

RESEARCH ARTICLE

Why did I change when I went to therapy? A qualitative analysis of former patients' conceptions of successful psychotherapy

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Abstract

Aim: Much research has been undertaken to identify significant events and change processes in psychotherapy. Most of these studies use categories and concepts consonant with the researcher's particular theoretical affiliation. But how do patients themselves, retrospectively, give meaning to what they felt most important for their realization of change? The present study sought to identify specific experiences and reflections of former psychotherapy patients who described their previous therapy as successful. **Methods:** Semi-structured, qualitative, in-depth interviews with ten former psychotherapy patients, recruited through an advertisement in a local newspaper. A descriptive and hermeneutically modified phenomenological approach was used to analyse interview transcripts, technically carried out with the assistance of Nvivo 8 software. **Findings:** The different ways the participants gave meaning to change processes and events clustered around the following themes: (i) Being in a relationship with a wise, warm, and competent professional, (ii) Being in a relationship with continuity when suffering from feelings of inner discontinuity, (iii) Having assumptions and beliefs about oneself and one's relational world corrected, (iv) Creating new meaning and seeing new connections in one's life patterns. **Discussion:** Relates current findings to those of previous studies and addresses strengths and limitations of the study, including reflections on the possible influence of the researchers' theoretical and professional background. Replications of the study are proposed, with researchers of other theoretical affiliations, and with different groups of former patients.

Keywords: *Psychotherapeutic change, qualitative research, patient perspectives, phenomenology, hermeneutics*

Introduction

Many patients experience that psychotherapy changes their lives in important ways. But what makes such changes possible from the patients' own point of view? This interview study explored how former psychotherapy patients explicitly and conceptually gave meaning to positive psychotherapeutic change. Although much research has been undertaken on change processes in psychotherapy, most quantitative studies use categories and concepts consonant with the researcher's own theoretically informed way of understanding and describing change. There is a much smaller number of explorative, qualitative, and experience near studies without predefined categories.

The APA report on Evidence-Based Practice in psychology (American Psychological Association, 2006) maintains that qualitative research can strengthen the relation between practice and research by describing the subjectively lived experience of participants in psychotherapy and, further, that it is important to identify conditions that might maximise clinical expertise. Studying psychotherapy patients' experiences of successful therapies is in our view such a condition. While there are qualitative studies focusing on change

and outcome in psychotherapy, for instance Howe (1996), and recently Midgley, Target and Smith (2006), none of these studies has focused solely on how patients themselves give meaning to positive psychotherapeutic change. Hence, to balance the situation, more studies investigating how patients themselves give meaning to the many aspects of therapeutic change are needed (McLeod, 2001).

Some previous qualitative studies have explored the change process as such. In a mixed methods study concerning remission from dysthymia, Svanborg, Bäärnhielm, Wistedt, and Lützen (2008) asked former patients how they explained their obtained change. A common answer was the experience of having acquired tools to handle life, an understanding of illness that facilitated a new way of approaching their particular problems, and enhanced flexibility of thinking. Higginson and Mansell (2008) interviewed people about change processes at a more general level (not necessarily connected to psychotherapy), and compared the answers to theoretical constructs about change. The following themes emerged as the most central ones: hopelessness and issues of control; the change process; new self versus old self; and putting their problem into perspective. In an international

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interview study of recovery among service users with serious mental illnesses, Davidson et al. (2005) found that important themes included the person's determination to 'get better', establishing a degree of self-control, to be accepted as, and to accept oneself as a normal person who exists beyond the psychosis, having one's rights respected and returning to a meaningful social role through work and or positive relationships outside of the formal mental health system.

Carey et al. (2007) conducted a study where patients were interviewed at the end of therapy to examine the foregoing change process. They found that change occurred through the domains of feelings, thought and actions, and that the themes of motivation, aspects of self, tools, learning, therapeutic interaction, and relief through talking were all central. The studies by Higginson and Mansell (2008) and by Carey et al. (2007) differed from our own in that they aimed at exploring and discussing 'mechanisms' of change and how change occurs, utilising predefined conceptions within a specific theoretical framework (Perceptual Control Theory).

In the present study, our aim was phenomenological: To give accounts of patterns in the ways former patients themselves give meaning to therapeutic change; that is, *what* they, in retrospect, find most important. In line with the phenomenological aim of this study we will try to sum up and give voice to the experiential dimensions and 'folk psychology' (Bruner, 1990) accounts of the participants, and we will keep researcher-based theoretical frameworks in the background. However, we will discuss our findings in light of knowledge obtained from contemporary psychotherapy research, and reflect upon the relational and cultural context of our findings. Hopefully, such first-person perspectives can contribute to developing new and more experience near theoretical frameworks, so that therapy in the future can be conducted in ways more consonant with patient perspectives and understanding. This, probably, will contribute to more positive treatment outcomes.

