the respective type of therapy, based on clinical grounds not clear to us because we had no access to file charts and no opportunity to retrospectively interview the people in charge of each single case. Identification of type of therapy was based on the formal training qualifications of the therapists. The target number of participants was 40. To allow the patients a reasonable refractory period to cope with possible termination/separation reactions and gain some perspective on their experiences, the target interval after termination was set to 6 to 12 months. After approaching 100 former patients in a consecutive backward order, a total of 40 patients had responded positively to the invitation. Because the last eight patients to respond were PDT, they were excluded to ensure that the CBT and PDT groups were of roughly equal size. Of the 32 patients who were interviewed, all except one were included in the study. This patient was excluded from the study because of signs of psychosis during the interview, which seriously

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compromised the quality of her account. Of the 31 patients who participated in the study, 27 were women and 4 were men. Their age ranged from 20 to 65 years at the time of the interview ($M =$ 43 years, $SD = 11$). Socioeconomic status was markedly heterogeneous, as were patients' presenting psychopathology, which covered a spectrum of both neurotic and psychotic problems. No formal diagnoses were available to us, but because this was a special psychotherapy subclinic within a larger outpatient clinic, all cases had been judged as suitable for some type of psychotherapy. Fourteen patients had previously been in CBT, whereas 17 had taken part in PDT. Length of CBT varied from 2 to 48 months ($mdn = 6$), and PDT varied from 18 to 120 months ($mdn = 34$). All therapies were conducted with once-weekly sessions. The highest durations in each group were extreme outliers. Because of an unanticipated nonresponse rate in our initial sample, we had to extend our inclusion criterion in terms of time between termination of treatment and the interview. The final variation was from 6 to 24 months ($mdn = 15$) for CBT and from 6 to 20 months ($mdn = 12$) for PDT.

The number of therapists was 14: five in CBT and nine in PDT. Nine were women (64%) and five were men (36%), and they ranged in age from 39 to 62 years. All were university trained (or were trained at university-approved private institutes) in their respective type of psychotherapy and were licensed by the National Board of Health and Social Welfare.

Interviewers

The interviews were conducted and coded by Thomas Nilsson and Martin Svensson and supervised by Rolf Sandell. Our basic training has been in psychodynamic therapy, but Thomas Nilsson, Martin Svensson, and David Clinton have treatment and supervision experiences with CBT as well. Our theoretical orientation may best be described as interactional, in the Aptitude × Treatment × Outcome sense (Blatt & Felsen, 1993). Thus, we assume that different types of psychotherapy are differentially suitable to different patients and generate different types of effects. It was, in fact, this assumption that provided the impetus for this study.

The Interviews

Qualitative interviews were used to assess patients' experiences of change during psychotherapy (Fontana & Frey, 1994; McLeod, 2001; Sandell, Grebo, Härdelin, & Lauthers, 2005). Patients were interviewed for about 60 min (range = 40–90) using a semistructured interview schedule.[2] The interviews were patient centered and nondirective, trying as much as possible to not influence patients with any theoretical notions of what relevant change might be. Questions were thus formulated to be as theoretically neutral as possible. The interviews covered six specific domains, with equal emphasis on the part of the interviewer: nature of change, course of change, therapist's methods, therapist and the therapeutic relationship, external influences on change, and patient's own contribution to change.

Before the interviews, patients received a letter with information about the interview in an attempt to stimulate their thoughts on the subject. We believed such preparation would help generate more valuable material in the interviews. In the letter patients were asked to prepare themselves for the interview by attempting to think about what their life was like when they sought help, how they experienced their therapy, how life is today, and how therapy helped or not. If patients felt that change had taken place, they were asked to think about whether this was due to therapy or other events that took place at the same time. As an additional recall stimulus, patients were also asked to try and remember what the room looked like, how they felt going to the sessions, how they experienced their therapist, how they and the therapist were dressed, and so on.

The interviews started with a standard introduction of information concerning aim, structure, and length of the interview. At the start of the interviews, a time line technique was used (McKenna & Todd, 1997), intended to stimulate patients' memories of therapy by helping them chronologically to link their experiences in therapy to critical life events. McKenna and Todd offer some support for this idea. All interview domains were covered in each interview, although to differing extents and in different orders depending on the patient's response. The two interviewers conducted 16 interviews each, with one omitted from the final material, as described previously. Frequent meetings with the interviewers were scheduled so as to try to minimize differences in how they conducted their interviews.

Data Analysis

Interviews were tape-recorded and transcribed in their entirety and then subjected to intensive qualitative analysis. The software ATLAS.ti was used as an aid to the analysis (Muhr, 1997). ATLAS.ti is a facility to store and manipulate texts (and pictures, audios, or videos) by keeping records of codes, marking text, assigning codes, sorting codes and coded text, retrieving coded text, and so on. Before the analysis proper, each interviewer listened to each

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interview in its entirety to gain a general impression of the interview. The following analysis of the interviews was done jointly by Thomas Nilsson and Martin Svensson. The first round of coding of the data utilized the principles of text interpretation developed by Strauss and Corbin (1998). Each patient statement that could be related to psychotherapeutic change was allocated a code that summarized the original expression as closely as possible. Thus, a list of codes was accumulated during the initial coding round. After the initial coding of all interviews, all interviews were recoded to ensure that the final and complete set of codes was applied equally to all interviews. During coding a deliberate effort was made to produce codes that were not specific or otherwise linked to any particular theory. This was done to generate a representation of the experience of change as congruent as possible with the patient's description that would provide the basis for an unbiased comparison between the two psychotherapeutic perspectives. Further, so as to not favor either one of the two therapeutic approaches, coding was alternated so that every other interview alternated between PDT and CBT.

