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Risk factors for negative experiences during psychotherapy

Abstract

Background: It is estimated that between 3% and 15% of patients have a negative experience of psychotherapy, but little is understood about this. **Aims**: The aim of this study was to investigate the factors associated with patients' negative therapy experiences. **Method**: The data comprised 185 patient and 304 therapist questionnaires, 20 patient and 20 therapist interviews. Patients reported on an unhelpful or harmful experience of therapy, and therapists on a therapy where they thought the patient they were working with had a poor or harmful experience. These were transcribed and analysed using thematic analysis. **Results**: There was a **Lack of fit** between ***Patient needs***, ***Therapist skills,*** *and* ***Service structures***. This could result in **Fault Lines**, a tension between ***Safety and containment*** and ***Power and control***. This tension led to **Strain** and ***Poor Engagement***, which led to **Consequences** following the negative therapy experience. **Conclusions**: Patients require clear information, choice, involvement in decision-making, explicit contracting and clarity about sessions and progress. Opportunities for patient feedback should be the norm, where the therapist and service are vigilant for signs of deterioration and solutions considered.

Clinical and methodological significance of this article: Estimates of "unwanted effects," including long-lasting effects, of psychotherapy have ranged from 3% to 15%. Few empirical studies have been conducted in this area. This study aimed to address this gap and provide clinicians with a model of risk factors for negative therapy effects. The findings of this study indicate the importance of providing patients with a supportive service structure that offers clear information, choice and involvement in decision-making. Explicit contracting at the beginning of therapy and clarity about sessions and progress are also important in managing patient expectations throughout. Opportunities for patient feedback should be provided.

Keywords: risk factors, negative therapy experiences

Negative experiences during psychotherapy are common and may form part of a successful therapy. Most are short-lived and are appropriately managed by the therapist and patient; for example, appropriately responsive therapists will notice changes in the way their patients are working with them, and adapt the intervention, stop and discuss what is happening, obtain feedback, resolve difficulties and move forward collaboratively (Kramer & Stiles, 2015). However, for some patients, the negative experience may be more pervasive, long lasting and result in deterioration or lack of improvement (Lilienfeld, 2007). In a recent UK survey of patients' experiences of therapy, approximately 5% of patients reported a lasting bad effect from the therapy they received (Crawford et al., 2016). Estimates of "unwanted effects," including long-lasting effects, of psychotherapy have ranged from 3% to 15% (Berk & Parker, 2009); Mohr, (1995).

There are many terms used by researchers, therapists and patients to describe negative experiences such as harm, deterioration, unwanted events, adverse reactions, negative effects or outcomes, and different ways of measuring or identifying negative impacts (Dimidjian & Hollon, 2010). One method often used by researchers to identify potential negative response to therapy is through standard measures of patient outcomes (Whipple & Lambert2011), but even here there is no agreement on what constitutes a negative response to therapy; should this be deterioration, attrition, relapse?

Using standard patient outcome measures as a proxy for negative experiences, somewhere between 5% and 10% of patients deteriorate following therapy, and another 25–57% do not reliably improve (Cahill, Barkham, & Stiles, 2010) , Firth, Barkham, Kellett, et al. (2015); Smith, Glass, & Miller, 1980) Ogles, Lambert, and Sawyer (1995) re-analysed data from a large, multi-centre trial for depression in the US found 8% of patients completing therapy deteriorated.

A reliance on patient outcomes to measure adverse effects of therapy has the drawback of ignoring patients' voices and their experience of the therapy. It cannot be assumed that deterioration on outcome measures means that the patient had a negative experience of therapy, or indeed that symptomatic improvement ensures a good therapy experience.

When examined from the perspective of therapy recipients' experience, many user-led resources (internet sites, books) report negative effects of psychotherapy, giving personal testimony of damaging experience of therapy sometimes with severe consequences (e.g., Bates, 2006). Despite this, there is a dearth of empirical research on incidence, mechanisms and prevention (Parry, Crawford, & Duggan, 2016). In addition, often therapists and patients have differing views on outcomes of therapy (Mohr, 1995; Timulak, 2010) therapists have difficulty seeing or acknowledging treatment failures (Kächele & Schachter, 2014; Lambert, 2011), and patients often do not tell their therapist or services about negative experiences (Regan & Hill, 1992).

Another perspective on negative experience is the occurrence of adverse events during research trials. The methods and the actual reporting of harm during trials of psychological therapies are also poor (Jonsson, Alaie, Parling, & Arnberg, 2014; Vaughan, Goldstein, Alikakos, Cohen, & Serby, 2014). For example, one study of UK-funded trials found that trials of drug treatments were more likely to mention adverse events in their protocols compared with psychological treatment trials, and that when adverse events were mentioned, these used severe adverse events guidelines developed for drug rather than psychological interventions, such as death or hospitalization rather than self-harm or sudden symptom deteriorations, which may be more appropriate (Duggan, Parry, McMurran, Davidson, & Dennis, 2014). This has led to a call for stricter requirements regarding efficacy and safety of psychological treatment with particular reference to adverse events (Lilienfeld, 2007; Petry et al., 2008).

Linden (2013) developed a useful checklist for assessing unwanted events and adverse treatment reactions; however, as Werbart, Andersson, and Sandell (2014) pointed out, such definitions tend to locate the responsibility in the patient or the treatment, without consideration of therapist effects (Kraus, Castonguay, Boswell, Nordberg, & Hayes, 2011; Saxon & Barkham, 2012) or complex interaction between these systems and with a wider context. Lambert (2011), for example, highlighted how obstacles to treatment delivery may contribute to treatment failure and negative patient experiences.