For this study, we regarded a person's experience of change and the way he or she reflectively gives meaning to it as being two endpoints on a continuum. In line with phenomenology and hermeneutics, 'creating meaning' is regarded as an inherent part of having an experience. Hence, 'having an experience' can be seen as a spontaneous, first step of meaning making, while reflecting upon it will be an interpretation of this primary meaning making process. An interview situation will necessarily invite the participant into a reflective mode, but at the same time we try to grasp the 'freshness' of immediate experience by asking for descriptions of concrete episodes. For practical purposes, in this study, we will not separate these two steps of meaning making, but combine them.

Method

Participants

The participants were recruited through an advertisement in the largest local newspaper in Bergen (Norway), seeking persons who had undergone psychotherapy (of at least 15 sessions), had experienced that they had been significantly helped by the treatment, and felt that they had no need of therapy currently. Ten former patients were interviewed (nine females), age 27–61 years (median 54.5), therapies varying from 1–19 years (median 5.5). Most of the participants did not describe any identifiable 'brand name' of the therapy they had been through, but two named their therapist's approach as 'cognitive-behavioural', one had been through psychoanalysis, and two of the therapies were clearly identifiable as intensive psychoanalytic psychotherapy.

Semi-structured interviews

Semi-structured qualitative in-depth interviews were chosen to facilitate a flexible, explorative dialogue about each participant's personal therapy experiences, together with an invitation to reflect upon these experiences. Most interviews lasted about 1 hour; the shortest 45 minutes and the longest 2 hours. All interviews were transcribed by two graduate students in clinical psychology, none of them being part of the research team.

In this paper, we present and discuss findings from that part of the interview which focused on the participants' reflections about their overall experience of therapeutic change, and what kind of outcome they valued as most important. The interview also addressed each former patient's specific problems, and what he or she considered as a 'good outcome' with regard to these problems, specific change facilitating episodes, the experience of collaboration with the therapist, the patient's own specific efforts, change facilitating events in the patient's life outside therapy, and the experience of obstacles to change. These issues were explored with all participants, to make a comparison of experiential patterns possible. Follow-up questions were asked when participants gave descriptions on a too general or abstract level.

In those cases, we asked for examples of specific episodes to obtain 'mini-narratives' about the therapy process. For example: 'Can you, as detailed as possible, describe a particular event or incidence during therapy that contributed to positive change in a most important way? How do you think that particular incidence contributed to change?' In this way, we were able to identify both general ideas and specific examples that make it possible to explore the change experiences and the way that they are given meaning to.

Data analysis

Analysis of the interview transcripts was technically carried out with the assistance of Nvivo 8 software (QSR, 2008). Following Giorgi (1985) and Giorgi and Giorgi (2003), our aim was to generate knowledge of everyday therapeutic experience and stay close to the participants' own view of what had felt significant and important to them. By comparing the individual participants' accounts, we wanted to identify patterns of commonalities and differences in the way they had experienced change. For this aim, we used a method of systematic text condensation (Malterud, 1993, 2001). Analysis proceeded through the following stages: (i) Reading all the material to obtain a basic sense of the participant's experience of processes leading to change, (ii) Identifying units of meaning that represented different aspects of the participant's experience, (iii) Developing codes for those units, (iv) Condensing and abstracting the meaning within each of the coded groups of text fragments, and (v) Summarising the contents of each code group to overall descriptions of patterns and concepts reflecting the most important aspects of the participant's experiences.

Although the meaning patterns and concepts were developed from the interview data and theoretical concepts avoided, both the research question that initiated the dialogue with the participants and the reading of the data will necessarily be affected by the specific experiential horizon of each individual researcher (Gadamer, 1965). This pre-understanding, the researchers' interpretive role, and the specific cultural-historical context of the data are reflexively examined in the discussion.

The researchers

The study originated from the Bergen Relational Theory and Psychotherapy Research Group. The interviews were conducted by all three authors. The first author (PEB) has training in long-term psychodynamic therapy with children, adolescents, and adults. The second author (HH) has training in long-term psychodynamic therapy with adolescents and children, while the third author (GHN) is a pioneer in short-term dynamic psychotherapy with adults. PEB and HH have 13 years of clinical experience, GHN close to 40 years. All three authors have an interest in interpersonal and relational psychodynamic approaches, and in psychotherapy integration. PEB is also working with humanistic-existential and contemplative approaches.

