

An exploratory study of patients' sudden losses during outpatient CBT and therapists' experience of difficulties

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Abstract

Objective: Patients' sudden deterioration in symptomatology, also called sudden losses, is a rarely explored phenomenon.

Method: Psychological distress of 1,763 patients treated by 140 therapists was monitored after every therapy session. Patient-reported outcome measures and patients' therapy satisfaction was assessed. Therapists rated their experience of difficulties for every patient repeatedly over the course of therapy.

Results: More than one-quarter of patients (26.5%) experienced at least one sudden loss during therapy. Patients with sudden losses did not differ significantly in psychotherapy outcome and therapy satisfaction from patients without sudden shifts. Therapists did not experience professional self-doubt more often when working with sudden loss patients.

Conclusion: Sudden losses were not necessarily harmful for the outcome of psychotherapy and patients' global therapy satisfaction. The results suggest that sudden losses can be compensated over the course of treatment.

KEYWORDS

professional self-doubt, psychotherapy outcome, sudden gains, sudden losses, therapists' experience

1 | BACKGROUND

Patient-focused research monitors patient progress over the course of treatment and is concerned with improving therapy outcome by providing more individualized therapy recommendations (Lutz, De Jong, & Rubel, 2015). One approach in patient-focused research is to investigate discontinuities in patients' symptomatology during therapy, also known as sudden shifts. Sudden shifts are meaningful positive or negative changes in patients' symptomatology and defined by three criteria (Lutz et al., 2013). First, a reliable deterioration/improvement between the pre-loss/gain session and the after-loss/gain session. Second, a deterioration/improvement between the pre-loss/gain session and the after-loss/gain session that reflects at least 25% of the score on the outcome measure at the pre-loss/gain session, and third, the mean score on the outcome measure of the three pre-loss/gain sessions is significantly lower/higher than the mean score on the outcome measure in the three after-loss/gain sessions.

Sudden gains, in particular, have been a topic of increased research interest in the past few years. Tang and DeRubeis (1999) were the first to quantitatively define positive discontinuous symptom changes throughout the course of treatment and found that sudden gains were associated with better treatment outcome at termination and follow-up. Following research confirmed these results and showed that sudden gains are a frequent phenomenon among patients with different disorders like depression (Hardy et al., 2005; Lutz et al., 2013; Tang, DeRubeis, Beberman, & Pham, 2005), social anxiety disorder (Bohn, Aderka, Schreiber, Stangier, & Hofmann, 2013; Hofmann, Schulz, Meuret, Moscovitch, & Suvak, 2006), generalized anxiety disorder (Deschênes & Dugas, 2013), posttraumatic stress disorder (Aderka, Appelbaum-Namdar, Shafran, & Gilboa-Schechtman, 2011; Doane, Feeny, & Zoellner, 2010; Krüger et al., 2014), or obsessive-compulsive disorder (Aderka, Nickerson, Bøe, & Hofmann, 2012). A meta-analysis also showed that the occurrence of sudden gains within a therapy predicts significantly better outcomes at the end of therapy (Aderka et al., 2012).

Even though we know from preceding studies that there is a positive association between patients' sudden gains and therapy outcome, the causes and mechanisms of sudden gains are still not clarified. On the one hand there is some evidence that sudden gains are triggered by patients' cognitive change (Tang & DeRubeis, 1999; Tang et al., 2005) or an increased narrative meaning making process (Adler, Harmeling, & Walder-Biesanz, 2013), while on the other hand some studies failed to find evidence for cognitive mediated change factors in pre-gain sessions (Andrusyna, Luborsky, Pham, & Tang, 2006; Bohn et al., 2013; Hardy et al., 2005; Hofmann et al., 2006; Vittengl, Clark, & Jarrett, 2005).

Moreover, we do not know much about the reason why patients, who experienced a sudden gain, have better treatment outcomes. One recent study analyzed post-gain sessions and found increases in patient-reported therapeutic alliance scores as well as coping skills; these results suggest that sudden gains may facilitate change factors and lead to an upward spiral in the therapeutic process (Wucherpfennig, Rubel, Hofmann, & Lutz, 2017).

A substantial number of findings on sudden gains has been reported within the last decade, whereas sudden losses are rarely investigated (Lutz, Bachmann, Tschitsaz, Smart, & Lambert, 2007; Lutz et al., 2013; Tschitsaz-Stucki & Lutz, 2009). The existing naturalistic studies reported that approximately 10% of patients experience at least one sudden loss in the course of therapy (Lutz et al., 2007, 2013), indicating that sudden losses are a frequent phenomenon encountered in therapeutic work. Moreover, sudden loss sessions were associated with a deterioration of the therapeutic alliance as well as worse therapy outcomes and longer treatments for patients who experienced a sudden loss (Lutz et al., 2013, 2007).

Due to the small number of research studies addressing patients' sudden deteriorations, little is known about the association with patient characteristics and specific factors/events related to sudden loss. One study analyzed video recordings of sudden loss sessions and found that therapists tended to use cognitive interventions more often during a sudden loss session. Another result was that patients in sudden loss sessions gained more insight into their problems compared to the other shift type sessions. Nevertheless, sudden loss sessions differed a lot between each other in their attributes and were additionally influenced by the varying interventions and reactions of the therapist (Tschitsaz-Stucki & Lutz, 2009).

An exploration of the therapeutic relationship, instead of patients' symptomatology, revealed that open confrontation ruptures occurred more frequently in sudden loss sessions than in sudden gain sessions (Ehrlich & Lutz, 2015). Open confrontation ruptures, for example, describe patient's unsettled complaints about the therapist, the therapy, the progress in therapy or the basic conditions (Safran & Kraus, 2014).

Difficulties in the therapy process, like alliance ruptures, stagnation or impasses are usually accompanied by negative feelings in therapists (Elkind, 1992). Hill et al. (1996) reported that therapists felt frustrated, disappointed, angry, hurt, confused, and ended up doubting their abilities as a result of impasses in psychotherapy. Sudden losses may, therefore, imply a challenging situation for therapists. The way therapists cope with demanding situations and therapies is discussed as being particularly important for the progress and outcome of psychotherapy and patients' perception of the therapy (Hill, Spiegel, Hoffman, Kivlighan & Gelso, 2017; Rønnestad & Skovholt, 2013).

Studies on how therapists experience and manage difficult situations in the therapeutic process are mostly based on qualitative methods and usually do not investigate the therapists' and clients' perspective within the same study. There are only few exceptions where the clients' and the therapists' views were investigated within the same study (e.g., Coutinho, Ribeiro, Hill, & Safran, 2011).