These definitional and reporting or measurement issues are due in part because the authors have taken one aspect of the therapy process and do not consider the broader phenomena of negative experiences following therapy and why they might they occur. It appears that negative experiences may occur because of a combination of factors; they could be as a consequence of patient or therapist factors, in-therapy events (Barlow, 2010), or because of "decisions made about the treatments" (Dimidjian & Hollon, 2010). These potential risk factors are discussed below.

In a review of 46 studies of patient factors, Mohr (1995) indicated that a diagnosis of borderline personality, obsessive-compulsive disorders or people with interpersonal difficulties were most consistently associated with negative outcomes. Practitioner rated severity of symptoms was also an indicator of poor outcomes, but the opposite was true of self-rated severity. Poor patient motivation and those who do not anticipate that therapy may be difficult have also been identified as patient factors related to negative experiences. Strupp (1980) in a case study comparison of a successful and an unsuccessful case, also found patient factors and the good working relationship influenced therapy outcomes.

Therapist factors associated with negative outcomes have included lack of empathy, initial underestimation or subsequent recognition of the severity of the patient's problems leading on to an inappropriate course of therapy, failure to provide focus and structure in therapy, negative countertransference, or high concentrations of transference interpretations (Dimidjian & Hollon, 2010). Disagreements with patients about therapy are also associated with negative outcome (Mohr, 1995)

In-session therapy events have tended to focus on relationship factors, such a ruptures (Coutinho, Ribeiro, Hill, & Safran, 2011) or broader relational factors (Werbart, Von Below, Brun, & Gunnarsdottir, 2014) and on patient and therapist identified hindering events (Castonguay et al., 2010; Llewelyn, Elliott, Shapiro, Hardy, & Firth-Cozens, 1988).

Many of the above factors contain "micro-theories," for example, Safran and Krauss (2014) have developed a model of rupture-repair sequences in therapy, providing helpful recommendations to clinicians about how to recognize and resolve alliance ruptures. However, there is a lack of integration of such models focusing more generally on the processes or risk factors leading to a failed therapy or negative experience following a course of therapy. This has led to a call for better recording and routine monitoring of adverse effects and negative patient experiences and for research to investigate the causes and mechanisms of these experiences (Crawford et al., 2016). The aim of this study, therefore, was to investigate the risk factors associated with patients' negative therapy experiences, using a broad criterion, recalling a specific therapy that the patient had found unhelpful or harmful, or which a therapist believed to have been unhelpful or harmful.

Method

Design

This study comprises a survey of patients and therapists with follow-up interviews with survey participants who consented to take part in an interview. Patients were asked about an unhelpful or harmful therapy experience and therapists were asked about a therapy that they thought had been unhelpful or harmful for the patient. No time limit since the unhelpful experience was specified.

Recruitment and Participants

Patients were recruited through mental health and other voluntary organizations (e.g., MIND, Relate, Rethink), service user organizations (e.g., National Service User Network), local service user advocacy groups and counseling services in England. Therapists were recruited through their professional bodies (including the British Association of Counselling Psychology, British Psychological Society, UK Council for Psychotherapy, and British Association of Behavioural and Cognitive

Psychotherapy), conferences and articles in practitioner journals. Potential participants were guided to the research website and a link to the questionnaires. To take part in the study participants (therapists and patients) had to be over 18 years of age and have had experience as either a therapist or patient of individual psychotherapy. No other inclusion or exclusion criteria were imposed. Participant information was provided and consent was required. The study was favourably reviewed by the NHS National Research Ethics Service for Yorkshire and The Humber (REF 11/YH/0275).

A total of 193 patients and 322 therapists completed the survey questionnaires, of which 185 (96%); and 305 (95%), respectively, were usable. Of these, 27 (14.6%) and 73 (24%) were male. Patients' ages ranged from 20 to over 70 years (*M* = 45) and therapists' ages ranged from 20 to 69 years (*M* = 40); patients stated their ethnicity was White (*N* = 155; 80.3%), Asian or Black British (*N* = 13; 7%), Mixed/Other (*N* = 13; 7%), and therapists White (*N* = 267; 87.5%), Asian or Black British (*N* = 24; 8%), Mixed/Other (*N* = 7; 2.3%).

Patient participants reported on therapy experiences that were from a variety of settings: 40% National Health (NHS) mental health services; 25% private practice; 14% NHS primary care services; 8% voluntary organizations; 3% work place/college/university services; and 10% other or more than one setting. The types of therapy patients received included: 12% CBT; 10% psychodynamic; 7% humanistic/person-centred; 6% psychoanalysis; 5% integrative/eclectic; 4% cognitive analytic; 31% did not know; and 25% other or more than one therapy reported. A variety of therapists were seen: 30% psychotherapist; 27% counsellor; 17% clinical psychologist; 6% psychiatrist; 13% other or more than one professional reported; and 7% did not know.

