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Clients' Experience of Non-Response to Psychological Therapy: A Qualitative Analysis

Kay Radcliffe, Ciara Masterson, Carol Martin: University of Leeds

Corresponding author: Kay Radcliffe, Leeds and York Partnership NHS Foundation Trust, Offender Pathway Development Service, Unit 24, Sugar Mill Business Park, Oakhurst Avenue, Leeds, LS11 7DF; kay.radcliffe@nhs.net; Tel: 0113 8557951 / 07980 969013 ; Fax: 0113 8557953

Ciara Masterson, Leeds Institute of Health Sciences, University of Leeds, Worsley Building, Clarendon Way, LS2 9NL, c.masterson@leeds.ac.uk; Tel: 0113 3432732

Carol Martin, Leeds Insitute of Health Sciences, University of Leeds, Worsley Building, Clarendon Way, LS2 9NL, c.martin@leeds.ac.uk; Tel: 0113 3432732

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Abstract

Objective: The evidence is that therapy only works for some. This study aims to explore clients' subjective experience of non-improvement, specifically how do participants who feel they have not benefitted from psychological therapy describe the experience and make sense of their therapy?

Method: Eight people from an National Health Service, Psychological Therapies Department within the UK who felt that their therapy had not resulted in improvement undertook semi-structured interviews, which were analysed using Interpretative Phenomenological Analysis.

Results: Participants described a process, beginning with their difficulties, negative feelings about themselves, and initial hopes and anxieties for therapy. Once in therapy, participants described overwhelming fears of losing control and of being judged. They described attempts to manage these fears, using self-censoring and compliance. After therapy, while most could identify some gain, they felt disappointed and that they were having to 'make do'. The sense of not having succeeded or being sufficiently deserving of further input, in turn, reinforced participants' initial negative self-beliefs.

Conclusion: Although participants identified themselves as not having improved through therapy, the accounts suggested more complexity than this. All participants reported detrimental effects and accounts contained qualified,

thoughtful descriptions of experience and feelings: participants acknowledged some gains, even though they felt that therapy had not met their expectations.

Keywords: Non-improvement, therapy process, psychological therapy, client experience

Introduction

The evidence is that therapy only works for some and yet the experience of non-improvment is not much considered in the research literature. This study aimed to address this by exploring the subjective experience of a group of clients who felt that their therapy had not been helpful. A considerable number of clients fail to respond to psychological therapy: estimates of non-response in practice are as high as 60% (Hansen, Lambert & Forman, 2002) and British National Health Service (NHS) statistics report recovery rates of 40-50% (The Centre for Economic Performance's Mental Health Policy Group, 2012). Research on the estimated 10% of clients who deteriorate as a result of therapy (Lambert & Ogles, 2004) has led to potentially harmful treatments being identified (Lilienfeld, 2007) and changes to training strategies proposed (Castonguay, Boswell, Constantino, Goldfried, & Hill, 2010). There is relatively little research on the clients who leave therapy unchanged.

Psychotherapy aims to achieve change through 'an interpersonal relationship that moves through the stages of engagement, pattern search, change (giving up the old pattern and maintaining a new pattern), and termination' (Beitman, Soth & Bumby, 2005, p.65). However, the definition and measurement of this

change is problematic. Wampold (2001) lists a number of definitions of change, such as bringing unconscious material to conscious awareness in psychoanalysis, altering unhelpful thinking in cognitive therapies, improving relationships in interpersonal therapies and changing family dynamics in systemic therapy. The measures used to demonstrate change are equally varied (Froyd, Lambert & Froyd, 1996), meaning that success in measuring change across different therapeutic encounters is problematic.

Across the types of therapy, with their different aims, and the numerous measures used, summaries of research evidence provided by meta-analytic techniques inform us that psychotherapy is generally effective, and furthermore that there is little, if any, difference in treatment efficacy across therapies (Wampold & Imel, 2015). This conclusion seems stable over time: while considerable research resource has been spent establishing the effectiveness of a variety of interventions, recent studies do not demonstrate higher proportions of improved clients, or better, as in more effective, treatments (e.g. Johnsen & Friborg, 2015). This still means, therefore, that a considerable number of clients remain unchanged or worse at the end of their therapy, a significant cost for both individuals and society.