Further, there is a set of recent studies using a quantitative approach, that explored therapists' experience of difficulties and its association with early patient-rated working alliance (Nissen-Lie, Monsen, & Rønnestad, 2010) and patient-reported therapy outcome (Nissen-Lie et al., 2015; Nissen-Lie, Monsen, Ulleberg, & Rønnestad, 2013; Odyniec, Probst, Margraf, & Willutzki, 2019). These studies focused on two factors representing challenging emotions which therapists can encounter during their therapeutic work: Therapists' professional self-doubt (PSD) and negative personal reaction (NPR). While PSD reflects therapists' doubt of their professional efficacy, NPR represents negative feelings toward patients and reduced empathy for them. Both scales were discussed as indicators of therapists' emotional maturity and willingness to critically evaluate one's work as a therapist (Nissen-Lie et al., 2015; Odyniec et al., 2019). While PSD seems to predict better treatment outcomes and working alliances among experienced therapists (Nissen-Lie et al., 2010, 2013, 2015), NPR, in terms of self-confidence, seems to be beneficial in novice therapists (Odyniec et al., 2019).

While we looked at sudden shifts in general, the main purpose of this exploratory study was to investigate patients' sudden losses. We therefore first looked at the number of patients experiencing sudden loss, frequency and timing of sudden losses, and patient characteristics that are associated with sudden losses. Moreover, we wanted to explore how patients' sudden losses are related to therapy outcome and global therapy satisfaction. As sudden loss sessions may imply challenging situations for the therapist within the treatment (Ehrlich & Lutz, 2015; Lutz et al., 2013), we investigated whether therapists differentiate between patients with sudden shifts in terms of PSD and NPR.

1.1 | Research questions

In our analysis we addressed the following research questions (no specific hypotheses were stated because of the exploratory nature of the study):

- 1) How many patients experience a sudden shift, what is the frequency of sudden shifts, and what are the descriptives of the different shift groups in our sample?
- 2) Do shift types differ in patients' therapy outcome and global therapy satisfaction?
- 3) Does therapists' experience of difficulties in terms of PSD and NPR differ between shift types?

2 | METHOD

2.1 | Participants

2.1.1 | Patients

The sample consisted of $N = 1,763$ patients treated by 140 therapists at the psychotherapy outpatient center of Ruhr-University Bochum. Data were collected between 2002 and 2014. Informed consent was obtained from all participating patients at the beginning of therapy. Procedure and method were approved by the ethics committee of Ruhr-University Bochum. Patients who did not meet the criteria for a mental disorder and those with serious substance abuse or acute crises (suicidality, psychosis or manic episodes requiring inpatient treatment) were excluded from treatment. Also, patients not meeting the general conditions of the outpatient center (treatment by psychotherapists in training under supervision, participation in the standard assessments for research purposes) did not participate in the study. All patients who provided the SCL-9-K for at least six sessions to calculate sudden losses (see below) and a minimum of one therapist's state-based difficulties (TDS-IP) assessment were included. In addition, only therapists with at least two patients (to compute therapist effects in our sample) fulfilling the inclusion criteria were analyzed. For a comprehensive description of the sample see Table 1. Diagnoses reported in Table 1 were based on the German version of the Structured Clinical Interview for Axis I and II DSM-IV Disorders (Fydrich, Renneberg, Schmitz, & Wittchen, 1997; Wittchen, Wunderlich, Gruschwitz, & Zaudig, 1997) and conducted by the therapist treating the patient.

2.1.2 | Therapists

All 140 therapists held a Masters' or equivalent degree in psychology and worked at a psychotherapy outpatient center of a university. Therapists were either licensed in cognitive behavioral therapy (CBT) or in advanced training to become a licensed CBT psychotherapist. CBT trainees were supervised every fourth session on average by a senior psychotherapist with at least 5 years of experience as licensed psychotherapist and at least 3 years of experience in teaching psychotherapy. Seventy seven percent ($n = 107$) of therapist were female. Therapists were $M = 29$ years old on average when they started to treat their first patient participating in the study ($SD = 5.04$; range, 23–52). Average patient caseload per therapist was $M = 12.59$ ($SD = 6.94$; range, 2–42). On average 15% of patients within a therapist's caseload experienced at least one sudden gain ($SD = 12.4$; range, 0–75%), 11.2% of the patients experienced at least one sudden loss ($SD = 11.2$; range, 0–50%), 14.2% of patients experienced both at least one sudden gain and at least one sudden loss over the course of therapy ($SD = 12$; range, 0–67%) and 59.5% were patients who experienced no sudden shifts during the treatment ($SD = 18$; range, 0–100%).

2.2 | Treatment and patient allocation

All patients received a CBT-based treatment (Schulte & Eifert, 2002) at the university counseling center. Treatment sessions typically took place on a weekly basis, lasting 50 min (see Table 1 for overall average treatment length) and trainees conducted therapy under supervision. Treatments were based on individual case conceptualization. Therefore, therapists did not follow a specific manual, but supervisors encouraged trainees to use evidence-based interventions from CBT manuals. Patients were allocated to therapists based on the patients' registration for a therapy and therapists' capacity. The assignment was not randomized and did not follow any particular selection criteria. The first available therapist treated the next patient from the waiting list.