Attempts were made during the coding to avoid experience-distant interpretations of the interview material or looking for latent meanings. As such, the aim was to allow the patient's experiences to speak for themselves. When patients sometimes seemed to contradict themselves, we decided to describe the patient's experiences in their complexity rather than attempt to judge which statement was truer or most significant. Before a statement was coded, it was first considered in the entirety of its context to avoid using the patient's statement in a way that the patient might not have intended (e.g., when patients used irony).

Based on the aims of the study, six specific questions were put to the interview material: What changed? What happened with these changes after termination? What aspects of therapy contributed to change? What are patients' theories about how psychotherapeutic change may come about? What made therapeutic work more difficult? What else might have helped if there was too little change? The specific codes of the patients' statements were then assigned to these questions. Because we regard them as mutually exclusive, this work proceeded in an iterative fashion until the majority of codes had been assigned to one of our questions.

Following a person-oriented approach rather than a variable (or, in this case, a code) approach (Bergman & Magnusson, 1997) and inspired by Wachholz and Stuhr (1999), we then tried to cluster the patients into ideal types on the basis of their accounts of their experiences. The most obvious and noninferential typology that could be found was in terms of whether we judged a case as satisfactory or not from the point of view of outcome. The categorization reflected our overall appraisal of whether, based on the patient's account, the case had had a satisfactory outcome, whatever the patient felt about various aspects of the treatment.[3]

Classifications of each case was made independently by the two interviewers and then compared. The interviewers diverged in relation to only two interviews, in which cases the categorization of the interviewer who had himself conducted and transcribed the interview was chosen. Thus, cases were categorized in terms of being either satisfactory or unsatisfactory, further divided on the basis of their type of therapy, yielding four ideal types.

Our construction of the four ideal types was primarily guided by the number of statements per code and the number of patients responsible for these statements. This distinction was made to differentiate between high numbers of statements by single patients and by multiple patients. Also, however, we took into account how a statement was delivered in the interviews (e.g., in passing or with emphasis or given great importance in relation to the patient's overall evaluation of his or her psychotherapy experience). Finally, we endeavored to construct the ideal types so as to synthesize a coherent narrative of the experiences of being a satisfactory or unsatisfactory case in either type of therapy. As a consequence of these considerations, the quantitative order among the codes (in terms of frequencies) was not strictly adhered to. In our reconstructions, we have considered the codes assigned to the six questions/tables as a common population of codes.

In view of the narrative nature of our findings, we call the ideal types "satisfied patients" and "dissatisfied patients," each with either CBT or PDT. For reasons of convenience and because the majority of the patients were female, we refer to patients in the feminine in the following accounts of the types. To avoid confusion, we consequently refer to therapists in the masculine.

Ethical Considerations

Prospective participants in the study received written information about the project and confidentiality. Informed consent was obtained from all those choosing to participate. The study was approved by the relevant ethics committees. Participants received no remuneration for participation.

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Results

The four ideal types were based on different numbers of patients. There were eight (57%) satisfied and six (43%) dissatisfied CBT patients. Among the PDT patients, 11 (65%) were satisfied and six (35%) were dissatisfied. The proportions do not differ between CBT and PDT, $\chi^2(1, N=31) = 0.19$, $p=.67$.[4]

The codes summarizing patients' statements and assigned to each of the specific questions are presented in Tables I to VI. The tables provide the number of specific statements assigned to each code given by satisfied and dissatisfied patients in CBT and PDT. Because some patients gave multiple statements assigned to the same code, the percentage of patients with a particular code for each form of therapy is also given.

Before finally synthesizing our ideal types, we tested whether the patients of any particular therapist deviated in a striking fashion from other patients in terms of satisfaction, thus unduly influencing our typology. There was no significant difference among the therapists in the numbers of satisfied and dissatisfied patients, $\chi^2(13, N=31) = 19.76$, $p=.10$. We also tested whether the satisfied and unsatisfied patients differed in treatment duration, $t(29) = 0.49$, $p=.63$, or length of the termination-to-interview interval, $t(29) = 0.52$, $p=.61$ (two-tailed tests).

Satisfied Patients

Common experiences among the satisfied patients. A general experience after therapy was that therapy helped in the long run (Item 41). Specific changes included finding new coping tools (Item 25), especially understanding and coping with feelings more easily (Item 24), thereby experiencing less anxiety (Item 28). A spin-off effect of the treatment noted by patients was the awareness that changes in one area of life could result in the ability to make changes in

Table I. Codes Referring to Patients' Experiences of Change.