Lambert (2007) asserted that to reduce negative effects of therapy, we must first be capable of predicting them. Therapists have limited abilities in predicting deterioration in clients (Hannan et al., 2005) and research has consistently found discrepancies between client and practitioner perceptions (Hodgetts & Wright, 2007; Llewellyn, 1988), particularly when client views of therapy are negative (Von Below & Werbart, 2012). Researchers have attempted to identify

factors associated with non-response. Van, Dekker, Peen, Van Aalst and Schoevers (2008) highlighted some client factors related to non-response: being over the age of 40; experiencing chronic depression; and being non-adherent to treatment. Lorentzen, Høglend, Martinsen and Ringdal (2011) found that non-responders showed more dissatisfaction with their therapy. They speculated that treatment preference played a role; 50% of non-responders in their study would have preferred individual rather than group psychotherapy. Werbart, Von Below, Brun and Gunnarsdottir (2015) interviewed young adults who showed no improvement or deterioration on self-report measures following long term, psychoanalytic psychotherapy. The findings demonstrated the complexity of 'non-improvement', in that participants described both positive and disappointing aspects of therapy. The authors suggested that these positive aspects of the therapy may have kept the participants engaged. Despite completing their therapies, these participants felt that therapy had not met their expectations, with the core theme in the findings translated as 'spinning one's wheels'.

Given the importance of client assessment of change it seems essential to explore client experience to advance our understanding of the mediational processes involved in therapeutic change (Elliott & James, 1989). However, literature pertaining to client experience of therapy change is scant. Knight, Richert & Brownfield (2012) reviewed the literature on client experience of change and highlight that much of this focuses on helpful and hindering aspects of therapy. Despite the high proportion of clients who are assessed as not achieving the desired level of change, research into the experience of these

clients is minimal. By exploring subjective experience, it is plausible we could devise strategies to promote client change within therapy, ultimately improving outcomes.

The research question this study aimed to address was: how do participants who feel they have not benefitted from psychological therapy describe the experience and make sense of their therapy?

Method

Design

Eight people who felt that their therapy had not resulted in improvement took part in semi-structured interviews, which were analysed using Interpretative Phenomenological Analysis (IPA). IPA is focused on accounts of experience, accepting that an account is an interpretation of experience and that the researcher interprets this account further in the light of similar accounts, personal experience and psychological theory (Smith, Flowers & Larkin, 2009).

Ethical approval for the study was granted by an NHS research ethics committee.

Sampling and recruitment

Participants were recruited from an NHS Psychological Therapy Service (PTS) in the United Kingdom. Within the NHS, mental health services operate within a ‘stepped care’ model in which the least intensive intervention is offered first. In this model, mild to moderate mental health problems are first seen within

primary care, whereas more complex or enduring mental health problems are 'stepped up' to secondary care services. The PTS operated at secondary care level; clients had either previously been seen in primary care services with no benefit or were considered to have problems too complex for primary care services. PTS therapists were clinical psychologists or specialist psychological therapists. The PTS offers time limited therapies including cognitive behaviour therapy (CBT), cognitive analytic therapy (CAT), psychodynamic therapy or an eclectic approach. Given that 'therapy non-response' was client defined, clients who had received at least six sessions of individual therapy and been discharged within the past six months were invited to join the study. Participants were excluded if they had not completed therapy, felt their experience of not benefitting from therapy was related to events external to therapy, were receiving therapy for psychosis (as it was felt their experience of therapy would be sufficiently different to compromise the homogeneity of the group), were deemed not to have capacity or would require an interpreter (due to the qualitative nature of the study).

The sample. Eight participants (4 women and 4 men) were included in the final analysis. All participants were White British, ranging in age from mid-twenties to late sixties. All participants described themselves as experiencing depression and anxiety. Other problems included suicidal thoughts (5 participants) and relationship problems (5 participants). Due to ethical considerations, access to participants' therapy records was not available. Therefore, the type of therapist and specific therapy offered to participants can only be ascertained from the account given by the individual participant.

Participants were often unclear about the type of therapy they received but within the interviews there were descriptions of CBT, CAT and integrative approaches. All participants had received other input: 6 from primary care services; 5 had received group therapy; 5 from community mental health teams and 3 had received inpatient services. At the time of interview, 2 participants had engaged in another episode of psychological therapy and another 2 were waiting for further therapy.

Interviews

A semi-structured interview schedule was developed, with feedback from service user panels, to elicit detailed accounts of participants' experiences of the therapy process. This included both open (e.g. 'how did you find the therapy process as a whole?') and more focused questions (e.g. 'tell me about anything you feel could have been done differently for therapy to have had a better outcome for you').

Whilst some participants disclosed multiple experiences of therapy, the primary focus of the interview was the experience that triggered the invitation to participate in the study. Interviews (duration: 66 to 137 minutes) were audio-recorded, then transcribed verbatim, anonymized, and checked for accuracy.

Analysis

The analysis followed a process typical of IPA; each transcript was read several times to develop familiarity and ensure that the participant experience '*becomes the central focus of the analysis*' (Smith et al., 2009, p. 82), while initial notations were made on the transcript. The next steps involved the development of emergent themes. Although the entire transcript was used in the process, the primary focus was on the sections of data concerned with the client's experience of the identified therapy episode. The group analysis was an iterative process whereby emerging themes were checked against the transcripts, where extracts were read in context.