TABLE 1 Sample description

	Overall sample	Patients with no sudden shifts (N)	Patients with only sudden gains (G)	Patients with only sudden losses (L)	Patients with sudden gains and sudden losses (GL)	p-value ⁺
N	1,763	1,011 (57.4%)	286 (16.2%)	202 (11.5%)	264 (15%)	
Age						
M (SD, range)	37.39 (12.5, 15–81)	37.7 (12.52, 15–78)	36 (12.75, 15–81)	37.36 (12.02, 15–68)	37.68 (12.55, 16–78)	–
Gender						
Female	1,040 (59%)	556 (55%)	180 (63%)	127 (63%)	182 (69%)	≤.000
Male	723 (41%)	455 (45%)	106 (37%)	75 (37%)	82 (31%)	
Diagnosis						
Single	996 (56.5%)	592 (58.6%)	152 (53.1%)	114 (56%)	138 (52.3%)	–
Comorbidity	671 (38.1%)	356 (35.2%)	118 (41.2%)	83 (41%)	115 (43.5%)	–
Anxiety disorders	1,120 (63.5%)	656 (65%)	175 (61.2%)	128 (63.4%)	161 (61%)	–
Affective disorders	892 (50.6%)	464 (45.9%)	162 (56.6%)	109 (54%)	157 (59.5%)	≤.000
Eating disorders	172 (9.8%)	86 (8.5%)	26 (9.1%)	24 (11.9%)	36 (13.7%)	–
Somatic Symptom disorders	96 (5.5%)	61 (6%)	12 (4.2%)	10 (5.0%)	13 (4.9%)	–
Substance Abuse disorders	87 (4.9%)	53 (5.2%)	14 (4.9%)	8 (4.0%)	12 (4.5%)	–
Personality disorders	60 (3.4%)	27 (2.7%)	11 (3.8%)	14 (6.9%)	8 (3%)	≤.03
Schizophrenia disorders	18 (1%)	15 (1.5%)	–	2 (1%)	1 (0.4%)	–
Impulse Control disorders	22 (1.3%)	14 (1.4%)	4 (1.4%)	3 (1.5%)	1 (0.4%)	–
Number of Diagnosis						
M (SD, range)	2 (1.07, 1–9)	1.97 (1.09, 1–9)	2 (0.93, 1–5)	2.05 (1.09, 1–6)	2.08 (1.12, 1–6)	–
Number of sessions						
M (SD, range)	36.58 (17.51, 7–96)	31.56 (15.73, 7–94)	37.94 (17.14, 7–90)	40.75 (16.13, 9–89)	50.73 (16.74, 16–96)	≤.000
Number of Sudden Losses						
M (SD, range)	0.36 (0.68, 0–4)	–	–	1.15 (0.44, 1–4)	1.5 (0.75, 1–4)	≤.000

(Continues)

TABLE 1 (Continued)

	Overall sample	Patients with no sudden shifts (N)	Patients with only sudden gains (G)	Patients with only sudden losses (L)	Patients with sudden gains and sudden losses (GL)	p-value ⁺
Number of Sudden Gains						
M (SD, range)	0.46 (0.75, 0-6)	-	1.17 (0.47, 1-5)	-	1.57 (0.88, 1-6)	≤.000
GSI at intake						
M (SD)	1.23 (0.69)	1.15 (0.71)	1.36 (0.63)	1.30 (0.68)	1.34 (0.69)	≤.000
IIP at intake						
M (SD)	1.61 (0.55)	1.54 (0.58)	1.74 (0.49)	1.69 (0.52)	1.68 (0.52)	≤.000
N	1,081	595	192	119	175	

Abbreviation: GSI, Global Severity Index.

+ The reported p-value comes from the overall comparison between the four shift groups. Post-hoc comparisons between the groups are reported within the text.

2.3 | Measures

2.3.1 | Measure for the identification of sudden shifts

The SCL-9-K (Klaghofer & Brähler, 2001) is the short version of the Derogatis Symptom Checklist (SCL-90-R; Franke & Derogatis, 2002) and assesses subjectively perceived impairment based on psychological symptoms of a patient within the last 7 days. Patients rate their symptoms on a 5-point Likert scale ranging from 0 ("not at all") to 4 ("very much"). The 9-item scale was administered at the end of each session. The session-by-session SCL-9-K scores were used to define sudden shifts (see below). Klaghofer and Brähler (2001) developed the SCL-9-K by selecting the item with the highest correlation from each subscale with the Global Severity Index (GSI-90). The scale showed reliable psychometric qualities. It is correlated with the GSI-90 at $r = 0.93$ and showed a comparable mean to the GSI-90. Cronbach's α was 0.87. Significant correlations with the Giessen Symptom Checklist, the Hospital Anxiety and Depression Scale, the Nottingham Health Profile, the Sense of Coherence Scale, and the Whiteley Index have also been reported (Klaghofer & Brähler, 2001). Internal consistency in our sample was Cronbach's $\alpha = 0.87$ for the first assessment point and Cronbach's $\alpha = 0.92$ for the last.

2.4 | Patient-reported outcome measures

The study assessed two common psychotherapy research measures with which patients rate their current psychological distress and interpersonal problems. Moreover, patients rated their subjectively perceived therapy progress compared to the time before the therapy and their global therapy satisfaction over the course of treatment. Figure 1 shows the time points during therapy and times when different measures were administered.

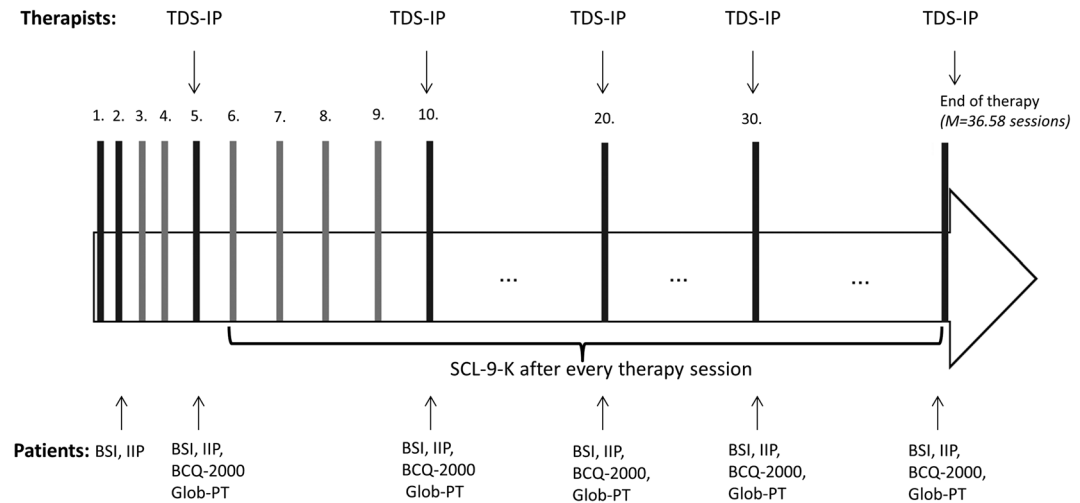


FIGURE 1 Shows the times at which the difficulties scales were administered. Each therapist answered the questionnaire at least once but on average $M = 3.48$ times per patient ($SD = 2.10$; range, 1–11). PSD obtained an acceptable internal consistency score in the general sample of therapists (Orlinsky & Rønnestad, 2005: Cronbach's $\alpha = 0.77$) and good Cronbach's $\alpha = 0.80$ at the first assessment point in our sample. NPR showed an acceptable internal consistency score in the general sample of therapists (Orlinsky & Rønnestad, 2005: Cronbach's $\alpha = 0.74$). Cronbach's α in our sample was 0.76 at the first assessment point. NPR and PSD correlated with $r = 0.66$, when aggregated across the different time points. BCQ-2000, Bochum Change Questionnaire 2000; Glob-PT, Global treatment satisfaction-Patient; IIP, Inventory of Interpersonal Problems; NPR, negative personal reaction; PSD, professional self-doubt; TDS-IP, therapists' difficulties scales-individual patient