Ethics

The study was approved by the Regional Committee for Medical and Health Research Ethics (Region West), and by the Norwegian Social Sciences Data. All interviews were undertaken within the localities of a university outpatient clinic. To prevent inadvertent retriggering of a participant's past problems, the

interviewers were especially observant to signs of such reactions. If, for example, non-verbal signs of rising anxiety were observed, the interviewer might change to a less direct or more supportive questioning style or, temporarily, change topic. All participants were offered the opportunity of a follow-up contact. None of them made use of this opportunity. However, one participant contacted us because she wanted to supply further information about her treatment experiences.

Findings

The explicit overall idea: What was most important in my therapy?

We started out with somewhat mixed expectations when asking the participants about their general idea about such a complex topic as their own therapy experiences. Our intention in raising this question was mostly to make clear what we were interested in, and to make the process of therapy a topic for further reflection when later addressing more specific aspects of the participants' therapy experiences. As expected, the participants did not necessarily give an immediate and comprehensive answer to the opening question. However, all of them at some point during the interview expressed one or more general ideas about what stood out as the most important change facilitating aspect of their treatment. The general assumptions about change were, of course, something that had to be interpreted also in light of the more specific accounts of the therapy processes.

Theme 1 – Having a relationship to a wise, warm and competent professional

A common theme in all interviews was that the participants experienced their therapist in ways that can be summed up as 'wise', 'warm', and 'competent'. We coded the participants' statements under the rubric of these concepts in cases where the participants used them spontaneously, or they expressed experiences that we interpreted as synonymous or similar in meaning content (for instance, 'He always knew how to make me feel secure', was coded as 'competent'). One participant shared her idea of what had contributed most to her change in the following words:

... (the) strength, warmth, and safety that I met in my female therapist who saved me.

The same participant also provided an interesting elaboration on the feeling of safety that grew out of the relationship with her therapist. She described herself as very lonesome and 'hungry' for contact during much of the decade with her being in therapy. The therapist's clinical wisdom manifested itself in that she (the therapist) was able to take responsibility for

giving the 'right doses' of contact to the patient, and at the same time communicate compassion for her.

Another participant, who also had been in a real long-term therapeutic relationship in a similar way highlighted the therapeutic impact of her therapist's personal characteristics:

I do not believe in standardized ways of working, I think that the therapist has to be a wise person, someone who has made his knowledge a part of himself, and who sees what needs to be done in the specific situation.

However, both this participant, and others, considered it important that the therapist was also able to demonstrate skilled use of more specific methods and techniques, and a clear professional stance. One participant described her therapist's ability to handle the balance between being personal and flexible, on the one hand, and being professional, on the other, as her single most important experience in therapy:

When I was in crisis, he was flexible ... I was allowed to come every day for a week or so. At the same time he was very professional. He was able to use examples from his own life, and still stay professional – it is a very thin line out there. He managed to balance. Some doctors are just so distanced, and think that they shall be that way. But he was very professional, and at the same time he was a real person.

By the way of summary, we may say that when personal characteristics of the therapist were described by the participants as critical change agents, it was a description of how such personal characteristics took shape within the frame of a professional role.

Theme 2 – Having a relationship with continuity, safety and hope when feeling inner discontinuity

Most participants had been in long-term therapy. Added to the fact that they experienced the above positive characteristics in their therapist, several participants pointed to the continuity and duration of therapy as a most important factor. However, when continuity was regarded as important, it was inseparable from positive emotional qualities of the therapeutic relationship. Continuity over a certain time-span was emphasised as important when it gave rise to feelings of safety and hope; that is, the experience of being embedded in a relationship to a therapist perceived as wise, emotionally available, and professional in attitude. Common to those participants who highlighted duration and continuity, was their mentioning that they had suffered with different kinds of inner discontinuity, either in the form of periods of strong and negative feelings and hopelessness, or periods of 'gaps' in their feeling of personal identity, due to psychotic episodes. When a

therapist's personal characteristics were experienced as basically positive, the fact that the relationship continued even when one's emotional states felt chaotic, became a source of security and hope. Here is one account:

It was the therapist that represented hope through all those years ... during those periods when I had no hope myself ... that it [the relationship] continued, without it being said ... but you feel it ... the strength that I feel has been there ... and it still is there (after therapy has ended) ...