Of the 304 therapists, 55% worked in NHS secondary care; 34% NHS primary care; 4% NHS Specialist/Tertiary Care; 3% Private setting; 4% Mixed/other setting. Their professions included: clinical psychologists (36%); psychotherapists (23%); counsellors/counselling psychologist (10%); CBT/High Intensity therapists (4%); Psychological Wellbeing Practitioners (6%); Assistant/Trainee Therapist (7%); Nurse Therapist (4%); other/more than one therapy (9%); and not given (1%). Fifty percent of therapists said they offered cognitive, behavioural or cognitive behavioural therapy, 8% integrative/eclectic therapy, 2% used a person-centred approach, 19% offered more than one therapy type and 9% other therapies (including Art therapy, Dialectical behavior therapy, eye movement desensitization and reprocessing, Systemic therapy) and 1% not given.

The sample for interview and qualitative analysis was drawn from survey participants who had agreed to be interviewed (139 patients and 108 therapists). Sample size was determined by the need to achieve maximum variation across age, gender, and type and setting of therapy, and the requirement to achieve saturation point; 40 interviews were thought to be necessary to meet both requirements, based on evidence of data saturation sample sizes in thematic analysis of qualitative research (Ando, Cousins, & Young, 2014). In total, 10 face-to-face and 30 telephone interviews were conducted. Five face-to-face and 15 telephone interviews were with patients; the same number of interviews was conducted with therapists. Telephone interviews were offered to participants who were unable or unwilling to travel for a face-to-face interview.

The ages of patients who were interviewed ranged from 20 to over 60, of whom 15 were female. Ten patients received therapy in National Health (NHS) mental health services; three in private practice; six NHS primary care services; and one at a voluntary organization. The types of therapy

patients received included: CBT (five); psychodynamic (five); humanistic/person-centred (two); cognitive analytic (one); and six did not know. The ages of therapists who were interviewed ranged from 20 to over 60, of whom 10 were female. Twelve therapists worked in the National Health (NHS) mental health services; two in private practice; three NHS primary care services; and one at a voluntary organization (two with missing data). Ten of the therapists offered CBT, three offered a psychodynamic approach, three an integrative approach, one humanistic/person-centred, one cognitive analytic therapy, and one art therapy (one with missing data).

The face-to-face interviewers and analysts (JC and LB-E) were female, and had behavioural scientist and health psychologist backgrounds; one telephone interviewer was male (KD-B) and a drama therapist, the other two (GH & GP) were female clinical psychologists. The two survey analysts were female (GK and RO); one was a clinical psychologist and the other an occupational psychologist. All had training and experience in interviewing for research projects and training in qualitative research methods.

Questionnaire and Interview Schedule

Survey questionnaires for both patients and therapists were designed specifically for this study and are available from the corresponding author. Questions were derived by the research group, which included both therapy providers and service users. The questionnaire was piloted before use.

The patient questionnaire asked respondents to identify one experience of a specific course of therapy that had ended and had been unhelpful, and to answer a number of questions about that specific therapy experience, such as type, duration, frequency, setting, and about the therapist and the respondent. Open questions asked for details of the therapy and how it was unhelpful or harmful, how it ended and what might have helped improve the therapy.

The therapist questionnaire asked about a specific course of therapy, which had ended, that had been unhelpful or harmful for the particular patient. The questions asked mirrored the patient questionnaire. No time limit since the therapy ended was set for therapists or patients.

Both patients and therapists were asked to rate how unhelpful or harmful this event had been for themselves or the patient on a scale of 1(Unhelpful as a whole but some good came out of it) to 10 (Extremely damaging with lasting effects). Patients generally reported their negative experiences as more harmful than the therapist reported patient negative experiences (M = 7.3, SD 3.6 and M = 3, SD 1.88, respectively). These ratings were not significantly associated with therapy setting or therapists' profession.

All interviews followed a similar topic guide. Participants were asked to focus on a particular negative therapy experience and describe what happened, for example, how therapy started, how therapy did not help them/the patient or made them feel worse, when concerns were first experienced and what was done. Participants were also asked to reflect on their experiences and think how the experience had affected them and what might have helped. The face-to-face interviews were held at the respondent's home or at the university and were approximately one hour in length. The telephone interviews took between 30 and 60 minutes. All interviews were transcribed and checked by the interviewers, but not with the participants.

Analysis

There were six sets of transcripts; patient questionnaire free text (*N* = 185), therapist questionnaire free text (*N* = 304), patient telephone interviews (*N* = 15), patient face-to-face interviews (*N* = 5), therapist telephone interviews (*N* = 15) and therapist face-to-face interviews (*N* = 5) and each set was considered separately with the basic analysis, thematic analysis described below, following the same format for each set of transcripts.

The thematic analysis followed the steps described by Braun and Clarke (2006). First, the researchers familiarized themselves with the transcripts and then coded all sections of each transcript looking at both the semantic and conceptual meaning of the data. These codes were then organized into themes or repeating patterns in the transcripts. This work also involved looking for relationships between the themes and involved revisiting the transcripts to ensure these were reflected in the data as a whole. This process was inductive as this is an under-researched area, although the researchers worked primarily from a realist epistemological position.

Two researchers independently coded 15 questionnaire free texts and then met to agree a preliminary list of codes and themes. A further 15 questionnaires were coded by both researchers and the codes and themes were reviewed by the researchers who checked back with the coded data and transcripts to ensure the themes were grounded in the data. The remaining questionnaires were coded by one researcher only.

The same basic format was followed for the telephone transcripts—both researchers coded the first two transcripts, and following discussion and agreement on codes and themes, the remaining transcripts were coded by one researcher. Both researchers analyzed all of the face-to-face transcripts.