2.4.1 | Brief Symptom Inventory (BSI)

Psychological distress over the course of therapy was assessed with the BSI (Franke, 2000; German translation of Derogatis, 1975). The self-report questionnaire consists of 53 items answered on a 5-point Likert scale and is a short form of the Derogatis Symptom Checklist (SCL-90-R; Franke & Derogatis, 2002). We used the overall Global Severity Index (GSI), which is regarded as sensitive to psychotherapy change (Ogles, Lambert, & Masters, 1996). The BSI has shown an internal consistency of Cronbach's $\alpha = 0.92$ and a retest reliability of $r_{tt} = 0.90$ (Franke, 2000). In our study, the Cronbach's α at intake was 0.96 and 0.97 at the end of treatment.

2.4.2 | Inventory of Interpersonal Problems (IIP)

The overall interpersonal problems score was calculated as the mean of all 64 items of the German Version of the Inventory of Interpersonal Problems (IIP-D; Horowitz, Rosenberg, Baer, Ureño, & Villaseñor, 1988; German translation by Horowitz, Alden, Kordy, & Strauß, 2000). Test-retest reliability ($r_{tt} = 0.98$), internal consistency (Cronbach's $\alpha = 0.94$) and construct validity of the IIP-64 have been demonstrated to be excellent (Horowitz et al., 2000). In our sample, the internal consistency at the preassessment was Cronbach's $\alpha = 0.94$ and 0.97 at the end of treatment.

2.4.3 | Bochum Change Questionnaire 2000 (BCQ-2000)

The BCQ-2000 directly assesses patients' subjectively perceived therapy progress (Willutzki, Ülsmann, Schulte, & Veith, 2015). The questionnaire includes 26 items with a 7-point Likert scale with the stem question "compared to the time before the psychotherapy" followed by a context question like "(1) I feel more secure right now.... I feel less secure right now (7)." In our study, we used the overall score of all 26 items, with lower scores indicating higher subjectively perceived therapy progress compared to higher scores. The BCQ-2000 showed high internal consistency (Cronbach's $\alpha = 0.96$) and meaningful correlations with other psychotherapy outcome measures, especially with goal attainment (Willutzki et al., 2015). Internal consistency of the overall scale in our study was Cronbach's $\alpha = 0.96$.

2.4.4 | Global treatment satisfaction-Patient (Glob-PT)

Global treatment satisfaction was assessed by asking the patient "How helpful was the therapy for you?" and "Were your expectations of this therapy fulfilled?" Clients answered the questions on a 6-point Likert scale ranging from 1 ("quite the opposite (I feel even worse)") to 6 ("absolutely/completely") (Meyer & Schulte, 2002). The measure was used in different preceding studies and showed satisfactory validity (Michalak, Kosfelder, Meyer, & Schulte, 2003; Teismann, Willutzki, Michalak, & Schulte, 2008). Correlation between the two items at the end of the treatment in our study was $r = 0.88$.

2.5 | Measure of therapists' experience of difficulties

2.5.1 | Therapists' difficulties scales-individual patient (TDS-IP)

The TDS-IP (Willutzki, Hernandez-Bark, Davis, & Orlinsky, 1997) was used to assess therapists' experience of difficulties with a specific patient at a particular time. The TDS-IP is a patient-specific adaptation of the TDS (Orlinsky & Rønnestad, 2005) from the International Study on the Development of Psychotherapists (ISDP; Orlinsky & Rønnestad, 2005). For more information about the construction of the TDS-IP see Odyniec, Victor, Berner, and Willutzki (2016) and Odyniec et al. (2019). The TDS-IP focuses on the patient-therapist dyad and can be interpreted as therapists' state-based difficulties by asking the therapists about the frequency of difficulties they

experienced with each of their patients at several time points over the course of therapy. All items start with the question: "In your current work with your patient [*'name of the patient'*] how often do you experience...?" followed by the different core items. Thus, it is possible to assess therapists' difficulties contextualized for a particular therapist-patient dyad with the TDS-IP (Odyniec et al., 2019). With 19 items the TDS-IP assesses three subscales: "professional self-doubt", "negative personal reaction", and "frustrating treatment case." Nissen-Lie et al. (2010) showed that PSD and NPR accounted for a meaningful amount of variance in early patient-rated alliance and outcome. Therefore, we focused on these two scales in our research. For a comprehensive description of the two scales see Odyniec et al., 2019.

Intercorrelations between therapists' experience of difficulties and the patient-reported outcome measures are reported in Table 2 (beginning of therapy) and Table 3 (end of therapy).

2.6 | Identification of sudden shifts

Sudden losses were calculated with Microsoft Excel (Microsoft Office Professional Plus 2010, Version 14.0.7128.5000) as proposed by Lutz et al. (2013). Lutz et al. (2013) adopted the sudden gain criteria of Tang and DeRubeis (1999) to identify sudden shifts. While sudden gains are large unexpected improvements between two consecutive sessions, sudden losses are large unexpected deteriorations between two consecutive sessions. According to Lutz et al. (2013), the following three criteria were applied to define sudden losses/gains on the basis of the SCL-9-K:

- (1) Deterioration/improvement between the pre-loss/gain session (N) and the after-loss/gain session ($N + 1$) is at least 0.51 points (see below) on the SCL-9-K.
- (2) Deterioration/improvement between the pre-loss/gain session (N) and the after-loss/gain session ($N + 1$) reflects at least 25% of the score on the SCL-9-K at the pre-loss/gain session (N).
- (3) The mean score on the SCL-9-K of the three pre-loss/gain sessions ($N-2$, $N-1$, and N) is significantly lower/higher than the mean score on the SCL-9-K in the three after-loss/gain sessions ($N + 1$, $N + 2$, and $N + 3$).

TABLE 2 Intercorrelations of the patient-reported outcome measures at therapy intake and therapists' experience of difficulties (PSD and NPR)

Pre outcome measures	1	2	3	4	5
1. SCL-9-K	-	0.619***	0.483***	0.076***	0.005
<i>n</i>		1,752	1,081	1,763	1,763
2. GSI			0.538***	0.105***	0.054
<i>n</i>			1,081	1,752	1,763
3. IIP				0.061	0.007
<i>n</i>				1,081	1,081
4. PSD_mean					0.659***
<i>n</i>					1,763
5. NPR_mean					-

Note: PSD_mean and NPR_mean = Mean score of the therapist' experience of difficulties scores across the time points per patient.