Quality checks. Yardley's (2007) four characteristics of good qualitative research informed the process: sensitivity to context; commitment and rigour; transparency and coherence; and impact and importance. IPA encompasses a dynamic, double hermeneutic stance; as interpretations are made, the researcher needs to be aware of their personal stance, which will influence interpretation. The principal researcher kept a reflective diary to keep track of meanings and viewpoints during analysis. In addition, peer researchers and supervisors were consulted throughout to ensure that the account met 'transparency and coherence' criteria. The findings have been considered in relation to the wider literature, and clinical implications are outlined in the discussion.

Results

The interviews allowed the emergence of narratives with a timeline, and this timeline has been adopted as a structural element in the representation of the findings (see Table 1; numbers represent how many participants contributed to the theme). The themes are described with use of participants' quotes (each participant has been allocated a pseudonym to identify his/her contribution).

(Insert Table 1 here)

Negative views of self

During the interviews there were many statements indicating how participants viewed themselves before they entered therapy. The dominant sense was one of low self-esteem and ***worthlessness***, '*I don't have any right to question it'* (Cameron). Participants felt that they had been damaged, for which they ***blamed themselves***, *'I think all this is 'cause of me. All that that I see going on, is down to me and my failings'* (Peter). This was sometimes attributed to family experience: *'I thought I was my dad waiting to happen and that I was necessarily a bad person and that all I ever did was damage people'* (Cameron).

Many participants felt they did not deserve help: *'guilt because I'm taking up a slot that could be somebody else's that probably needs it more than I do'* (Melanie *I feel that I'm not necessarily deserving of happiness or the care that people might show'* (Cameron). Moreover, some participants felt they could not improve: *'I didn't really believe that anyone else could help'* (Melissa).

The changing feelings about therapy

Initially, some identified a state of feeling lost and desperate; *'I just didn't know where else to go, didn't feel as though I could be on my own'* (Melissa). Often, others had supported the participants to seek therapy: ' *with the help of the girlfriend at the time, she said, you can get help and you need help and that was that. I can say almost, that I wouldn't have sought out therapy if I was on my own'* (Cameron).

When taken into therapy, the first state reported was relief and most participants described a positive and **desired relationship**: '*it was really nice to have that kind of structure and have someone there to help you if you didn't think things were going well'* (Melissa). Therapists were experienced as validating; *'the latest* [therapist]*, she said, 'You would never have felt important enough and you lived with the guilt of thinking everything's your fault'* (Christine).

Two participants identified aims, **desired endpoints**, which were improvements in their capacities for good relationships and changes in themselves and their approach to life's challenges: *'And not to feel so desperate for company, for someone to love you. But often that's what gets you into trouble'* (Christine); *'you sort of hope that the counselling will sort things out, that it's gonna be the be-all and end-all; that when you come out of it it's like, 'Oh, it's amazing. I feel better. I've sorted this out. I know where I'm going, know who I am and now I can face the world and get on''* (Melanie).

Fear of overwhelming feeling

In the next stage of therapy, most participants described **fear of losing self-control**: *'you start talking; a lot of emotion comes up when you're fighting to keep it down'* (Christine). Participants feared discussing difficult issues in case their distress became intolerable and unmanageable: *'because my brain, it's either been completely shut off because of the trauma, and when it's been switched on it - open the flood gate and there it goes.* [I've] *never been, been able to let it slowly come out, so I can deal with a little bit at a time. And that's what was happening with the therapy - I was just dealing with the tiny, but it's the rest of it still behind the dam'* (Donna). *'It does make you look at in a bit more depth maybe than you're prepared to, you know you sort of think 'that's a sore point…and do I really want to open that can of worms?' because we don't have enough sessions to get through it, so trying to talk to someone about what's bothering you and to get to the bottom of that without getting those feelings too far in front, because when you come to the end of the session, you've got to bottle it all back up, take it back with you on the bus or in the car. It's like unfinished business'* (Melissa).

Some participants also described a **fear of judgment**. Participants described attempting to avoid what they feared was overwhelming affect, including guilt and shame: '*I've lived with all of that as a terrible guilt thing. I think I'm being weighed down with guilt and shame'* (Christine); *'and sometimes when you do say it, you feel ashamed of saying what you're saying but it's how you feel'* (Melanie). Participants feared that by disclosing what they perceived as shameful and unacceptable material, the therapist would make negative

judgements: '*I think you don't want to be totally honest because you don't want someone else knowing what's going on in your head because you feel, like, it's strange'* (Melanie). One participant compared two therapy episodes: *'I thought he'd be going to the pub with his mates going, 'God, I've got a right one in the…shrink's room here!' So, I just thought I couldn't really work with him even though he seemed a really nice chap'*, and then commented on the more recent episode thus: *'you don't bother any more about hiding stuff. And you think, 'actually, I'm just gonna talk now', you don't get as anxious about what the other person's thinking, which, I've got a big thing about that'* (Chad). These extracts indicate a relationship between the difficulty of processing emotion and the service limits, which may affect the outcome and increase the likelihood that service users may not feel they have improved sufficiently.