Once the separate analyses were completed, the four interview researchers met to discuss the two sets of codes and themes from the patient interviews and, separately, the two sets from the therapist interviews. Finally, all researchers considered the analyses from the questionnaires and interviews for patients and therapists. At each stage, common themes were merged and any differences between patient and therapists, or interview and questionnaire groups noted.

The relationships between the resultant themes were then considered and a model of factors that participants linked to negative experiences of therapy was derived. These relationships are identified as linking themes.

Quality Assurance

The researchers took steps to reduce the impact of their own biases through (i) keeping a reflective diary of reactions and assumptions and (ii) through working in pairs and then as a group, ensuring that the work of individual analysts was reviewed and audited, and the findings were grounded in the transcripts and agreed between the team (Elliott, Fischer, & Rennie, 1999; Hill et al., 2005). The researchers were from a variety of backgrounds, which also helped to reduce bias. Triangulation of findings was achieved through bringing together codes and themes from across different sources of data (Patton, 1999).

Experts by experience were involved at two stages of the study. An expert by experience researcher was part of the team who designed the study and commented on the methods and the development of the interview topic guide. A second expert by experience audited the analysis of the patient

transcripts. Her comments were used as part of the discussion when revising and agreeing the themes.

Results

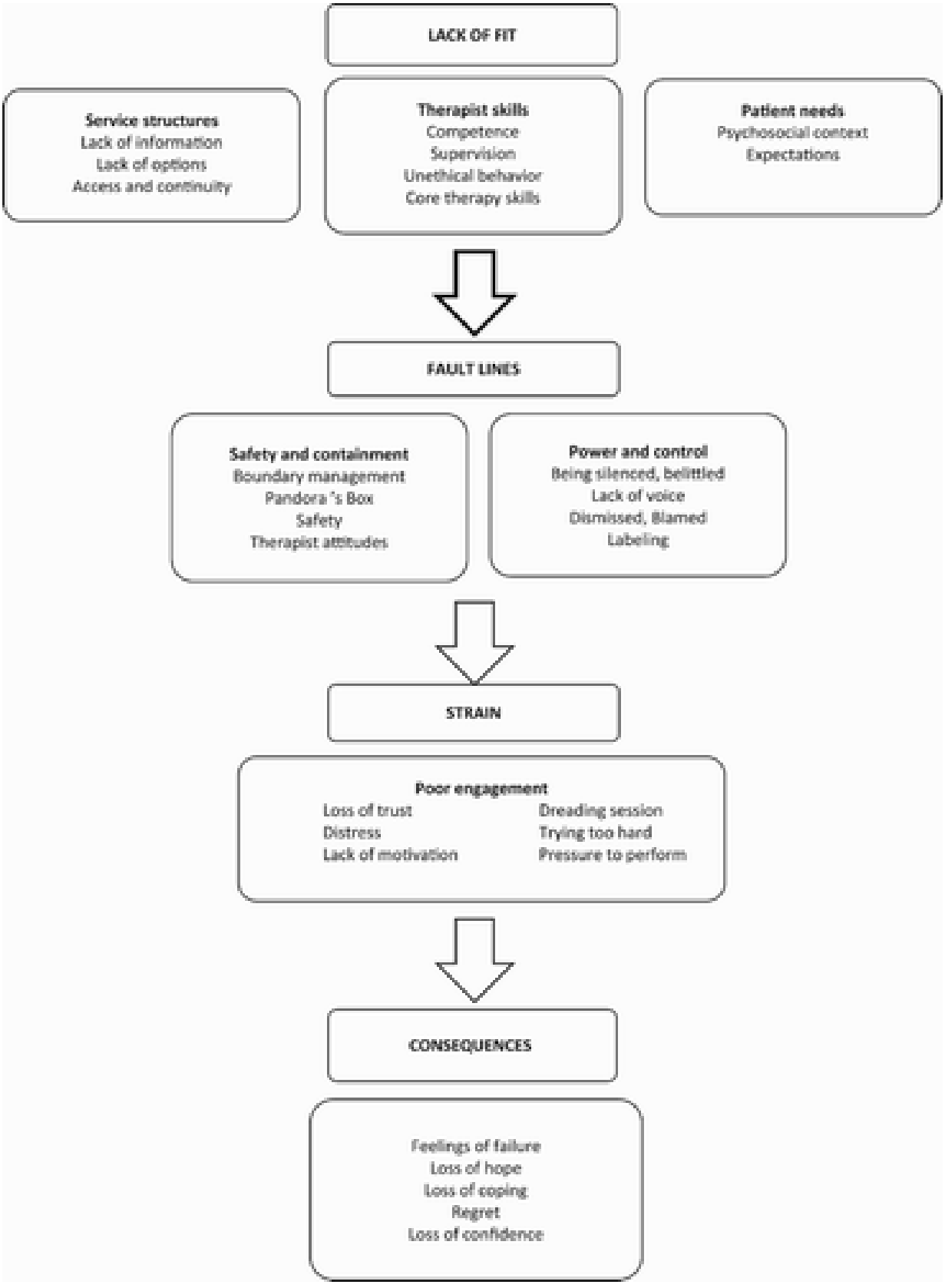
The findings of the final stage of analysis are presented as a model of risk factors for negative therapy experiences (Figure 1). The model includes the linking themes of a potential "Lack of fit" leading to a "Tension" that results in "Strain" and "Consequences" of negative experiences for both therapist and patient, illustrated in Box 1. In the text, the main themes from the analyses are in **bold** and sub-themes in ***bold*** and ***italics.*** Quotes from the transcripts for each of the themes are provided in italics and in brackets, *P* indicates this is a patient quote, *T* indicates a therapist quote, *Q* that the quote is taken from a questionnaire, FI from a face-to-face interview, and TeI a telephone interview. Any differences in the themes between patients and therapists or between methods of data collection are noted in the text.