	Satisfied				Dissatisfied			
	No. statements		% Patients		No. statements		% Patients	
Item	CBT	PDT	CBT	PDT	CBT	PDT	CBT	PDT
1. Am able to cope with difficult situations	15	9	88	45	1	1	17	17
2. Am less afraid of my own weaknesses	0	4	0	36	0	0	0	0
3. Am mature enough for closeness	0	1	0	9	0	0	0	0
4. Am more reflective	0	2	0	9	0	0	0	0
5. Am more tolerant	0	3	0	9	0	0	0	0
6. Am reassessing things in life	0	5	0	27	0	0	0	0
7. Can accept myself more easily	0	7	0	45	1	1	17	17
8. Can deal better with destructive relationships	0	5	0	36	1	0	17	17
9. Can distinguish between my inner and outer worlds	0	1	0	9	0	1	0	17
10. Can look after myself	0	3	0	27	0	0	0	0
11. Can make appropriate demands on myself	1	0	13	0	0	2	0	17
12. Can set limits and boundaries	2	15	25	82	0	2	0	33
13. Can take more responsibility	0	5	0	27	0	1	0	17
14. Can understand myself better	0	18	0	82	4	11	17	83
15. Can understand others better	2	3	13	19	0	0	0	0
16. Care about myself	4	19	38	55	0	3	0	33
17. Changed my way of relating to others	0	18	0	73	0	4	0	33
18. Don't feel so ashamed or guilty	0	8	0	18	0	4	0	17
19. Enjoy spin-off effects from therapy	4	6	25	45	0	2	0	33
20. Feel a basic sense of security	1	13	13	45	0	1	0	17
21. Feel a new sense of strength	0	4	0	9	0	3	0	50
22. Feel a right to my own life	0	9	0	55	0	1	0	17
23. Feel more vulnerable	0	1	0	9	0	0	0	0
24. Feelings are easier to understand and cope with	6	5	50	36	1	1	17	17
25. Found new coping tools	9	5	50	27	5	0	33	0
26. Have increased self-confidence	5	13	38	64	0	3	0	50
27. Have less anger	0	2	0	18	0	0	0	0
28. Have less anxiety	5	4	50	27	1	2	17	33
29. Have more freedom	1	3	13	9	1	0	17	0
30. Have retaken control of my life	11	8	75	36	0	1	0	17
31. My life's story is more coherent	0	7	0	45	0	2	0	33
32. My problem has been normalized	9	3	63	18	2	2	33	33

Note. CBT = cognitive–behavioral therapy; PDT = psychodynamic therapy.

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Table II. What Happened With Changes After Therapy?

Item	Satisfied				Unsatisfied			
	No. statements		% Patients		No. statements		% Patients	
	CBT	PDT	CBT	PDT	CBT	PDT	CBT	PDT
33. Became aware of relapse risks	5	5	38	27	0	1	0	17
34. Changes became integrated	7	5	50	18	0	1	0	17
35. Changes came after therapy finished	0	6	0	18	0	2	0	33
36. Felt alienated from my own changes	4	0	13	0	0	0	0	0
37. Felt better day by day	5	2	50	18	1	1	17	17
38. Felt we had completed our task when therapy ended	3	8	25	36	0	4	0	67
39. Kept on working with things by myself	3	6	25	55	0	2	0	33
40. Needed therapeutic “refilling”	6	4	38	18	1	2	17	17
41. Therapy helped in the long run	5	8	63	55	0	2	0	33
42. Therapy helped in the short run	1	0	13	0	5	1	67	17
43. There was no change	0	0	0	0	10	0	67	0
44. There wasn’t enough change	1	4	13	18	8	4	50	50
45. Things got worse	0	0	0	0	2	2	17	17
46. What we had talked about started to turn up in everyday life	2	2	13	18	1	3	17	50

Note. CBT = cognitive–behavioral therapy; PDT = psychodynamic therapy.

other areas (Item 19): “I could never have had the job I have today if I couldn’t show myself to be a reasonably well-adjusted and whole person.”

The issue of completion presented itself in the patient’s mind in various ways. Along with a feeling that the therapeutic task had been completed (Item 38) was the awareness of relapse risks (Item 33) and the belief that one might need therapeutic “refilling” (Item 40).

Whichever type of therapy the patient had been in, motivation (Item 81) and involvement from both parties (Items 72, 77) were felt as necessary helping factors. There was also an awareness of one’s self-agency and responsibility as a change agent (Item 68). At the same time, the person of the therapist and his skill was essential. Basically, the patient felt that she and the therapist did click together, as through a kind of personal chemistry (Item 74). She was thus able to rely on the therapist (Item 55) and let herself be inspired by him to face her fears (Item 87). The therapist was also able to create enough structure in sessions for constructive work to be done (Item 50).

The satisfied PDT patient. The most distinctive experience of change with the PDT patient was the feeling of understanding oneself better than before (Item 14). This involved a feeling of now having a more coherent life story (Item 31), thereby having, more than before, a basic sense of security (Item 20) and being less afraid of one’s own weaknesses (Item 2), accepting oneself more easily (Item 7), and feeling increased self-confidence (Item 26). Basically, one now felt a right to one’s own life (Item 22): “Despite going through so many difficult things in my life, I’ve now been able to piece these things together. So my life feels whole instead of fragmented.” As a consequence, the patient was now prepared to take on more responsibility (Item 13), look after herself (Item 10), and take care of herself (Item 16). The therapy had helped the patient to reassess things in life (Item 6), for instance her relationships. She now felt more able to relate to other people in meaningful ways (Item 17). This entailed setting limits and boundaries for them when that was needed (Item 12). Thus, she was now better able to deal with destructive relationships (Item 8): “I’ve now been able to find a way of functioning in the day-to-day world that allows me to experience things myself and not on the basis of what others need. I’ve always been there to take care of others’ needs but never my own. It’s a big change. Today I go first. It means that I feel a lot better, and that I can now stand up for myself.” A sequel to the treatment was that the patient was able to continue after termination to work on problems on her own (Item 39).

The principal ways in which the satisfied PDT patient felt these changes had come about was by talking about, and reflecting on, herself (Item 78), thereby finding connections and patterns (Item 59), “piecing things together,” and doing this again and again in a working-through fashion (Item 93): “Turning myself inside out and analyzing all sorts of small things, and then putting them back in the right place. That has been a tremendous help for me.” Thus, the satisfactory therapy became a matter of getting to the root of things (Item 102). Also contributing was the broadening of the patient’s horizon by looking at herself in a wider context and

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Table III. What Aspects of Therapy Contributed to Change?