This participant had been suicidal for longer periods of time, and also had been through a number of hospitalisations. At times, hope was just experienced as something the therapist 'carried' for her, and she felt that her life totally depended upon the fact that her therapist would still carry hope. At one point she had written a poem which she brought with her to the interview, and which she read aloud:

Do not say that there is no hope. Hold on to faith through the dark hours, through the dark years. The painful moment goes away, comes back, goes away, comes back. Goes, comes, goes, comes, goes.

Another participant, who described the continuity of the therapy relationship as being of the utmost importance to her, had been through severe traumatic experiences with periods of hospitalisation for polio during her childhood. These periods had involved longer separation from her parents. In the interview, she described periods in her therapy where the most important thing was not what her female therapist said or did, but the fact that she 'was there':

She became the security that I never had as a child. When she sat in her chair, and I was lying on the couch ... I crumbled together on that couch, because I turned into the little girl when I came in there. She became my mother, in a way. The mother that I always had missed. But she should just be there, and never touch me. I was afraid of hands.

This participant experienced her therapist's willingness to be there together with her during periods of strong inner terror and flashbacks as most important. Also, the therapist's office as such became an important source for the feeling of continuity. The participant described a number of instances when the therapist gave her the opportunity to stay in the office and rest after a session, with the therapist going out for lunch.

In summary, when strong and confusing feelings, and inner discontinuity reigns, continuity in the relationship with the therapist as a real and emotionally stable person became a very important source of hope and safety for these participants.

Theme 3 – Having beliefs about oneself and one's relational world corrected

At the level of general ideas of what had been important in facilitating change, most participants also pointed to what can be described as correcting the 'meaning' dimension of therapy or, more specifically, to have beliefs about oneself and significant persons in one's life, corrected. From a therapist's perspective, this is often considered a core component in therapy, especially among cognitively oriented therapists. From a patient's perspective, this aspect of therapy does not necessarily have to do with 'brand-names'. Here is the account of a participant who had been in analysis for five years:

She (the analyst) helped me correct misunderstandings about people and how the world functions ... misunderstandings that had made me unhappy.

This participant described her analysis as a kind of relationship where her total world-view had changed. She stated that she changed from an elitist view on people, where she made quick judgments and sorted them into categories – such as 'successful'/'unsuccessful' – to a view of persons that made it possible for her to be more curious about them, and to make closer relationships with them.

Another participant, who also had been in a therapy that easily could be identified as psychodynamic, saw changes in her beliefs about other people as the most significant contributor to her successful outcome. In her view, this was linked to how she and the therapist had explored childhood experiences and how these experiences strongly influenced her perceptions of and actions towards other people in the present.

A third participant, who described this particular aspect of her therapy as critical for her improvement, had been in cognitive therapy. She experienced that being confronted with the 'bare facts' about how she let herself be totally dominated by other people's views about her were a most important insight.

Theme 4 – Creating new meaning and see new connections in life patterns

The idea of having been helped by having one's beliefs and belief systems corrected, was closely related to another aspect of the 'meaning dimension' of therapy, namely to create *new* meaning and to see new connections in one's life patterns. That is, for many participants, successful 'change' was closely linked to 'seeing life in a different way'.

However, as will become apparent, making new choices and changes in one's habitual patterns of behaviour was also highlighted as an important factor in the striving for health. However, new meaning making, the ability to see connections in one's life patterns, and to understand how life has become as it

is, were described as important in itself, independent of it being a result of or a premise for other changes.

One participant, who had been suffering from psychosis, maintained that therapy:

... helps because you see yourself and your situation in a new way. It helps you to see your history a little bit from above, or from the outside, or from a different angle. And this makes it possible to find out that you are an OK human being ... and you can find out whether you need medicine.

From the perspective of this participant, successful psychotherapy and her continued need for medication was not seen as a contradiction, but rather seemed to be seamlessly integrated. For her, to give new meaning to the troubles that had been a part of her life, and the greater self-acceptance that followed, also involved greater acceptance of being in need of pharmacological support.

Another participant, who also had suffered from psychosis and had been in therapy for nearly two decades, gave the following account of her therapy experience:

I learned very much from seeing connections. I know that it is not fashionable any longer to go back to childhood ... but we saw some connections between experiences that I had in childhood and experiences during my psychotic episodes ... the terrors ... and the complexes that I had. And I feel that I have become more secure, and have more acceptances for myself. It made me understand myself better, and also made it easier to understand others.

It is interesting to see how this participant also addresses conflictual views that are often expressed by health professionals appearing in media, i.e. that spending time in exploring childhood memories is rather pointless. For this participant, having had the opportunity to explore significant meaning patterns linked to her childhood experiences made her feel that the content of her psychotic experiences was possible to share with someone, and for others to understand. They then were easier to accept, and thereby making her more secure. She also drew lines between being better at understanding herself and being more able to understand others.