Coping with the fear/managing therapy

In response to these anxieties, participants found ways to manage in therapy. Six participants felt unable to be open and some described active avoidance of specific issues or emotions, **hiding**: *''masking myself over the real issues and just talking about stuff that I wasn't passionate about, I'd only ever skirt what I wanted to talk about but then go into more safe stuff'* (Chad). Timing was sometimes significant: *'I didn't really want to talk a lot about what had happened. I wanted to try and think about what was happening in the present and try and change that. So I only spent about ten minutes talking about what had happened at home in the past, 'cause I thought just don't want to dwell on that'* (Melissa).

Even when the participant felt that disclosure was important, there were times it felt impossible: *'the main thing for me was to get my story out. In my mind I thought, if I could get all of my story out it would be lesser on me . But I didn't get it all out, because there's some things you can't say, ever'* (Christine). One participant was aware that a therapist might challenge this avoidance: '[therapy] *that forces me to dig deep, I'd be worried about doing a runner then!* [chuckles] *You know if somebody really forced me to, into a corner, I don't know how I'd react to that'* (Peter).

In addition to this lack of disclosure, there was a sense of **passivity** in the face of the process. Some described becoming compliant in order to avoid the therapist's judgement, the fear of which was sometimes based on the participant's own self-blaming: *'I can't really blame it on her coz it was, it was probably more me, but again, it was probably me turning up and just trying to please her, but then going away and being frustrated with myself coz it was another session gone.'* (Chad).

For others, it was the therapist's fault that nothing had happened; *'But by the time I'd gone, spent another year with* [therapist], *I really feel like she should've been a lot more focused on getting me to a place where I would've been all right on my own, and I'm like, well if I knew the answer to that I wouldn't need the help in the first place'* (Cameron).

From this state of passive acceptance, a sense of frustration developed: *'I began to think, well, how's this gonna work; seeing my life flash before my eyes. It works for some people, I suppose. It just didn't work for me.'* (George); *'I*

needed help in showing me how to change, and sat in a room talking didn't give me that' (Peter)

Left with difficult feelings

While six participants were able to describe some therapeutic gain, they made it clear that these were not the changes they felt they needed. Participants understood themselves as **making do**. Participants commended the practical and structured elements of therapy sessions: *'looking at a day at a time, what things you can do during the day and having some fun bits and having some bits where you kind of try and achieve some goals, that kind of thing, so that was quite good'* (Melissa). Sometimes there was an explicit appreciation of the therapist taking control and directing topics: *'Personally, structure is, really important. There's such a limited amount of time when you go into a session with someone it's good for them to say, right, this is what we're looking at today'* (Cameron).

Some participants felt that they were left worse off after therapy, despite being able to describe something positive that they had taken from the therapy; *'Through no fault, it's made it worse, because like I said it's kind of buried it more. So it's a lot harder to access, so then when it does happen, it happens with a vengeance, it's awful. And it's almost relearning how to cope again'* (Donna); *'I think what hurts worse is the fact that, just the little bit of light in the dark is, is enough to give you hope and then, when time runs out, and you're crashing and burning'* (Cameron).

All participants expressed a pervasive sense of **disappointment**: *'I'm dealing with stress levels on a daily level a lot better than I used to. But I still can't sleep. And I still get the bad dreams, and I still have flashbacks, and I don't think I've moved any further on those'* (Donna). '[therapist] *kept asking me if I was getting anything out of it, you know, say, how do I feel? Do I feel any better - just feel the same, nothing's changed. The thoughts are still there, the way, I'd treat other people. It's just the same'* (Peter). *'I talk better now about it, than I did before I had therapy. But you're still left with the unresolvedness, I'm still living with it basically'* (Christine).

For the majority of participants, the experience of therapy **reinforced the negative views of self** they held when they entered therapy. Some felt they were too damaged and that therapy could not help them; *'I don't know whether I can be cured, whether I can be helped'* (Peter). *'and maybe, they can't do anything, does that mean I'm beyond help? it's just the fact that, I've taken this risky set of steps in trying to fix something, and I really feel, I've only been convinced that it's very definitely broke'* (Cameron).

Some participants resorted to habitual self-characterisations to make sense of their experience, and blamed themselves for the failure of therapy: *'There is a feeling of disappointment and failure coz it's not working, but it was more this overwhelming feeling that I'd got it wrong, something I'd done hadn't worked.'* (Melanie). *'just me thinking it's my fault and that I should, try harder and learn something from it.'* (Cameron).