Abbreviations: GSI, Global Severity Index; IIP, patients' interpersonal problem; NPR, negative personal reaction; PSD, professional self-doubt.

***Correlation is significant at the 0.001 level (two-tailed; significant after Bonferroni correction).

TABLE 3 Intercorrelations of the patient-reported outcome measures at the end of therapy and therapists' experience of difficulties (PSD and NPR)

Patient-reported post outcome measures	1	2	3	4	5	6	7
1. SCL-9-K	–	0.714***	0.544***	–0.373***	0.424***	0.139***	0.046
<i>n</i>		1,752	1,123	1,650	1,751	1,763	1,763
2. GSI			0.700***	–0.439***	0.503***	0.138***	0.045
<i>n</i>			1,115	1,646	1,747	1,752	1,752
3. IIP				–0.415***	0.437***	0.158***	0.086
<i>n</i>				1,095	1,113	1,123	1,123
4. Glob-PT					–0.703***	–0.233***	–0.118***
<i>n</i>					1,645	1,650	1,650
5. BCQ-2000						0.167***	0.048
<i>n</i>						1,751	1,751
6. PSD_mean							0.659***
<i>n</i>							1,763
7. NPR_mean							–

Note: PSD_mean and NPR_mean = Mean score of the therapist' experience of difficulties scores across the time points per patient.

Abbreviations: BCQ-2000, Bochum Change Questionnaire 2000; Glob-PT, Global treatment satisfaction-Patient; GSI, Global Severity Index; IIP, patients' interpersonal problem; NPR, negative personal reaction; PSD, professional self-doubt. ***Correlation is significant at the 0.001 level (two-tailed; significant after Bonferroni correction).

Criterion (1) was considered to be met when the deterioration/improvement between two consecutive sessions was at least as large as the reliable change index (RCI; Jacobson & Truax, 1991) of the SCL-9-K. The RCI was calculated with the norm values reported by Klaghofer and Brähler (2001). The resulting RCI was 0.51, this means that the deterioration/improvement between two consecutive sessions had to be 0.51 points or more.

To calculate criterion (3) two-sided *t*-tests for two-samples (type: heteroscedasticity) were calculated comparing the three pre-loss/gain sessions (N-2, N-1, and N) against the three after-loss/gain sessions (N + 1, N + 2, and N + 3) with a significance value of $p \leq .05$. It has been argued that *t*-test for two-samples is no valid inferential test in this context because the scores before and after the loss/gain are correlated, nevertheless, we used *t*-test for two-samples as it is frequently used to define sudden shifts (Lutz et al., 2013).

According to these criteria, only those patients who filled out the SCL-9-K in at least six consecutive therapy session could experience a sudden loss only (L), a sudden gain only (G), both gains and losses (GL), or no shifts (N).

2.7 | Analysis

As patients were nested within therapists and measurement time points were nested within patients, multilevel regression models for continuous data were estimated to address the second and third research question. If such a nested data structure is ignored, higher α error and smaller confidence errors of model parameters can result in conventional ordinary least square analysis (Raudenbush & Bryk, 2002). In the present study, the intraclass correlation coefficient (ICC) varied from 0.01 to 0.31 at the therapist level and from 0.20 to 0.79 at the patient level.

At the therapist level the ICC from unconditional null model, was 0.02 ($p = .09$) for patients' symptomatology (BSI), 0.01 ($p = .24$) for patients' interpersonal problems (IIP), 0.02 ($p = .02$) for patients' subjectively perceived therapy progress (BCQ-2000), and 0.06 ($p < .001$) for patients' global therapy satisfaction (Glob-PT). This indicated that therapist effects in our sample were small for patients' outcome measures, but not for patients' global therapy

satisfaction. Moreover, therapists differed from each other in their experience of difficulties. The ICCs for therapists' PSD and NPR was 0.31, indicating that the therapist accounted for 31% of the variance in both scales. For PSD and NPR, the random effect on the therapist level was significant ($p < .001$).

Patients differed significantly from each other on all outcome measures of this study. The ICC from unconditional null model at the patient level was 0.71 ($p < .001$) for patients' BSI, 0.79 ($p < .001$) for patients' IIP, 0.47 ($p < .001$) for patients' subjectively perceived BCQ-2000, 0.49 ($p < .001$) for patients' Glob-PT, 0.27 for therapists' PSD and 0.20 for therapists' NPR.

The type = complex and type = two level procedures in Mplus 7.11 was used to deal with the nested data at both levels of analysis (for more information, see Muthén & Satorra, 1995). Descriptive analyses were conducted with IBM SPSS Version 25.

2.8 | How many patients experience a sudden shift, what is the frequency of sudden shifts, and what are the descriptives of the different shift groups?

Standard descriptive analyses were applied to answer this study question. Analysis of variances with Bonferroni corrected post-hoc tests were conducted to investigate the relationship of sudden shift types and age, number of diagnoses, treatment length as well as impairment at therapy intake. Associations between shift types, gender, and diagnoses were investigated with χ^2 tests.

2.9 | Do shift types differ in patients' therapy outcome and global therapy satisfaction?

Four linear multilevel models as described above were performed to investigate whether shift groups differ regarding patients' progress. The estimated regression coefficients allowed us to establish differences between patients at the early stage of therapy (approximately fifth therapy session) and over the course of treatment. We added a time variable (session number) and three time-invariant dummy-variables one for each shift group type (sudden gains only (G), sudden losses only (L), both sudden gains and sudden losses (GL)). We specified the no shift patients as reference group. Moreover, we controlled for differences in patients' symptomatology (GSI) and interpersonal problems (IIP) between the shift groups at therapy intake (second therapy session) by adding patients' pre-scores into the model. Differences between shift groups were tested by adding contrasts. Bonferroni correction was applied.

2.10 | Does therapists' experience of difficulties differ between patients with different shift types?

Multilevel models were performed for each of the two outcomes to investigate whether therapists' experience of difficulties differs on average between the shift groups. The first model included PSD as the dependent variable and the second model NPR. Similar to the second research question we added three time-invariant dummy variables into the models to compare the different shift groups with each other. Bonferroni corrected results are presented in Table 5.

3 | RESULTS

3.1 | Descriptives of the different shift groups

First, we investigated the number of patients experiencing sudden losses, the timing of the losses, frequency during CBT outpatient psychotherapy as well as patient characteristics associated with sudden losses.