Metaphors like 'seeing oneself and one's life situation' and things 'becoming clearer', were often used when the creation of new meaning was being described. For instance, one participant who had been to therapy because of anxiety, hypochondrias and relational difficulties told that:

... it felt like an inward focus in consciousness. That you learn that you have many layers when you speak from the deep layers ... in a way you hear yourself speak ... it is hard to describe, I almost feel that I need poetry to describe it ... it is like

moments of double consciousness. This consciousness was light, filled with feelings, and suddenly I could express what my feelings were in a crystal clear way . . .

For this participant, the change process was experienced very much as a process of inward discovery, with 'seeing' and 'hearing' what is inside. Although he mostly used sensual and spatial metaphors when he told about the change process, he described the results of therapy as primarily symptom relief and changes in ways of relating to others. None of the participants described 'insight' or the experience of new meaning as the most important therapeutic change facilitating factor, although many of them regarded it as a *part* of their change process.

Discussion

Our results are in line with findings from quantitative studies indicating that the therapist as a person, and his or her interpersonal and communicative competence, is a strong predictor of therapeutic outcome (see e.g. Wampold, 2001). The therapist's particular orientation, or the 'brand name' of the therapy, did not seem very important to our participants. This is also in line with findings from other qualitative studies (e.g. Carey et al., 2007).

The 'meaning' dimension of psychotherapeutic change manifested itself as two sub-dimensions: (i) Having old and dysfunctional beliefs corrected, and (ii) creating new meaning. These two sub-dimensions are of course connected: When old beliefs are corrected, one also finds oneself in a 'vacuum', and new meanings have to be created. For some participants, however, the 'new meaning' aspect of therapeutic work seemed most important, due to the fact that part of their self-experience, and also their emotional life, had been rather chaotic and confusing. For these participants, the 'new meaning' dimension became strongly related to the experience of continuity in the therapeutic relationship. The therapist's stable psychological presence was felt as stabilising, and therefore made it possible to create more order and structure to experiences that threatened to overwhelm them. In a previous study, we found similar views, among therapists, with regard to the importance of repeated 'repairs' of the therapeutic alliance when we studied psychotherapist's experiences (Binder, Holgersen, & Nielsen, 2008).

The research question, and also the interpretation of the participants' ideas and narratives, will necessarily have the researchers' horizon of understanding and engagement as their starting point (Alvesson & Skoldberg, 2000). As experienced psychotherapists ourselves, part of our interest in the research question for the present study was motivated by our personal experiences with therapies that brought positive change in our own patients' lives – and, of course, also therapies that were less successful. This gives us a first hand knowledge about therapy, and

also preconceptions of what a psychotherapeutic success might be, and what kinds of processes that may lead to it.

However, a different kind of dialogue might be possible if, for instance, non-professional former users of psychotherapy services conduct these kind of interviews (see e.g. Trivedi & Wykes, 2002). Moreover, our particular theoretical stance may also have activated a special attention and sensitivity to relational phenomena leading to change. This contains the risk of a 'relationship-factor'-bias. However, in some respects, such a bias may also be an advantage, as it makes it possible to follow up the participants' descriptions about relational phenomena, and explore them in detail. If clinical researchers with a more technical orientation to psychotherapy will do similar interviews, a comparison with our results might be interesting and clarifying.

Our 'purposeful sampling' of former patients gave us participants who had clear opinions about their therapies; they experienced high degrees of satisfaction with their therapies, they were relatively articulate, and they were highly motivated to share their points of view. Most of them had been to therapists in private practice. A comparison with participants recruited directly from outpatient clinics on a background of therapist evaluations could also possibly yield interesting differences. In private practice, therapy is an agreement between two persons; in outpatient clinics there is also a culture of bureaucracy and system variables that regulate the contact and the frame.

Conclusion

The way the participants made meaning to change processes and events clustered around the following themes: (i) Being in a relationship with a wise, warm and competent professional, (ii) Being in a relationship with continuity when suffering from feelings of inner discontinuity, (iii) Having assumptions and beliefs about oneself and one's relational world corrected, (iv) Creating new meaning and seeing new connections in one's life patterns. More such open and explorative studies on former patients with other backgrounds, and having therapy delivered in other settings, are needed – along with explorations of the topics in question done by researchers with other stands in relation to the subject, e.g. studies done in collaboration with former non-professional users of psychotherapy services.

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