Some participants had decided to seek more therapy, either because they were still struggling with life: *'So you were back in that situation again, and in need of this counselling and guidance'* (Melanie) or because they were able to identify something positive about themselves: *'because I believe there's something to be got from* [therapy], *even though I kind of, felt a bit worse after the last set; if anything, surely that's a bit more reason to give me help this time because I'm still willing to work, I've, stuck with either chasing therapy or being in it or the principle in general [of therapy] as somewhere I might be able to get um, help.'* (Cameron).

Discussion

Participant narratives described a process starting with negative constructions of themselves alongside the initial hopes and anxieties brought to therapy. Once in therapy, two types of overwhelming fear emerged, one of losing control, the other of being judged. Participants described attempts to manage these fears within sessions using self-censoring and compliance to manage their experience of the therapeutic relationship. After therapy, while most participants could identify some positive gain, they felt disappointed that they had not achieved what they had hoped for, that they were having to 'make do'. This lack of success reinforced participants' initial negative self-beliefs, although for some there was sufficient hope that they continued to seek help.

Understanding lack of progress: The dimensions

In relation to the model of psychotherapy process described earlier (Beitman, Soth & Bumby, 2005), the process halted for participants in the 'pattern search' stage. They described becoming stuck in either avoidance or compliance, potentially repeating old patterns. In relation to the eight stage assimilation model (Stiles et al., 1990), participants were aware of the need to approach unpleasant experiences but avoided doing so *(unwanted thoughts)*, or struggled to develop an effective understanding of their difficulties *(problem clarification*, *personal insight/new perspective*). In spite of the benefits some described, none described experiences that could be seen as *problem solution, mastery* or *moving on to new issues.*

Expectations

Client expectations are estimated to contribute around 15% of outcome variance and if expectations are not addressed or met, therapy outcomes may be adversely affected (Lambert, 1992; Greenberg, Constantino & Bruce, 2006). Farber (2003) reported that, along with therapeutic alliance, duration of therapy predicted disclosure; several of our participants felt they had not been given a long enough therapy. Two recent studies offer examples of dissatisfaction ensuing after a mismatch of type of therapy and client wishes (Nilsson, Svensson, Sandell & Clinton, 2007; Werbart et al., 2015). Nilsson et al. (2007) found that clients undertaking either CBT or psychodynamic therapy were satisfied when their view of change matched well with the therapy they received, while disappointed clients suggested that it was the type of therapy that hindered their therapeutic progress. Most of our participants were unsure of the type of therapy they received. Some described elements of intervention

of several types, although it is unclear whether these were planned integrative approaches or whether the therapists tried a variety of interventions as they attempted to find a helpful route through therapy.

Therapeutic alliance

Therapeutic alliance is perhaps the most significant single factor predicting outcome (Wampold & Imel, 2015), and can be seen as comprising goals, bond and tasks (Bordin, 1979). Particpants found it hard to recount clear agreements about therapeutic tasks and goals. In terms of emotional bond, participants varied in the way they described their experience of the therapeutic relationship. Some experienced the therapist positively, for example, as validating. This contrasts with findings from the literature on harmful therapy, where therapists are experienced as uncaring (e.g. Bowie, McLeod & McLeod, 2016). Some of our participants described experiences of fearing judgement from a critical therapist. Others reported feelings of frustration with their therapist's passivity (c.f. Werbart et al., 2015) and several expressed a desire for more structure. Werbart's participants attributed their lack of change to the behaviour of their therapists ('passive, distanced, and not really committed to their joint work' p.555) whereas our participants mostly highlighted the impact of their own lack of emotional disclosure and blamed themselves. The nature of the data means that it is impossible to ascertain whether the therapists had noticed and tried to overcome the developing impasse (Hannan et al., 2005).

Disclosure

Expression of distressing emotion may be necessary during therapy; this is thought to facilitate processing emotional experience (Kennedy-Moore & Watson, 2001). Clients who disclose traumatic events have reported that '*the disclosure process initially generates shame and anticipatory anxiety but ultimately engenders feelings of safety, pride, and authenticity'* (Farber, Berano & Capobianco, 2004, p.340). The lack of disclosure which our participants described has been linked in the literature with shame, which acts to inhibit disclosure of negative emotions, directly affecting the therapeutic alliance (Black, Curran & Dyer, 2013). The lack of disclosure appears to be a common and problematic element in psychotherapy that relates to outcomes (Hook & Andrews, 2005). Farber (2003, p.590) found that experiences least likely to be disclosed were those which involved personal failure; *'there is an exquisite ambiguity in patients regarding highly charged disclosures: they both want their therapist to know and desperately want to protect themselves from shame and scrutiny'*. MacDonald & Morley (2001) suggested that clients may habitually avoid disclosure due to predictions that others will respond negatively: this seemed to be the case in this sample, even though participants reported that the experiences they could not bring themselves to disclose were relevant and important for their recovery.