TABLE 4 Patients' therapy progress and satisfaction and its association with sudden shifts

	GSI, estimate (SE)	IIP, estimate (SE)	BCQ-2000, estimate (SE)	Glob-PT, estimate (SE)
Fixed effects				
GSI_pre/IIP_pre	0.65 (0.02)***	-0.95 (0.02)***	-	-
Early stage of therapy				
N	0.23 (0.02)***	-0.08 (0.03)	3.52 (0.03)***	3.74 (0.042)***
G	0.13 (0.04)***	0.09 (0.03)	0.14 (0.07)	-0.049 (0.075)
L	0.17 (0.04)***	0.08 (0.04)	0.18 (0.05)***	-0.21 (0.07)**
GL	0.19 (0.03)***	0.12 (0.03)***	0.16 (0.05)**	-0.14 (0.07)
Changes over time in therapy				
Time*N	-0.005 (0.001)***	-0.005 (0.001)***	-0.02 (0.001)***	0.02 (0.001)***
Time*G	-0.005 (0.001)***	-0.004 (0.002)**	-0.007 (0.002)**	0.003 (0.002)
Time*L	-0.001 (0.001)	0.002 (0.001)	0.003 (0.002)	-0.001 (0.002)
Time*GL	-0.001 (0.001)	0.000 (0.001)	0.001 (0.002)	-0.001 (0.002)

Note: Bold characters indicate significant results. The table shows the estimates of the Bonferroni corrected comparisons between the no shift group and each of the other three shift groups. The asterisks next to the *N* values show that the estimates of the no shift group differ significantly from 0.

Abbreviations: BCQ-2000, Bochum Change Questionnaire 2000; G, sudden gain patients; Glob-PT, Global treatment satisfaction-Patient; GSI, Global Severity Index; IIP, inventory of interpersonal problem; L, sudden loss patients; GL, sudden gain and sudden loss patients; N, no shift patients.

** $p \leq .001$.

*** $p \leq .001$.

TABLE 5 Therapists' experience of difficulties and its association with patients' sudden shifts

	PSD, estimate (SE)	NPR, estimate (SE)
Fixed effects		
N	1.002 (0.06)***	0.44 (0.03)***
G	0.0001 (0.05)	-0.005 (0.03)
L	0.17 (0.07)	0.01 (0.04)
GL	0.13 (0.06)	0.01 (0.03)

Note: Bold characters indicate significant results. The table shows the estimates of the comparisons between the no shift group and each of the other three shift groups after Bonferroni-correction. The asterisks next to the *N* values say that the estimates of the no shift group differ significantly from 0.

Abbreviations: G, sudden gain patients; GL, sudden gain and sudden loss patients; L, sudden loss patients; N, no shift patients; NPR, negative personal reaction ; PSD, professional self-doubt.

*** $p \leq .001$.

We identified 627 sudden losses (1.1% of 56,683 assessments) in 466 patients (26.5% of 1,763 patients), showing that more than one-quarter of patients in our sample experienced at least one sudden loss. While 43.3% ($n = 202$) of patients with sudden losses had only sudden losses during the course of their treatment, 56.7% ($n = 264$) of them experienced sudden losses and sudden gains. Most patients with sudden losses experienced only one sudden loss (74%, $n = 345$), while 19.3% ($n = 90$) had two sudden losses, 4.7% ($n = 22$) showed three sudden losses, and 1.9% ($n = 9$) suffered four sudden losses. The median of the first sudden loss session of a patient was $Mdn = 24$ ($M = 27.36$, $SD = 15.44$; range, 6–82).

Looking at sudden gains, we identified 750 sudden gain sessions (1.3% of 56,683 sessions) in 550 patients (31.2% of 1,763 patients). Two hundred eighty six (52%) of sudden gain patients had only sudden gains and 264 (48%) experienced sudden gains and sudden losses. Most patients with sudden gains ($n = 550$) had one sudden gain

(74.5%, $n = 410$), while 17.3% ($n = 95$) had two sudden gains, 6.2% ($n = 34$) had three sudden gains, and 2.1% ($n = 11$) experienced up to six sudden gains. The median of the first sudden gain session of a patient was $Mdn = 21$ ($M = 25.44$, $SD = 16.1$; range, 6–92).

Regarding patient characteristics there was a significant relationship between the four sudden shift groups and gender ($\chi^2(3, N = 1,751) = 20.573$, $p < .000$), affective disorders ($\chi^2(3, N = 1,667) = 20.287$, $p < .001$), as well as personality disorders ($\chi^2(3, N = 1,667) = 8.950$, $p = .03$). Subgroup comparisons of the no-shift group with each of the other groups revealed that women were more likely to experience a sudden gain ($\chi^2(1, N = 1,297) = 5.410$, $p = .02$), a sudden loss ($\chi^2(1, N = 1,213) = 3.931$, $p = .047$), or both sudden gains and sudden losses ($\chi^2(1, N = 1,275) = 16.130$, $p < .001$) than men. Moreover, patients who experienced a sudden gain ($\chi^2(1, N = 1,218) = 10.281$, $p < .001$) and patients with sudden gains and sudden losses ($\chi^2(1, N = 1,201) = 13.746$, $p < .001$) were more often diagnosed with affective disorders than patients from the no shift group. Patients with only sudden losses were more often diagnosed with a personality disorder than patients with no sudden shifts ($\chi^2(1, N = 1,144) = 8.670$, $p = .003$). No other differences between the groups were found.

Further, the shift groups differed from each other regarding impairment at therapy intake ($F(3, 1,748) = 11.112$, $p < .001$). Patients with no shifts reported lower symptomatology scores on the GSI ($M = 1.15$, $SD = 0.71$, $n = 1,000$) than patients with sudden gains only ($M = 1.36$, $SD = 0.63$, $n = 286$), sudden losses only ($M = 1.30$, $SD = 0.68$, $n = 202$), and both gains and losses ($M = 1.34$, $SD = 0.69$, $n = 264$). The same differences were found for patients' interpersonal problems at therapy intake ($F(3, 1,077) = 8.935$, $p < .001$). Patients with no shifts had less interpersonal problems ($M = 1.54$, $SD = 0.58$, $n = 595$) than patients with sudden gains only ($M = 1.74$, $SD = 0.49$, $n = 192$), sudden losses only ($M = 1.69$, $SD = 0.52$, $n = 119$), and both gains and losses ($M = 1.68$, $SD = 0.52$, $n = 175$). Moreover, there was a significant relationship between average treatment length and the different shift patterns ($F(3, 1,795) = 105.105$, $p < .001$). Patients with both gains and losses (average treatment length $M = 50.73$ sessions, $SD = 16.74$, $n = 264$) had significantly more treatment sessions than patients with sudden losses only ($M = 40.75$ sessions, $SD = 16.13$, $n = 202$), sudden gains only ($M = 37.94$ sessions, $SD = 17.14$, $n = 286$), or no shifts ($M = 31.56$ sessions, $SD = 15.73$, $n = 1011$). Patients with both sudden gains and sudden losses experienced more sudden gains than patients with only sudden gains ($F(1, 549) = 45.526$, $p < .001$) and more sudden losses than patients with only sudden losses ($F(1, 465) = 33.868$, $p < .001$). No differences regarding age or number of diagnoses were found. For descriptives and p -values of the overall comparison between the different shift groups see Table 1.