	Satisfied				Unsatisfied			
	No. statements		% Patients		No. statements		% Patients	
Item	CBT	PDT	CBT	PDT	CBT	PDT	CBT	PDT
47. A kind of subtle influence	2	7	25	45	0	0	0	0
48. A therapist being nonjudgmental	0	4	0	27	0	0	0	0
49. Being able to demonstrate competence	3	0	25	0	0	0	0	0
50. Being provided with structure	10	7	75	45	1	0	17	0
51. Being understood	3	2	38	18	2	5	17	50
52. Doing homework	4	0	38	0	0	0	0	0
53. Emotional support	4	11	38	73	0	3	0	50
54. Exposure to frightening things	17	1	75	9	0	0	0	0
55. Feeling I could rely on the therapist	4	5	38	36	3	0	33	0
56. Feeling pleasure in sessions	7	3	63	27	0	2	0	33
57. Feeling strong enough for therapy	1	1	13	9	0	0	0	0
58. Feeling the therapy hour was mine	0	5	0	18	0	1	0	17
59. Finding connections and patterns	0	10	0	55	3	6	33	50
60. Finding the answer with the therapist's help	3	5	13	27	1	0	17	0
61. Focusing my mind on something else	1	0	13	0	0	0	0	0
62. Focusing on the here and now	1	0	13	0	1	0	17	0
63. Going through things again and again	0	3	0	18	0	2	0	33
64. Having someone to look up to	1	2	13	9	0	0	0	0
65. Having someone who listened	2	2	25	18	4	11	33	83
66. Having somewhere to go to	0	2	0	9	1	1	17	17
67. Having time for myself	0	3	0	18	5	1	17	17
68. I was the prime agent of change	4	8	50	55	1	4	17	33
69. Images and words that conveyed insight	0	3	0	18	0	0	0	0
70. Keeping adequate distance from each other	2	9	13	64	0	2	0	17
71. Learning to relax	4	0	25	0	3	0	33	0
72. My own involvement	5	8	38	55	1	1	17	17
73. My willingness to face unpleasant things	15	2	63	18	1	0	17	0
74. Personal chemistry	6	4	38	36	4	3	33	33
75. Practical advice	1	1	13	9	5	0	50	0
76. Pragmatic goals	4	1	38	9	1	0	17	0
77. Real involvement from the therapist	4	6	50	36	3	2	50	33
78. Reflecting and talking about myself	0	4	0	27	1	0	17	0
79. Sharing the same approach to therapy	0	1	0	9	0	0	0	0
80. Straightforward explanations	17	0	100	0	0	3	0	33
81. Strong motivation	9	10	75	64	2	2	33	17
82. The therapeutic work was guided by my needs	1	7	13	55	2	1	17	17
83. The therapist agreed with me	0	6	0	27	0	4	0	33
84. The therapist being nondemanding	1	1	13	9	0	0	0	0
85. The therapist could endure a lot	0	3	0	27	1	6	17	50
86. The therapist could widen my horizons	1	9	13	55	4	2	17	17
87. The therapist imbued me with courage	7	6	50	36	1	1	17	17
88. The therapist took care of my worries	0	6	13	18	1	0	17	0
89. The therapist's professionalism	1	10	13	64	0	0	0	0
90. The therapist's sensitivity	2	8	25	55	0	3	0	50
91. Trust	0	3	0	9	0	1	0	17
92. Words of wisdom	1	5	13	18	0	0	0	0
93. Working through trauma	2	13	13	55	0	4	0	67
94. Working together	2	5	25	36	1	1	17	17

Note. CBT = cognitive–behavioral therapy; PDT = psychodynamic therapy.

realizing the proportions of things (Item 86). This occurred not only in sessions (Item 78) but at other times: An important consequence of being in therapy was that it aroused the patient's thinking about herself and started a process of self-reflection on her own (Item 96).

More generally, the relationship with the therapist was conducive to a beneficial outcome in various ways. Thus, the therapist's sensitivity (Item 90), emotional support (Item 53), and agreement (Item 83) were important, as was an adequate distance (Item 70). The therapist's nonjudgmental attitude

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Table IV. What Are Clients' Theories About How Change Has Come About?

Item	Satisfied				Unsatisfied			
	No. statements		% Patients		No. statements		% Patients	
	CBT	PDT	CBT	PDT	CBT	PDT	CBT	PDT
95. Being helped by an expert	12	1	63	9	5	3	67	17
96. Being stimulated to think on my own	0	7	0	36	0	0	0	0
97. By changing on the inside	0	2	0	18	0	0	0	0
98. By coming to question the way I think about myself	0	7	0	27	0	0	0	0
99. By using the relationship with the therapist	0	4	0	18	0	0	0	0
100. Changing how I think and feel led to changes in how I behave	0	4	0	27	0	0	0	0
101. Facing fears/using exposure techniques	17	1	75	9	0	0	0	0
102. Getting to the root of things	0	21	0	73	3	4	33	50
103. Letting myself become vulnerable in therapy	0	2	0	18	2	2	17	33
104. Rebuilding myself from ground up	0	7	0	27	0	0	0	0
105. Taking time and having patience	1	14	13	55	3	2	17	17
106. Therapy had a ripple effect and one change led to another	0	6	0	27	0	2	0	17

Note. CBT = cognitive–behavioral therapy; PDT = psychodynamic therapy.

(Item 48) and endurance and acceptance (Item 85) were also valuable. Among more technical factors, the PDT patient mentioned the therapist's professionalism (Item 89) as well as the feeling that the therapist was able to adapt to the momentary therapeutic needs of the patient (Item 82). An important component was the therapist's patience (Item 105), which contributed to the patient's feeling of being allowed to take one's time: "I don't think we could have just started somewhere in the

Table V. What Made the Therapeutic Work More Difficult?