Limitations

This study allowed an exploration of the experience of clients undergoing a psychological therapy offered by a public sector organisation outside a clinical

trial setting. In terms of quality, the staff in this service were qualified and accredited mental health professionals trained in specific therapy approaches and some were experienced with more than one model. The service required regular supervision of qualified clinicians and was supportive of practice requirements from the relevant professional and accrediting organisations. In this way, the accounts describe and capture something of the routine experience that NHS users have. Alongside the advantages of a study exploring real-life therapies are several limitations. One is the difficulty of ascertaining the type of therapy and the degree of adherence to the model. Some participants described elements potentially drawn from more than one model and without the therapist's input, it was impossible to ascertain the reasons for this. This means that these findings cannot be used to comment on the practice of a specific type of therapy. It is possible that clients may react to anxiety in any therapy with similar strategies. There are, however, some characteristics of this sample that may lead to specific experiences. One of these is the pressure placed on NHS practitioners to optimise their clinical work. These participants described experiences of a service where they had been offered a specific number of sessions, defined as the maximum for the service, which would not be the case for all settings.

In order to be referred into this service, the difficulties experienced by participants were identified as complex, severe or risky. It is possible that a sample with different characteristics would have emerged if the participants had been invited into a therapy outcome study (e.g. Werbart et al. 2015), were drawn from international health settings or had been recruited from therapists

undertaking independent practice. Studies recruiting participants from other settings would enable therapists to ascertain how prevalent these themes are across samples.

The route used for recruitment led to a self-selected sample of people, contacted after their therapy had ended, who felt unimproved, with the limitation that these participants may have felt more strongly about communicating their experience than others. This method of recruitment prioritized their subjective experience over the views of the therapist, and over standard measures of symptom change. It is possible that taking these into account when recruiting may have resulted in different findings; research incorporating different combinations of these three may offer further insights.

Clinical Implications

It is not clear from the accounts whether, or how clearly, therapists had informed clients about the process of therapy or of risks, including non-improvement (Boisvert, 2010). While some participants were able to describe specific interventions, few gave a sense of their therapy overall. The reasons for this are unclear, but it may be worth therapists reviewing the process of socializing clients to the nature and process of therapy. This might include steps for achieving agreement of clear and achievable goals and tasks, and of agreeing points for reviewing progress. Defining and seeking examples of gains, especially for those more abstract aims, may increase the use of therapy and facilitate later recall. The possibility of recalling deails of achievements in

therapy may support individuals to identify and value change even when this change is partial. This suggestion is supported by Werbart et al. (2015), which despite the differences between the therapy setting in their study and the current study, also concluded by emphasizing the value of agreeing goals and preparing clients for the tasks of therapy.

A strand common to several of these accounts was a response to the planned duration of therapy; participants felt that the number of sessions offered seemed insufficient for dealing with the issues. While there is an argument for being explicit about the length of therapy offered, in terms of informed consent and for offering clients the opportunity to prepare themselves for the experience, this step was seen by some clients as inhibiting, contributing to the decision not to disclose. Discussion in therapy that includes opportunities for negotiation, both near the start and later in therapy, might be significant for clients who feel reluctant to disclose or are anxious about asserting their needs.

Participants recounted episodes of non-disclosure as a significant element in the lack of progress they experienced. They described ways in which they saw therapy as insufficiently supportive, with examples of perceived limitations to the therapeutic relationship and of constraints intrinsic to the boundaries set in conventional therapy sessions. There was little detail about therapist conduct or responses to these two strategies and it is not clear whether there were examples of therapists not recognising or responding to them, or whether the therapist did not manage to find an effective response. Therapists may find that increased attention to these two potential self-protective strategies may enable

them to find more effective ways to identify and manage these interactions, to the benefit of clients.

Participants reported that they knew for some time that they were not improving and that therapy was 'going nowhere'. No participant described a process that might have been systematic case tracking, so warning signs may not have been as evident to the therapists (Whipple & Lambert, 2011). Given the evidence for the value of case tracking (Boswell, Krause, Miller & Lambert, 2015), it is particularly worth considering in relation to clients with characteristics that might indicate complexity and long duration.

These participants had characteristics that might make a good outcome less likely, such as duration of problem and previous unsuccessful episodes of therapy (Lambert, 2013). Furthermore, in many NHS Psychological Therapies Services, there are long waiting lists and almost no choice over therapy or therapist. The clinicians in these services are aware of these factors and often want to help, sometimes to an extent that they make decisions about starting or continuing treatment that they later recognize as being unhelpful (Hopper, 2015). Given the finding in this study that *no change* does not equate with *no effect*, and that an unhelpful intervention may harm, it might be beneficial for services to implement assessment strategies that minimize the chance that a client is offered an intervention that does not help. Whatever the constraints of the services which offer psychological therapy, it may be that making a decision to *not* offer therapy at a particular time or in particular circumstances will lead to a less negative outcome.