Box 1. Therapist and patient case studies.

Therapist TTeI-40 spoke of the complex nature of the patient's difficulties and how 'It became apparent that their [patient's] needs are, however, much greater than I, and the service I'm working with, provide for' (**Lack of fit**: ***Service structures*** and ***Therapist skills***). In an attempt to manage this, the therapist focused on ensuring a good assessment and treatment plan. However, they reflected: 'I was quite clear in my formulation with him as to where the work could go and where I felt it would be beneficial to go and I was possibly too much in control of that' (**Fault lines**: ***Power and control***) and 'I found myself pushing him and really trying to engage him' (**Fault lines**: ***Power and control*** leading to **Strain**: ***Poor engagement***). The therapist also said of the therapy 'It was too focused on my own understanding' (**Strain**: ***Trying to hard***) and later 'Some of the interpersonal difficulties he had were very much based around security and fear of rejection … .There was never really an anchor point to it, he didn't really connect to anything' (**Fault lines**: ***Safety***). When asked about the end of therapy, the therapist replied 'It was a difficult ending. He was a patient who I was aware in myself I didn't look forward to seeing' (**Strain**: ***Dreading session***). The therapist later said 'So yeah its, um, it did, it was something that I reflected on quite negatively-about myself' (**Consequences**: ***Failure***).

Patient PTeI-31 said that 'the first couple of interviews he [therapist] did nothing, other than he would sit there and say, well why are you here and so I would say well OCD … . and then he said is there anything else and I said yes there is. So I tentatively approached it, and I really wish I hadn't (mm), because he jumped on it and it was almost aggressive in his manner and his demeanor' (**Lack of fit**: ***Therapist skills*** leading to **Fault lines**: ***Therapist attitudes***). The patient continued that therapy then felt 'It was like Pandora's Box because I'd kept the lid on for so long (yeah) and now all of a sudden the lid is off (yeah) and these horrible things are coming out to the forefront with no way of dealing with them, and no way of (mm) with no, no coping mechanism' and that she 'was never in control of how the therapy went; I was never asked if it was making me uncomfortable and if I was ok to proceed' (**Fault lines**: ***Safety and containment*** linking to ***Power and control***). The patient walked out of the session and did not return (**Strain**). The patient later commented that she had never tried psychotherapy again: 'To be honest with you, I could not sit down now and go through all what I went through again' (**Consequences**).

Figure 1. Model of risk factors for negative experiences during psychological therapies.



Lack of fit: Service Structures

Some patients described not having a choice in their care and being offered no ***Options***[1], sometimes receiving a treatment they did not want, and often being given very little ***Information***[2] about the service, their treatment, their therapist or their diagnosis; others described difficulties with ***Access and continuity***[3] of treatment.

[1]So there was, it was Hobson's choice that you either take it from this person or, or not. (PTeI-1)

[2]I think I expected a bit more of a framework of progress. (PTeI-2)

[3]I feel like you're the victim of the process all the way through, … they always miss the mark … .. She went on maternity leave, that's why it finished … I was supposed to be going to see somebody else but that didn't happen. (PFI-3)

Like patients, therapists also talked about a lack of fit between the service and patient need[4,5].

[4]… The team has taken the attitude now that some clients are tertiary level, just because our Trust hasn't invested in tertiary level services doesn't mean that [we] should mop all those up as well. (TTeI-1)

[5]The therapy ended as contracted after 6 months due to demand on service and agreed service provision. (TQ-2)

Lack of fit: Therapist Skills

Some therapists described examples where they felt that they were working beyond their level of ***Competence***[6,7], often seeing patients because they believed that if they did not offer help, the patient would be offered nothing. Sometimes therapists only recognized this lack of appropriate skill in retrospect when reflecting on the encounter, realizing that the complex nature of some patients' problems, plus their own lack of experience, could have resulted in therapy being harmful. Inadequate or insufficient ***Supervision***[8] at the time of therapy delivery compounded these problems.

[6]I just think that it was me trying to help somebody, at a time at which they were outside of my competency and, that's a shame to them and to me. (TFI-3)

[7]To have recognised my own limits sooner and to not have continued. I believe the culture of being flexible, moving around and meeting the client needs had clouded my clinical judgement and my own needs in being able to assess what my own requirements for providing a containing space were. (TQ-4)

[8]I'm sure I would have benefitted from taking this case to supervision but there were more pressing cases and insufficient supervision time for so many complex clients on my caseload. (TQ-5)

Some reports from patients contained clear instances of therapist ***Unethical behavior***[9,10]

[9]The therapist was struck off his professional register whilst working with me, for having a relationship with another patient. He decided to carry on working and told me about his situation, saying that I could decide what to do. (PQ-6)

[10]The therapist took phone calls during the session. He mentioned things about another client. I was too polite and naive to complain (I'm not now!). (PQ-7)

In addition, some patients described therapists as not possessing ***Core therapy skills***, such as empathy, listening skills, confidence, dealing appropriately with risk issues, or structuring a session and providing an appropriate focus[11,12]. Therapist and service inflexibility was also a common concern for patients[13].