Item	Satisfied				Unsatisfied			
	No. statements		% Patients		No. statements		% Patients	
	CBT	PDT	CBT	PDT	CBT	PDT	CBT	PDT
107. Being afraid of making the therapist angry or sad	0	1	0	9	0	8	0	50
108. Being viewed more as a thing than a person	1	0	13	0	14	3	67	33
109. Could not do homework assignments	0	0	0	0	5	0	17	0
110. Did not dare to try exposure training on my own	2	0	13	0	4	0	17	0
111. Did not want to let unpleasant things happen in therapy	1	0	13	0	1	0	17	0
112. Feeling dejected	0	0	0	0	10	12	67	67
113. Feeling worried about not achieving	0	0	0	0	0	4	0	17
114. Frustrated and feeling lost	0	9	0	45	1	7	17	50
115. Important problems weren't addressed	0	6	0	18	0	2	0	33
116. It was "just a job" for the therapist	0	2	0	9	5	0	33	0
117. It was difficult to make practical use of what was learned in therapy	1	0	13	0	19	1	83	17
118. It was good in the beginning but then we got stuck	0	0	0	0	0	6	0	50
119. Lack of continuity	0	0	0	0	2	5	33	17
120. My own lack of motivation	0	0	0	0	2	0	17	0
121. Not being able to trust the therapist	0	1	0	9	2	5	17	50
122. Personal chemistry did not work	0	1	0	9	2	3	17	33
123. Problems with the therapeutic relationship were not resolved	0	0	0	0	6	12	33	67
124. Relaxation training was difficult	3	0	25	0	17	0	83	0
125. The therapist got frustrated by setbacks	0	0	0	0	6	2	17	17
126. The therapist was capricious and unpredictable	0	0	0	0	0	4	0	17
127. The therapist was emotionally absent	0	4	0	18	1	13	17	67
128. The therapist was hiding something	0	0	0	0	0	7	0	33
129. The therapist was ill-natured	0	0	0	0	1	0	17	0
130. The therapist's lack of expertise	0	0	0	0	4	1	33	17
131. Therapy ended too abruptly	0	1	0	9	7	7	33	50
132. Too much focus on the therapist	0	1	0	9	0	0	0	0
133. We could not agree on how to do things	1	3	13	27	7	14	67	67

Note. CBT = cognitive–behavioral therapy; PDT = psychodynamic therapy.

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Table VI. What Else Might Have Helped If There Was Too Little Change?

	Satisfied				Unsatisfied			
	No. statements		% Patients		No. statements		% Patients	
Item	CBT	PDT	CBT	PDT	CBT	PDT	CBT	PDT
134. A different kind of therapy	0	1	0	9	6	10	33	50
135. A longer therapy	0	0	0	0	8	0	17	0
136. A more active therapist	2	1	13	9	0	12	0	100
137. A more confrontational therapist	0	4	0	18	0	3	0	17
138. Acknowledgment from the therapist	0	0	0	0	0	2	0	17
139. Knowing more about the therapist	2	1	13	9	0	4	0	17
140. More expert help	2	0	13	0	2	1	17	17
141. More of an emphasis on reflection and understanding	5	0	13	0	11	0	50	0
142. More practical help	0	1	0	9	2	8	17	50
143. More sensitivity	0	0	0	0	1	3	17	17
144. More structure	0	1	0	9	1	7	17	33
145. Use of exposure techniques	0	0	0	0	2	0	17	0

Note. CBT = cognitive–behavioral therapy; PDT = psychodynamic therapy.

middle of things or have focused on something specific. Anxiety doesn't just depend on one thing; rather, it has to do with my whole life history."

Initially, however, the therapeutic work felt difficult, partly because the parties did not agree on how it should be done (Item 133) and the patient felt frustrated and lost (Item 114). Sometimes she had the feeling that the therapist was not really engaged in the work (Item 127) and that important issues were being left unaddressed (Item 115): "I remember how I was quite frustrated at the beginning of therapy. It didn't feel like there was any aim or direction to what we did or why we did it. I often wondered what was happening."

The satisfied CBT patient. In distinction from the PDT patient, most significantly, the satisfied CBT patient had now regained a feeling of being a normal person (Item 32) and being able to cope with difficult situations (Item 1): "It's been a relief to find out what I suffer from, and that I'm not really crazy. There are others who have the same problems, and something can be done about it." During the therapy the changes in the form of new behaviors and strategies became automatic, natural parts of the patient's life (Item 34): "You don't think so much about it now as in the beginning. Then you had all sorts of strategies that could be applied step by step, but now things have come to a point where you do these sorts of things without thinking about them." This started a process of feeling better day by day (Item 37). This meant retaking control over her life (Item 30): "I can still experience compulsions, but I'm functioning at a much higher level now. I can live an acceptable life that I couldn't do before when my life was so restricted."

What made these changes possible were primarily the patient exposing herself to frightening things and confronting them (Item 54) and her own willingness to face unpleasant things (Item 73). Thus, facing fears and exposure techniques were felt as critically effective (Item 101). Helpful in these confrontations was a general sense of pleasure in working with the therapist (Item 56): "How I used to feel such terrible anxiety, and how I sat with all that anxiety until it started to subside, and then I could see how something started to happen, that I had actually stuck it out and coped with it, and that felt absolutely fantastic." This was not an instant cure, however: "[Change came about by] doing things over and over again, so in the end it all became quite normal, and normal things aren't dangerous. That's when the problems disappear." Normalization, again, was an important factor (Item 32).