Conclusion

Although participants had identified themselves as not having improved through therapy, the accounts suggested more complexity than this. The accounts contained qualified, thoughtful descriptions of experience and feelings; participants acknowledged some gains, even though they felt that therapy had not met their expectations. Accounts of experiences early in therapy included more positive feelings, such as hope and liking, while post-therapy experiences were mixed and largely negative and all participants reported detrimental effects. As therapists, we might need to address our clients' expectations about change more effectively and to be aware that non-improvement is an experience that incurs negative effects including the reinforcement of negative self-beliefs. Engaging our clients in explicit discussions about therapy process and its limitations, including the potential effect of any maximum number of sessions, may be helpful in both improving outcomes and minimising the damage caused by therapy "non-improvement". The use of case tracking methods might be helpful for those clients at risk of no benefit, by allowing early identification of problems and encouraging discussion of lack of progress. This may especially important for those using self-protective strategies that result in impasse. It may be crucial for the future experience of self-critical clients that therapists find ways of inoculating against the self-blame which impacts the client's capacity to make use of future opportunities. Regardless of therapeutic model, this requires psychotherapy trainers to ensure there is sufficient attention paid during training to the quality of the therapeutic relationship,

including an exploration of therapist response to client anxiety and to apparent cooperation that allows discontent or fear to remain submerged.

References

Beitman, B. D., Soth, A. M., & Bumby, N. A. (2005). The Future as an Integrating Force Through the Schools of Psychotherapy. In: Norcross, J. C. & Goldfried, M. R. eds., *Handbook of Psychotherapy Integration,* 2nd ed. New York: Oxford University Press, pp. 65–83.

Black, R., Curran, D., & Dyer, K. (2013). The impact of shame on the therapeutic alliance and intimate relationships. *The Journal of Clinical Psychology*, 69(6), 646–654.

Boisvert, C. M. (2010). Negative Treatment Effects: Is It Time for a Black Box Warning? *American Psychologist*, 65(7), 680–681.

Bordin, E. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research and Practice*, 16, 252–260.

Boswell, J. F., Kraus, D. R., Miller, S. D., & Lambert, M. J. (2015). Implementing routine outcome monitoring in clinical practice: Benefits, challenges, and solutions. *Psychotherapy research,* 25(1), 6-19.

Bowie, C., McLeod, J., & McLeod, J. (2016). 'It was almost like the opposite of what I needed': A qualitative exploration of client experiences of unhelpful therapy. *Counselling and Psychotherapy Research,* 16(2), 79-87.

Castonguay, L. G., Boswell, J. F., Constantino, M. J., Goldfried, M. R., & Hill, C. E. (2010). Training Implications of Harmful Effects of Psychological Treatments. *The American Psychologist*, 65(1), 34–49.

Derogatis, L. R. (1994). *Symptom Checklist 90-R: Administration, scoring, and procedures manual.* 3rd ed. Minneapolis, MN: National Computer System.

Elliott, R., & James, E. (1989). Varieties of Client Experience in Psychotherapy: An Analysis of the Literature. *Clinical Psychology Review*, 9(4), 443–467.

Farber, B. A. (2003). Patient Self-Disclosure: A Review of the Research. *Journal of Clinical Psychology*, 59(5), 589–600.

Farber, B. A., Berano, K. C., & Capobianco, J. A. (2004). Clients' Perceptions of the Process and Consequences of Self-Disclosure in Psychotherapy. *Journal of Counseling Psychology*, 51(3), 340–346.

Froyd, J. E., Lambert, M. J., & Froyd, J. D. (1996). A review of practices of psychotherapy outcome measurement. *Journal of Mental Health*, 5(1), 11–15.

Greenberg, R. P., Constantino, M. J., & Bruce, N. (2006). Are patient expectations still relevant for psychotherapy process and outcome? *Clinical Psychology Review*, 26(6), 657–678.

Hannan, C., Lambert, M. J., Harmon, C., Nielsen, S. L., Smart, D. W., Shimokawa, K., & Sutton, S. W. (2005). A Lab Test and Algorithms for Identifying Clients at Risk for Treatment Failure. *Journal of Clinical Psychology*, 61(2), 155–63.

Hansen, N. B., Lambert, M. J., & Forman, E. M. (2002). The Psychotherapy Dose-Response Effect and Its Implications for Treatment Delivery Services. *Clinical Psychology: Science and Practice*, *9*(3), 329–343.

Hodgetts, A., & Wright, J. (2007). Researching Clients' Experiences: A Review of Qualitative Studies. *Clinical Psychology and Psychotherapy*, 14, 157–163.

Hook, A., & Andrews, B. (2005). The relationship of non-disclosure in therapy to shame and depression. *British Journal of Clinical Psychology*, 44(3), 425–438.

Hopper, S. A. R., (2015). The therapist experience of client non-response. Unpublished DClinPsy dissertation, University of Leeds.