[11]I kind of felt like she was on the outside looking in instead of going, of travelling, a journey with me. (PTeI-8)

[12]She didn't react to how I was feeling like if I got upset she didn't really know what to do. (PFI-9)

[13]She was a textbook counsellor and used textbook counselling which just didn't apply to me. She didn't attempt to really find out what my issues were and then apply her knowledge accordingly. (PQ-4)

Lack of Fit: Patient Needs

Therapist inflexibility sometimes concerned the lack of consideration of the broader ***Psychosocial context*** of the patient, including family, social, housing and other factors. This theme was found in patient[14,15] and therapist transcripts[16]. Some patients[17,18] and therapists[19] also talked about the service (or therapy) not meeting their ***Expectations*** or needs.

[14]They should have waited until I was more stable. The care team was aware of my complex needs and ought to have considered a Psychotherapist/ specialist therapist. (PQ-10)

[15]They didn't look at the bigger picture it was just purely looked at as purely post-natal depression. (PFI-11)

[16]A care package (including housing) which would have involved the whole family and addressed some of the social problems which would have supported the client in undertaking the work required in therapy as she did not have the capacity to do it. (TQ-7)

[17]I think I expected a bit more of a framework of progress. (PTeI-12)

[18]Therefore didn't challenge (therapy traumatic - vomiting, shaking, couldn't work) because you'd waited eighteen months and because you'd been told that this was the crème de la crème. I didn't question that and it was like, oh well they must know what they're doing. (PFI-3)

[19]She appeared to take a passive approach to therapy, with an expectation that attending sessions in itself would lead to change. (TQ-8)

Fault Lines: Power and Control

Some patients experienced therapy as struggle for control. Often this struggle was implicit and patients described their experience as ***Being silenced***[20,21]where the therapist was seen as actively preventing the patient from raising issues of importance. Some patients described the experience of feeling passive and unable to speak out, captured in the theme ***Lack of voice***[22]. Other patients described therapists as showing little respect and experienced being ***Dismissed*** or ***Blamed*** for therapy not working[23].

[20]I felt all the way through there were certain things I didn't ask him because I didn't feel as though I should, I thought well he's the expert. (PFI-18)

[21]I had not been given the opportunity to give permission. My voice immediately silenced. I instantly felt powerless in our relationship, passive. I felt I was there to be "done to." (PQ-19)

[22][…] Never asked me anything in detail. Just completely dismissed it.

Somehow he seemed to make it seem as though it was all my fault. (PFI-20)

[23]I felt there was something very wrong with me as well: That I wasn't responding as I was supposed to respond. (PTeI-14)

Some patients said they experienced as damaging the language, including the use of less direct ***Labelling***that the therapist may have either unintentionally or inadvertently used. For example, one patient found the therapist's use of the word "fixing" made her feel trapped[24].

[24]Fixing! That therapist was trying to fix me; that's why she was talking more than me … and it made me feel like I was broke. (PFI-21)

Fault Lines: Safety and Containment

Some of the patients' concerns were related to containment issues[25], and others were violations of their ***Boundaries***[26]. Some therapists also recognized the impact of not providing enough structure and ***Safety***[27]. Patients described feeling unsafe[28] and occasionally therapists also experienced such feelings[29].

[25]And I was just asked questions and I responded to the questions, but it was making me feel quite upset talking about things which, you know, perhaps would have been better 15 minutes or so before the session concluded. (PTeI-14)

[26]On our first meeting outside the room, before having met or spoken to him before, I offered my hand out to shake. He moved straight in and hugged me. In my body I immediately felt uncomfortable; my hand ignored, my boundaries broken. I had not been asked if this was okay. (PQ-13)

[27]To have recognised my own limits sooner and to not have continued. I believe the culture of being flexible, moving around and meeting the client needs had clouded my clinical judgement and my own needs in being able to assess what my own requirements for providing a containing space were. (TQ-4)

[28]She wasn't a safe person to confide in or you couldn't get a sense that she could handle it really. (PTeI-12)

[29]I felt at risk in his presence as he was a very angry and dominating man who believed he could have "anything" he wanted. I am sure this concern was present in our therapy together and caused him to decide not to return. (TQ-9)

Some patients experienced fear during therapy as they talked about very difficult feelings, memories or events and felt unsupported and ill equipped trying to manage these emotions on their own, like

opening ***Pandora's box***[30]. This is in contrast to the previous sub-themes ***Being silenced*** and ***Lack of voice***.

[30]It left me in a, probably dangerous place I think, because I had suppressed all of my feelings all of my life to cope with trauma, and, you know, talking about stuff and all of my feelings were suddenly very apparent, and I had no skills to deal with that. (PFI-15)

Patients described a number of potentially harmful *Therapist attitudes*, such as the therapist being intrusive, defensive, withholding or judging; others described their therapist as anxious, unstructured, and unpredictable, or silent, or blaming and shaming[31,32].