What seemed important to the patient were her own pragmatic goals; she had a clear idea of what she needed from the start (Item 76). Contributing to change was the homework assignments (Item 52), the therapist's straightforward explanations (Item 80), and the concrete mastery of relaxation (Item 71). The therapist was basically felt to be an expert on one's problem (Item 95): "It was [the therapist's] way of working. She was calm and could explain what you might be feeling or what the anxiety was. I think she quite simply did a professional job."

Differences between the satisfied PDT and CBT patients. The treatment results were not as immediately obvious to the PDT patient as to the CBT patient. The latter, already during her therapy, was aware of gradual progress. Whereas she was more or less totally satisfied after termination, the PDT patient manifested stronger feelings of ambivalence

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when thinking about her therapy. Nevertheless, both patients continued to improve after termination, albeit in clearly different ways. The CBT patient became gradually more capable in applying the coping methods learned during therapy, and with time these became integrated into the patient's habitual behavior. The PDT patient continued to use self-reflection in coping with new experiences.

When speaking about change, the CBT patient was specific and focused on her presenting problems and the methods acquired to deal with them. The PDT patient's experiences reflected a wider scope that may be best described as involving her total personality. The patients' views on therapist and patient roles were also quite different. Whereas the CBT patient described herself with pragmatic and concrete aims and her therapist as an expert knowing how to achieve them, the PDT regarded the therapist as one who offered a secure space for the patient where they would cooperate to explore the patient's person and way of living in order to find alternative ways to be, a more positive self-regard, and a coherent personal history. The CBT therapist was described as active in structuring specific exercises and explaining, and change came about when the patient forced herself to confront her fears. Their cooperation was characterized by a pleasurable atmosphere. The PDT therapist was described as "passive in an active way," withdrawn and silent, still with almost tangible presence, accepting, understanding, summarizing, connecting, and integrating. Change occurred slowly in a painstaking and sometimes painful process in which the patient had to open up toward her inner life and confront it. This was facilitated by the therapist's keeping the proper distance, becoming neither totally withdrawn nor closely personal.

Dissatisfied Patients

Common experiences among dissatisfied patients. The dissatisfied patient felt that her psychotherapy had brought about an increased awareness of connections and patterns in her thoughts and behavior (Item 59) and that therapy relationship factors had contributed to this (Items 74, 77). Despite this, a basic common feeling among the dissatisfied patients was that there had been only insufficient change (Item 44). A feeling of resignation was quite prevalent (Item 112). Too abrupt a termination was a frequent feeling (Item 131), along with the feeling that genuine change would have required a more thorough and deep therapeutic process (Item 102). The patient and the therapist were not really able to agree on how to do therapy (Item 133), and there was a strong feeling that a different kind of therapy would have been better (Item 134). The patient's ideas about this different kind of therapy strikes the listener as very much like the other form of therapy in this comparison (i.e., CBT for the dissatisfied PDT patient and vice versa). This was sometimes quite explicit, as for the PDT patient: "It was okay, but I would rather have had a kind of therapy that wasn't so preoccupied with the past. My problems were acute, and I think that what I really needed was a cognitive–behavior therapy. You know, that you change yourself, your behavior." And for the CBT patient: "I guess I tend to think too much about what caused my problems, but it seems like this is something you're not supposed to speculate about. Instead you're supposed to focus on the problem. But perhaps cognitive–behavior therapy just isn't my type of therapy."

The dissatisfied PDT patient. Despite her general feeling of dissatisfaction with the fact that the change achieved was not enough, the patient still felt some positive effects of the therapy had been reached at the time of termination (Item 38), such as being able to understand oneself better (Item 14), increased self-confidence (Item 26), and the feeling of a new sense of strength (Item 21). However, these positive effects weakened shortly after termination. Several factors had contributed to the apparent change, such as working through a trauma (Item 93), the therapist's emotional support (Item 53), sensitivity (Item 90), and endurance (Item 85). The dissatisfied PDT patient, more than the satisfied one, also emphasized the feeling of being listened to (Item 65) and understood (Item 51).

Despite these positive experiences, the dissatisfied patient recalled a feeling of getting stuck (Item 118) and of frustration and feeling lost (Item 114): "This may sound somewhat contemptuous, but [the therapist] mostly sat wrapped up in a quilt not saying much at all. Many times it felt so difficult because I felt as if she was hardly there, present." The frustration was partly related to the therapeutic relationship, as when the patient felt unable to trust the therapist (Item 121), that the therapist was concealing something (Item 128): "I remember thinking, sometimes, my God, is she at all listening to what I'm saying?" The patient was also afraid of making the therapist angry or sad (Item 107) if she revealed her feelings of being stuck and lost and, therefore, never dared to try to resolve these problems within the therapeutic relationship (Item 123). The dissatisfied PDT patient would have liked the therapist to be more active (Item 136) and more concerned with providing practical help (Item 142).

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The dissatisfied CBT patient. The patient described the limited change achieved as finding some new coping tools (Item 25). Contributing to this was practical advice (Item 75), along with the therapist's expertise (Item 95). However, a strong feeling with the dissatisfied CBT patient was that there really was no change (Item 43) or that therapy helped only in the short run (Item 42): "It worked for the moment, but I can't say it worked, that I myself improved, I can't say that."