Johnsen, T. J., & Friborg, O. (2015). The Effects of Cognitive Behavioral Therapy as an Anti-Depressive Treatment is Falling: A Meta-Analysis. *Psychological Bulletin*, 141(4), 747.

Kennedy-Moore, E., & Watson, J. C. (2001). How and When Does Emotional Expression Help? *Review of General Psychiatry*, 5(3), 187–212.

Knight, T. A., Richert, A. J., & Brownfield, C. R. (2012). Conceiving Change: Lay Accounts of the Human Change Process. *Journal of Psychotherapy Integration*, 22(3), 229–254.

Lambert, M. J. (2013). *Bergin and Garfield's handbook of psychotherapy and behavior change*. New Jersey: John Wiley & Sons.

Lambert, M. J. (2007). Presidential address: What we have learned from a decade of research aimed at improving psychotherapy outcome in routine care. *Psychotherapy Research*, 17(1), 1–14.

Lambert, M. J. (1992). Psychotherapy Outcome Research: Implications for

Integrative and Eclectic Psychotherapists. In: Norcross, J., & Goldfield, M. eds., *Handbook of Psychotherapy Integration*, 1st ed. Oxford: Oxford University Press, pp. 94–129.

Lambert, M. J., & Ogles, B. M. (2004). The Efficacy and Effectiveness of Psychotherapy. In: Lambert, M. J. ed. *Bergin and Garfield's Handbook of Psychotherapy and Behavior Change*, 5th ed. New York: Wiley, pp. 139–193.

Lilienfeld, S. O. (2007). Psychological Treatments That Cause Harm. *Perspectives on Psychological Science*, 2(1), 53–70.

Llewellyn, S. (1988). Psychological Therapy as Viewed by Clients and Therapists. *British Journal of Clinical Psychology*, 27(3), 223–237.

Lorentzen, S., Høglend, P., Martinsen, E. W., & Ringdal, E. (2011). Practice-Based Evidence: Patients Who Did Not Respond to Group Analysis. *International Journal of Group Psychotherapy*, 61(3), 366–95.

MacDonald, J., & Morley, I. (2001). Shame and non-disclosure: A study of the emotional isolation of people referred for psychotherapy. *Psychology and Psychotherapy: Theory, Research and Practice*, 74(1), 1–21.

Nilsson, T., Svensson, M., Sandell, R., & Clinton, D. (2007). Patients' experiences of change in cognitive–behavioral therapy and psychodynamic therapy: a qualitative comparative study. *Psychotherapy Research*, 17(5), 553–566.

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative Phenomenological*

Analysis: Theory, Method & Research. London: Sage Publications.

Stiles, W. B., Elliott, R., Llewelyn, S. P., Firth-Cozens, J. A., Margison, F. R., Shapiro, D. A., & Hardy, G. (1990). Assimilation of problematic experiences by clients in psychotherapy. *Psychotherapy*, 27, 411–420.

The Centre for Economic Performance's Mental Health Policy Group. (2012). *How Mental Illness Loses Out in the NHS*. London.

Van, H. L., Dekker, J., Peen, J., Van Aalst, G., & Schoevers, R. A. (2008). Identifying Patients at Risk of Complete Nonresponse in the Outpatient Treatment of Depression. *Psychotherapy and Psychosomatics*, 77(6), 358–364.

Von Below, C., & Werbart, A. (2012). Dissatisfied psychotherapy patients: A tentative conceptual model grounded in the participants' view. *Psychoanalytic Psychotherapy*, 26(3), 211–229.

Wampold, B. E. (2001). *The Great Psychotherapy Debate: Models, Methods, and Findings*. Mahwah: Lawrence Erlbaum Associates.

Wampold, B. E., & Imel, Z. E. (2015). *The great psychotherapy debate: The evidence for what makes psychotherapy work,* 2nd ed. New York: Routledge.

Werbart, A., Von Below, C., Brun, J., & Gunnarsdottir, H. (2015). 'Spinning one's wheels': Nonimproved patients view their psychotherapy. *Psychotherapy Research*, 25(5), 546–564.

Whipple, J. L., & Lambert, M. J. (2011). Outcome Measures for Practice. *Annual*

Review of Clinical Psychology, 7, 87–111.

Yardley, L. (2007). Dilemmas in qualitative health research. *Psychology and Health*, 15(2), 215–228.

	Theme	Subthemes
Before therapy	Negative views of self (8)	Worthless (7) Self to blame (5)
The process of therapy	The changing feelings about therapy (6)	The desired relationship (6) The desired endpoints (2)
	Fear of overwhelming feeling (7)	Fear of losing self-control (6) Fear of judgement (shame) (3)
	Coping with the fear/managing therapy (7)	Hiding (6) Passivity (6)
After therapy	Left with difficult feelings (8)	Making do (6) Disappointment (8) Reinforced negative views of self (6)

Table 1: Participant experiences of a therapy they felt did not help

Word Count: 7076