[31]The attitude of the erm the therapist who would say things like erm now I am going to do this and then he would outline what he was going to do and so on, so it was he was going to do it, so he was more important than (mm) me. (PFI-16)

[32]So I wanted some quire concrete advice, but she didn't care to ask be about any of those she just sat there in the sessions (right) erm, very much a blank screen and I felt really unsettled by this. (PTeI-17)

Strain: Poor Engagement

Some therapists interpreted patient passivity as a ***Lack of motivation***, which was likely to lead to a disappointment in therapy[33]. Therapists also discussed therapy appearing derailed or off-track, so that plans considered prior to a session or in supervision were not carried through. Another theme expressed by therapists as a possible marker of a negative therapy experience was when they felt that they were ***Trying too hard***[34] or when they experienced feelings of ***Distress*** or anger[35]. Some therapists said that they knew things were not right when they experienced ***Dreading the session***[36] or ***Pressure to perform***[37].

[33]She appeared to take a passive approach to therapy, with an expectation that attending sessions in itself would lead to change. (TQ-8)

[34]I tried really hard, but I suppose one thing I learnt is that when I try even harder than usual, then it is likely that the client is "snagged" i.e. fears or rejects therapeutic success. (TQ-18)

[35]It brought out conflicting emotions in me. The "service user" part of me felt for him and wanted to stick up for him when others were harsh on him and yet I found him frustrating and the constant reference to his "mental illness" I had to listen to. (TQ-17)

[36]They'd give it to me both barrels when they were in that particular state- I came to dread having contact with that bit and which is bad therapeutically. (TFI-3)

[37]As a trainee CBT therapist I felt under pressure to "perform" and I think this was unhelpful. (TQ-19)

Patients also experienced ***Pressure to perform***[38] and ***Distress***[39]. They sometimes thought that their therapist did not think they tried hard enough and that this was the reason therapy was problematic.

[38]Yes, yes and I felt there was something very wrong with me as well that I wasn't responding as I was supposed to respond as well and that you know and that was about me, there's something wrong with me as well which could have added to feeling low. (PTeI-12)

[39]And finally I said one day, I hate this! You're just sitting there and you are not offering me any kind of help. (PTeI-22)

Therapists noted the difficulties described above further reduced patient ***Engagement*** and ***Trust***. Some commented on the lack of time to develop a good working relationship, particularly with clients who had previous relationship experiences of rejection[40]. Patients' comments on the relationship also focused on ***Trust*** issues[41]. Some patients and therapists noted that issues of confidentiality resulted in lack of trust.

[40]From the beginning it was understandably difficult for this client to form a relationship with me as she feared further rejection. (TQ-24)

[41]In fairness there was very little trust between me and the psychologist and I don't think they really stressed the confidential nature of what they were doing; by this time I was quite paranoid and you know I was petrified. (PFI-28)

Consequences

Patient and therapist themes describing the effect of a negative therapy experience were often similar. Patients described ***Feelings of failure***[42] ***, Loss of hope***[43], and ***Loss of coping skills***[44].

[42]She'd bring me books, big books in that said "Working with people with low self esteem" and I just used to think well that makes me feel crap, you know, that you think I've got low self esteem. (PQ-29)

[43]So you are left there thinking you are beyond help, do you know what I mean? You're left there thinking that this is the best that there is to offer and they are saying they can't do anything, you're beyond help, you're absolutely knackered. (PFI-30)

[44]Looking good was actually quite a profoundly important thing to me and to mock it, you know … ., and for someone to start, you know, challenging something which was actually a very kind of important psychological defense erm you know they took away-, you know the whole experienced, sort of you know, [pause] instead of giving me coping strategies it took them all away, yeah. (PFI-26)

In a similar way, therapists described a ***Loss of hope***[45] ***, loss of confidence***[46] ***, Regret***[47] and ***Feelings of failure***[48] . For some patients and therapists it was only on reflection and after a period of time or a different therapy experience that they were able to recognise the impact of the particular therapy they were commenting on.

[45]I feel a little hopeless about her, through the process of seeing her especially because I wasn't very long qualified when I worked with her. … And that's something to do with why I saw her for such a long time as well when there was no progress. (TTeI-22)

[46]The fact I've chosen him, you know it stayed in my mind you know erm as somebody who, I then felt hadn't made much progress with … it has made me kind of less confident. (TFI-24)

[47]I suppose if you spent all that time with someone and they're no further forward it is going to feel a bit like if not a deterioration you're going to wonder what was the point of all that. (TTeI-23)

[48]My supervisor was supportive and acknowledging the difficulties and that's, that's kind of how I coped with it. So it was upsetting and you can think this is a very complex client, but it was a bit like I'm failing. (TFI-21)

Discussion

In this study, it was rare for patients or therapists to describe a single contributory factor that led to a negative experience. Most patients and therapists indicated they had intended to make the best use of the therapeutic encounter, but became stuck in a negative interactional pattern from which change became impossible. Patients' journeys often began with their experiences not matching expectations; sometimes this started before they met with their therapist when the service provided little or no information or choice about what the service offered. The importance of organizational factors in the therapy experience has been identified in studies looking at initial attendance at outpatient clinics (Frankel, Farrow, & West, 1989) and dropping out of therapy (Werbart, Andersson, et al., 2014), but not when considering negative experiences. Service structures, policies and constraints are likely to shape therapy provision and this study highlights the negative impact these contextual factors can have.