The dissatisfied patient found relaxation training difficult to learn (Item 124). In the patient's mind, this specific experience was typical for the experience of being viewed more as passive thing than an active, thinking person by the therapist (Item 108): "I think I become tense because I have problems at home and I wanted to talk to her about that. But she didn't want that; she wanted to do relaxation exercises, but that, of course, I couldn't do." The dissatisfied patient felt it difficult really to apply in practice what she had learned during sessions (Item 117). Relationship issues made the therapy difficult, and the patient often had a feeling that her therapy was "just a job" for the therapist (Item 116). The dissatisfied CBT patient would have preferred a therapy with more emphasis on reflection and understanding (Item 141): "She did her job and I was the patient who came there in order for her to do this and that with me . . . These relaxation exercises shall be done, have I done my homework, and here's the homework for next week, like a lesson without any room for anything else."

Differences between the dissatisfied PDT and CBT patients. The little help that the dissatisfied patients felt they had had was strikingly different, depending on their type of therapy. The CBT patient felt that she was now more able to cope with certain problematic situations than she was before, although this was in a rather automatic fashion, using specific tips and hints from the therapist. The PDT patient, thanks to the therapist's listening and support, now had a greater capacity for understanding herself and her relations than before and thereby felt mentally stronger and more finished with her therapy. In contrast to the PDT patient's ambivalence, the CBT patient, nevertheless, was outright disappointed and negative.

Both patients experienced major problems in their relations to the therapists, albeit in different ways. The CBT patient considered the therapist to be intrusive and oppressive, applying a rigid predetermined therapy design, whereas the PDT patient felt her therapist was withdrawn, disengaged, and aloof, not providing the support and guidance that the patient had required and expected. Whereas the PDT patient felt herself left alone and deserted, the CBT patient felt restricted and steered by the therapist's fixed ideas about what to do while in therapy. She would have preferred more of a dialogue and more reflection in cooperation with the therapist in order to further her understanding of her situation. In contrast, the PDT client would have preferred an active, concrete, and instructive therapist focusing more on action exercises.

Discussion

Again, this study did not attempt to determine the relative efficacy of one form of psychotherapy over another or identify any causal relationships other than the patient's possible perceptions of such relationships. Nevertheless, it may be of some interest to note that the proportions of satisfied and unsatisfied clients were roughly equal in CBT and PDT (57% vs. 65% satisfied and 43% vs. 35% dissatisfied).

In terms of the proportions of satisfied to satisfied patients, there is thus little quantitative difference in outcome reported after CBT and PDT. This is in agreement with a long series of meta-analyses (Lambert & Ogles, 2004; Smith, Glass, & Miller, 1980; Wampold, 2001). The main conclusion of this study is that there are, nevertheless, obvious differences in the kinds or qualities of outcome that are reported, along with some experiences common to the two groups of patients. Thus, the qualitative perspective may complement the quantitative comparisons in showing that the same amount of change may have quite different contents. Whereas in a quantitative sense the two treatments produced equal outcomes in terms of patient satisfaction, the qualities of outcome were starkly different. Although both satisfied patients continued to improve after termination, the CBT patient was directly satisfied with her ability to apply specific techniques to cope with specific problems, whereas the PDT patient described herself as more self-reflective and with a wider range of personality-related changes, yet feeling more ambivalent about her therapy. The differences between the two were also striking in their descriptions of the therapeutic process. The CBT process was focused and structured, with the therapist being an active and directive partner in a pleasant cooperation. The perceived mechanism of change was typically described as the gradual confrontation of specific fears. The PDT process was one of open-ended, sometimes painful self-exploration, with the therapist more a witness at a proper distance, providing connections and summaries. Thus, in a way the CBT patient's version of the change that had taken place was more specific than

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that of the PDT patient. Our interpretation is that CBT itself is more specific, concrete, and focused in its aims and methods and less open-ended, which was reflected in the patient's experiences. Possibly, however, this difference merely reflects the fact that the CBT patient had less to report because she had been in treatment for a shorter time. It may indeed happen that, after several years of CBT, a patient would have similar qualitative experiences as the PDT patient, although one might then raise doubts as to whether such a long treatment had been CBT "proper."

However, there were also experiences common to the two satisfied patients, such as better coping abilities, particularly when feelings were concerned. The patients had achieved higher emotional stability with consequently abated anxiety. This is probably a central aim in psychotherapy generally. Various aspects of the relationship with the therapist were also felt by both to have been particularly helpful, as reported by previous scholars (e.g., Gershefski et al., 1996). The "common factors" (Hubble et al., 1999), such as both parties' involvement and motivation and a strong therapeutic alliance, were present in both patients' opinions on what contributed to change. If we assume that common experiences reflect common factors, we may also assume that the differences between the two patients' accounts may reflect specific factors, different techniques, and different approaches or stances (Ablon & Jones, 1998, 1999; Jones & Pulos, 1993) over and above these common factors. Directiveness versus nondirectiveness may be a concept that best summarizes these differences.

It is striking to listen to the patients' different theories about how change may come about. The satisfied CBT patient, for example, emphasized the value of exposure techniques, whereas the dissatisfied CBT patient did not mention this at all. Is this a result of their respective therapies, that the former had understood and learned the principles of exposure, or did this type of intervention agree more with the former patient's ideas of what she needed? Would the dissatisfied CBT patient have been satisfied if she had grasped the principle of exposure, or did the method not agree with her views on what works? A corresponding difference between the satisfied and the dissatisfied PDT client is the idea of time, patience, and extensive introspection as necessary for change, which was not at all recognized by the dissatisfied PDT patient. The dissatisfied patients' descriptions of factors that hindered their therapeutic work generally reflected their dissatisfaction with the specific therapeutic approach. Whereas the dissatisfied CBT patient perceived the therapist's obvious focus and directiveness as an objectification of her, the dissatisfied PDT patient experienced the therapist's neutrality and distance as an absence of aims and direction. The dissatisfied patients' views of their therapists' way of handling their treatments are in strong agreement with the ideal prototypes reported by Ablon and Jones (1998), albeit bordering on caricature. Conversely, the patients' views on how their therapies should have been conducted in order to be helpful agreed quite well with the ideal prototypes of therapy they did not have (i.e., PDT for the dissatisfied CBT patient and CBT for the dissatisfied PDT patient). Although it is possible that the dissatisfied patients had therapists who were simply not able to apply their method in a proper and suitable way, this finding, as it stands, is consistent with the idea of a kind of differential suitability that has been promoted by Beutler, Blatt, and others (e.g., Beutler et al., 1991; Beutler & Harwood, 2000; Blatt & Felsen, 1993). It is also consistent with Gershefski et al.'s (1996) and Levy et al.'s (1996) finding the same factors in CBT or IPT as helpful or hindering for different patients.