3.2 | Sudden shifts and their association with patients' therapy outcome and global therapy satisfaction

3.2.1 | Results for early stage of therapy

In a first step, we looked at the differences between the four shift groups at the early stage of therapy (approximately fifth therapy session). Results were corrected for multiple testing (p -value of $p \leq .008$) and are reported in Table 4.

Table 4 shows the estimates between the no-shift group and each of the other three shift groups. The results indicate that patients without sudden shifts had less symptoms (GSI), at the early stage of therapy, compared with patients from each of the other three shift groups.

Looking at interpersonal problems (IIP), patients with no shifts did not differ from patients with sudden gains only or sudden losses only, while patients with both, gains and losses ($b = 0.12$, $p < .001$) had significantly higher interpersonal problems at the early stage of therapy than patients from the remaining three shift groups.

Further patients with no shifts rated their subjectively perceived (BCQ-2000) therapy progress at the beginning of therapy similar to patients with only sudden gains and higher than patients with only sudden losses ($b = 0.18$, $p < .001$) and patients with gains and losses ($b = 0.16$, $p = .002$).

Moreover, patients no shifts had a comparable global treatment satisfaction to the other two shift groups (G and GL). Patients with sudden losses only ($b = -0.21, p = .002$) were significantly less satisfied with their therapy at the early stage of the treatment compared with the other three shift groups.

3.3 | Results for changes over time in therapy

In a further step, we investigated the association of sudden shifts, patients' treatment outcome and therapy satisfaction. First, we examined the changes over time within the no-shift group. Table 4 reports the detailed estimates of the no-shift group compared to each of the other three shift groups. The results showed that patients with no shifts had a significant decrease of symptomatology (GSI), interpersonal problems (IIP), and subjectively perceived therapy outcome (BCQ-2000) during treatment. Regarding the BCQ-2000, low scores indicate more improvement than high scores. Moreover, patients with no shifts had a significant increase in global therapy satisfaction over the course of therapy.

In the next step, we compared shift groups with each other and the following differences between shift types emerged:

3.3.1 | Brief Symptom Inventory (GSI)

Patients with sudden gains only showed a significantly higher decrease of symptomatology on the BSI (GSI) compared with patients with no shifts ($b = -0.005, p < .001$), patients with sudden losses only ($b = -0.005, p < .001$), and patients with both gains and losses ($b = -0.004, p = .002$). No differences occurred between patients with sudden losses only and the no-shift group and patients with both gains and losses and the no-shift group. Moreover, patients with sudden losses only and both gains and losses did not differ from each other regarding their average symptom reduction per therapy session.

3.3.2 | Inventory of Interpersonal Problems

The same association was found for patients' interpersonal problems. Patients with sudden gains only showed a higher decrease of interpersonal problems compared with patients with no shifts ($b = -0.004, p = .007$), patients with sudden losses only ($b = -0.006, p < .001$), and patients with both gains and losses ($b = -0.004, p < .001$). Again, no differences were found between patients with sudden losses only and the no-shift group and patients with both gains and losses and the no-shift group. Moreover, patients with sudden losses only and both gains and losses did not differ from each other.

3.3.3 | Bochum Change Questionnaire 2000

Patients with sudden gains only reported a higher subjectively perceived therapy progress than patients with no shifts ($b = -0.007, p = .002$), patients with sudden losses only ($b = -0.01, p < .001$), and patients with both gains and losses ($b = -0.008, p < .001$). No differences were found between patients with sudden losses only and patients with both gains and losses and the no-shift patient group. Again, patients with sudden losses only and patients with both gains and losses did not differ from each other.

3.3.4 | Global treatment satisfaction-Patient

Results revealed no statistically significant differences.

3.4 | Sudden shifts and therapists' experience of difficulties

In the third research question, we explored whether therapists' experience of difficulties in terms of PSD and NPR differed between sudden shift types. Table 5 shows the Bonferroni corrected results and reveals that no significant differences occurred between shift groups on therapists' PSD and NPR.

4 | DISCUSSION

The exploratory study analyzed patients' sudden shifts in symptomatology (sudden losses and sudden gains) concerning their frequency, their association with patient characteristics, patients' psychotherapy outcome and treatment satisfaction. In addition, sudden shifts were related to therapists' experience of professional difficulties (PSD and NPR). While all types of sudden shifts were analyzed, we were particularly interested in sudden losses as this phenomenon has not been researched as extensively as sudden gains. Moreover, our assumption was that sudden losses may represent a challenge for psychotherapists in the course of treatment and may be associated with therapists' experience of difficulties.

We found sudden losses to be a frequent phenomenon occurring in more than one quarter (26.5%) of analyzed therapies. We found women to be more prone for a sudden shift than men. Further, patients experiencing a sudden gain, or both gains and losses over the course of treatment were more often diagnosed with affective disorders than patients with no shifts. Patients with only sudden losses were more often diagnosed with a personality disorder than patients without sudden shifts. At the early stage of therapy (approximately fifth therapy session) they were less satisfied (Glob-PT) with their therapy than the remaining three shift groups and rated their therapy progress (BCQ-2000) as lower than patients with no sudden shifts or sudden gains only. Despite these existing associations between gender, diagnostic status, and subjectively perceived early therapy satisfaction/progress we assume that there might be other important transdiagnostic variables that are associated with sudden losses and could not be captured within this study. Taking into account that patients with sudden losses only and patients with both gains and losses had significantly more treatment sessions than those with sudden gains only or no shifts (see Table 1), these patients might have characteristics, like, for example, negative treatment expectations, more enduring and inflexible maladaptive patterns of cognition and behavior, or characteristics that require longer recovery rates. It is also possible that therapists need more time to reflect and adapt their therapeutic approach when working with sudden loss patients. Moreover, we cannot know from the data to which extent events occurring outside of therapy, like daily hassles or stressful life events, may be contributing to patients' sudden changes. Extra-therapeutic variables have been shown to be important in patients with a negative therapy progress (Probst, Lambert, Loew, Dahlbender & Tritt, 2015; White et al., 2015). Looking at the association between sudden losses and patient-rated therapy outcome, sudden loss patients did not have worse therapy outcomes compared with patients with no shifts. Our results diverge from preceding studies in terms of the number of patients experiencing a sudden loss (10% vs. 26.5%) and the relation between sudden losses and therapy outcome (Lutz et al., 2007, 2013).