If the lack of clarity about therapy continued, such as no clear assessment, agreed plan or focus, or clarity about sessions and progress, patients often found it hard to engage. Disclosure became problematic, particularly if they did not experience genuine concern or understanding by the therapist. Patients experienced sessions as unsafe, and at the extreme, either as uncontained or controlled, leading to a poor relationship with the therapist. The importance of maintaining a good therapeutic relationship is recognised by all therapy approaches. Participants in this study highlighted the consequences of not attending to relationship problems, as discussed by Bugatti and Boswell (2016), and of the incremental nature of risk factors potentially leading to negative experiences.

Therapists, when reflecting about the case they chose to describe, were aware that they had not managed patients' expectations well and that service demands sometimes took precedence over patient need. They described often not managing to provide or keep to a structure within and across sessions. They recognised that their own negative feelings and reactions were possible markers of difficulties and contributed to the continued lack of progress. Such negative feelings can also be understood as countertransference reactions and, as reported in their meta-analyses, poor management of countertransference is associated with poorer treatment outcomes (Hayes, Gelso, & Hummel, 2011).

Both therapists and patients indicated that they did not discuss their concerns with the other person, making resolution of any interpersonal problems almost impossible to achieve. It also meant that both therapists and patients were left with feelings of failure, regret and loss of hope. This replicates the findings by Moritz et al. (2015) who found that approximately 20% of patients and therapists who took part in an on-line study of wanted and unwanted effects of psychotherapy for obsessive-compulsive problems reported a loss of hope and the emergence of new symptoms.

Therapists discussed the complex nature of some of their work, and sometimes not being sufficiently experienced or skilled to manage the patients who came to the service, but knowing that there was no other service or therapist available. On reflection, therapist would talk about the service structure or culture that made it hard to discuss "failures" or to ignore service constraints. Lambert and colleagues have reported the positive value of providing feedback to therapists when a patient is at risk of treatment failure (Whipple et al., 2003). Although Whipple et al. (2003) did not focus directly on negative patient experiences, but treatment failures, this study provides an example of an intervention at service level.

The therapists in the current study rarely used supervision to discuss this sense of failure or lack of progress, sometimes because of time constraints or supervisor availability, nor did therapists talk in the interviews about the importance of, or difficulty using, some important core therapy skills, such as empathy and genuineness. Yet this was what patients wanted in order to feel respected and validated. In none of the transcripts was there mention of the opportunity for patients to feed back their experiences. Whipple et al. (2003) have reported the positive value of a service system for providing feedback to therapists when a patient is at risk of treatment failure. Werbart et al. (2014) also discussed the importance of complex, service-led interventions to reduce negative experiences. Other qualitative studies of patients' experiences of therapy often include themes of the importance of availability, continuity and consistency of services (Bee, Lovell, Lidbetter, Easton, & Gask, 2010; Chouliara et al., 2011).

The model developed from these findings incorporates events at service, patient and therapist levels. Individual factors in themselves are unlikely to produce a negative experience, but are additive, with risk increasing as more factors come in to play. Such complex interactions require large studies to more fully understand the nature of possible routes leading to negative therapy experiences and to the development of complex, service-led interventions to reduce such experiences.

This is an exploratory study, using service user and therapist experiences to shape our understanding of what has been called the "elephant on the couch" (Berk & Parker, 2009). A call for better recording and routine monitoring of adverse effects and negative patient experiences and for research on investigating the causes and mechanisms of these has been made recently (Crawford et al., 2016). This study provides a step to more systematically testing possible mechanisms that lead to negative therapy experiences and to considering interventions that services could adopt.

Strengths and Limitations

Limitations of the study include the unselected sample, and that although many relevant organisations and groups were contacted, we do not know how representative the sample was of patients and therapists who had negative experiences of therapy. The method of recruitment also meant the sample was heterogeneous with regard to patient diagnosis, service type and context. Although the sample included both patient and therapists, patient–therapist dyads were not targeted, so no comparison of views of the same therapy was possible.

Participants were asked to describe a therapy that had happened in the past, sometimes they reported events that had happened a number of years previously, and time and reflection will have

changed their reporting of events. We also were not able to verify the findings of this study with the respondents.

However, the samples included people from a range of therapy orientations and services and demographic characteristics, which aids the generalizability of the findings. Further strengths of the research were that the research team came from diverse backgrounds including experts by experience and themes were developed through working individually, then in pairs and finally as a team. This is also the first study that attempts to build a broader model of factors that are linked to negative experiences based on patients' and therapists' descriptions of such experiences.

A final limitation relates to the robustness of the causal links between lack of fit leading to fault lines, leading to strain and finally, consequences. Whilst the proposed causal chain fitted the data and was re-examined in the transcripts and illustrated in the case examples, it remains possible that to some extent these factors could be operating independently.

Implications

The model developed in this study indicates that negative experiences happen as a result of a complex set of factors that will require a number of interventions at different levels to reduce possible harmful impacts of therapy. As with Crawford et al. (2016) these findings show the importance of providing patients with clear information, choice and involvement in decision-making. In addition, supportive service structures, a genuine assessment, explicit contracting at the beginning of therapy and clarity about sessions and progress are important in managing patient expectations throughout.

Therapists should ensure that they exercise and continue to practise core therapy skills in support of providing a safe environment where patients are respected. Opportunities for patient feedback should be the norm, where the therapist and service are vigilant for signs of deterioration (either in mental health or therapeutic alliance) and solutions considered. Such work would provide a basis for future research that prospectively investigates aspects of the model, through trialling interventions with the aim to reduce negative patient experiences.

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