Because this was a retrospective study, we do not know whether there were any pretherapy differences between the groups on variables relating to diagnosis, severity, personality, motivation, and so on. We believe these are quite likely, however, and certainly such differences might explain the different experiences in the two groups. Instead of the randomized assignment that might have helped control for pretreatment variation, the patients were either self-selected or clinically assigned on the basis of what seems to have been rather unclear reasons, weak evidence, and vague theories. Admittedly, the knowledge of which factors make patients differentially suitable for different varieties of therapy is still far from complete (Beutler & Harwood, 2000). It appears obvious to us, for instance, that the dissatisfied patients would have been assigned to other kinds of therapies if such knowledge had been available to the clinicians.

Our method of analyzing the very extensive interview material was to structure it by grouping the patients according to whether the case might be considered satisfactory or not (which may or may not agree with subjectively perceived change or actual change on some test parameter) and using the distributions of the codes as basic indications of salience and importance. Besides providing some order to what was at first a huge mass of codes and statements, our approach was intended to offer the reader the possibility of judging our results and conclusions for him- or herself. Currently popular grounded theory (Strauss & Corbin, 1998) would have involved a series of interviews–analysis cycles. One relative advantage of the approach chosen is

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that our formal analysis has not influenced our interviews; also our reanalysis of the entire material has ensured that the same coding framework has been applied throughout.

We were not able to completely realize our sampling plans. This means, for one thing, that the patient sample was heterogeneous in terms of treatment duration and the interval between treatment termination and interview. We did not find any significant association between the grouping of the cases on the one hand and duration or follow-up interval on the other. Obviously, however, these tests only indirectly address the issue of whether the patients' qualitative experiences were influenced by these factors. It is in the nature of our sampling procedure that we cannot say anything definite about how representative our sample is for patients, whether at this specific clinic, or in Sweden, or universally. Surely, the motivation to take the time and effort to come for an additional interview is not general for former patients anywhere, so this was certainly a select group in that particular respect. That PDT cases were in the majority reflects the fact that these were more frequent among the 100 patients being contacted, in a proportion that is representative for the clinic, partly because of the availability of therapists with different orientations and training. The heavy predominance of female patients to male patients (87%) probably reflects a greater willingness among women to participate in the interviews but also the general predominance of women participating in psychotherapy in Sweden (Blomberg & Sandell, 1994; A.-M. Carlsson, 1993). The patients represented, so to speak, a rather large number of therapists, some of whom were private practitioners working on a freelance basis for the clinic and some of whom were employed full time. For reasons of confidentiality, further information on the individual therapists was not made available to us, but the sample of therapists was representative for the Swedish population in terms of gender and age (J. Carlsson et al., 2000). Some particularly important therapist variables that may have influenced the patients' accounts are the therapists' adherence to the kind of therapy they were supposed to deliver and their skills in doing so. We believe that, nevertheless, the natural variations across patients and therapists were reasonably well captured in our sample, albeit probably not in representative distributions.

It was surprising that comparative qualitative outcome studies are so extremely rare. In the great psychotherapy debate (Wampold, 2001), the quantitative perspective has been allowed to mask the possibility that, from a qualitative point of view, the contestants are not even quantitatively comparable because the "amounts" refer to different "contents." We consider this a first attempt that we hope will inspire more studies, with better control over the sampling and the treatments. Other varieties of therapy would, of course, also have to be included. Not least meaningful would be further studies focused on unsatisfactory cases. However paradoxical it may sound, that might shed more light on the possible need for matching of patients to therapy and therapist. An obvious clinical and ethical recommendation as a consequence of our study is that the therapist should use as much sensitivity as she or he can muster to decide whether the therapy she is offering is suitable or satisfactory to the patient or not. Dissatisfied clients should be asked about the reasons for their feeling and advised to try some other type of psychotherapy (or some other therapist) that may better meet their needs and complaints.

Notes

[1] We use the term "quasi-qualitative" for studies in which more or less predetermined coding categories or rating scales are used to analyze free-format responses to more or less fixed questions. Results are typically given in terms of frequency distributions across the categories (see, e.g., Gershefski et al., 1996). This is in contrast to qualitative studies, in which informal or conversational interviews are processed so as to construct or reconstruct and summarize more or less interpretative narratives.

[2] Available on request from the authors.

[3] It deserves to be emphasized that a "satisfactory case" is not simply one in which the patient says she feels good about the therapy, that she and the therapist had a good relation, and so on. In fact, there were cases in which the patient declared herself being quite satisfied that were classified as unsatisfactory and vice versa.

[4] The patient who appeared psychotic during the interview was excluded in this calculation because her confused and unrealistic account made it impossible to classify the case as either satisfactory or unsatisfactory.

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