One reason for this discrepancy may be the different outcome measures that provided the base for the identification of sudden losses. While Lutz et al. (2013) used an adaptation of the session report (SR; Grawe & Braun, 1994; Schulte & Eifert, 2002) assessing patients' subjectively perceived progress after every session, we focused—as in most of the sudden shift research (Aderka et al., 2012)—on changes in patients' symptomatology, measured here with a short version of the Symptom-Checklist-90-Revised, called SCL-9-K (Klaghofer & Brähler, 2001). Even though Lutz et al. (2013) stated that gains measured via symptom change and those measured via SR give comparable rates for sudden gains, this may not be true for sudden losses.

Moreover, the assessment of the SCL-9-K in our sample started with the sixth therapy session, and therefore we did not reliably identify early sudden shifts within the first sessions. This might have biased the classification of the different shift types. In the sample of Lutz et al. (2013) only a very small number of sudden losses (<<0.5% in relation to all therapy sessions) took place within the first five therapy session. Nonetheless, we might have missed a substantial number of sudden gains that would have led to a different classification of shift groups.

Another cause of the divergent findings might be differences in the data analysis strategy. While Lutz et al. (2013) applied an analysis of covariance on the prepost assessments of the outcome measures, we used multilevel modeling with repeated measurement time points within patients and controlled for the nested structure of the data (time points nested within patients and patients nested within therapists).

However, the discrepancy in the number of patients experiencing sudden loss and the divergent relations between sudden losses and therapy outcome in different studies has to be further investigated. More research on different samples is necessary to gain a better understanding of the frequency, causes, and impact of sudden losses. To our knowledge, all research addressing sudden losses to date is based on German samples that consist mostly of psychotherapy trainees.

In line with preceding research (Aderka et al., 2012) we found a beneficial relation between sudden gains and therapy progress (see Table 4).

The results of our study suggest that patients' sudden deteriorations are not necessarily harmful for the therapy outcome and can be compensated over the course of treatment. They might even be a regular part of the healing process for some client groups. Gaining insight into own cognitive, behavioral, and emotional patterns can be especially destabilizing for some patients and foster a sudden loss but be also necessary for improvement. Looking at the patients' global therapy satisfaction over the entire course of treatment, no differences were found between the four shift groups. These results support the interpretation that patients' sudden symptom deteriorations do not necessarily attenuate patients' positive expectations of therapy and its benefits over the course of treatment.

4.1 | Study strength and limitations

To our knowledge, this is the first study that investigated patients' sudden losses in association with a broad range of patient-reported outcome measures like symptomatology (GSI), interpersonal problems (IIP), subjectively perceived therapy progress (BCQ-2000), and global therapy satisfaction (Glob-PT). Moreover, the study linked therapists' patient-specific experience of difficulties with different types of treatment discontinuities and thus explored patient and therapist self-reports within one study. In contrast to preceding studies on patients' sudden losses, we applied multilevel modeling and took the nested structure of the data into account.

This study was not able to identify the causes and mechanisms by which sudden shifts influence therapy outcome and therapists' subjective experience of therapy. Further, we do not know whether and how patients' sudden shifts were addressed within the therapy. In a future research project, therapists could be retrospectively asked whether they realized and how they addressed their patients' sudden shifts. Moreover, analyses of video recordings of sudden shift sessions (and the three sessions before/after a sudden shift) could help to clarify potential causes, mechanisms under successful versus unsuccessful coping behavior of patients and therapists.

Therapists' experience of difficulties was not assessed after every therapy session. Therefore, the data did not allow us to reliably investigate the sequence of changes in patients' symptomatology in association with changes in therapists' experience or reflection of the treatment. Session-based ratings of therapists' subjective experience/reflection of the therapy would allow broader quantitative analyses but would also result in a higher workload for the therapists.

Moreover, two sample characteristics might affect the generalizability of results for other countries and populations. As this is a German sample, and psychotherapy in Germany covers more therapy sessions than in other countries, this might have affected the results. Replication studies on patients' sudden shifts based on samples from other countries are therefore required. The second point is that most therapies in this study were conducted under supervision as most of therapists involved are CBT trainees. Unfortunately, the available data did not allow us to distinguish reliably between licensed psychotherapists and trainees, but most therapists participating in the study were not yet licensed. Psychotherapist trainees are required to reflect themselves and their therapies under supervision, whereas licensed psychotherapists do therapy and self-reflection on a rather self-imposed basis. Supervision and other training conditions (video recordings of therapy sessions, access to routine outcome measurement) might have helped therapists to reflect own feelings, detect patients' sudden losses and avoid worse therapy progress for patients with sudden losses. Data from therapists with different career levels as well as more information about therapists' professional self-reflection and coping behavior could shed light on this topic.

Moreover, the necessity of six consecutive symptom assessments might have limited the generalizability of the results, as patients who might have experienced a sudden shift which we were not able to identify were excluded from the study.

An additional limitation of the study is the reliance on self-report for patient outcome and the absence of therapist or independent assessor evaluations. Video analyses of the therapy sessions would allow external assessment.

4.2 | Clinical implications and future directions

Sudden losses seem to be a frequent phenomenon in psychotherapy and do not necessarily lead to patients' worse therapy outcome or lower therapy satisfaction compared with patients with no sudden shifts. Nonetheless, more studies on independent samples are needed to replicate this result, as preceding studies showed a deterioration of the therapeutic relationship in sudden loss sessions and worse therapy outcomes for sudden loss patients. Consequently, therapists should seek supervision to clarify the causes for patients' sudden symptom deterioration and engage in self-reflection (e.g., Bennett-Levy, Thwaites, Haarhoff, & Perry, 2015; Rousmaniere, 2018) to ensure functional therapeutic action when working with sudden loss patients.

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