

THE THERAPIST EXPERIENCE OF CLIENT NON-RESPONSE

Sophie Anne Rosemary Hopper

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The candidate confirms that the work submitted is her own and that appropriate credit has been given where reference has been made to the work of others

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ABSTRACT

Introduction: This study aimed to explore the therapist subjective experience of client non-response, how they made sense of their experience and how they managed the experience.

Method: A total of seven therapists were recruited and interviewed using a semi-structured interview format, designed for the purposes of the study. The resulting transcribed interviews were analysed using interpretative-phenomenological analysis.

Results: Fifteen super-ordinate themes were found and organised across four discrete, but interacting stages; *'starting out'*, *'when therapy fails to progress'*, *'trying to end'* and *'it's over'*. The over-arching theme of *'the destruction of hope'* encompasses the experiential and time-ordered themes. The therapist experience was marked by challenging feelings of anxiety, helplessness, inadequacy, anger and guilt. Feelings of loss were also apparent, specifically regarding the omnipotence of therapy and the therapist's identity as a healer.

Discussion: The novel findings are discussed in the context of the extant evidence concerned with the therapist experience of non-response, the distinct contribution made by the current findings and the identified methodological limitations of the research approach.

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CHAPTER ONE: INTRODUCTION

The current study is interested in exploring the therapist experience of client non-response. In order to set the scene, there are a number of relevant issues to consider. Firstly, I will begin by offering a definition of psychotherapy and discuss its current position as an effective intervention. I will then discuss the multiple definitions of change in therapy, the complexities around how change is measured and by whom. I will then introduce the topic of therapy failure, and focus specifically on the topic under investigation; client non-response. I will then reiterate some of the definitional and methodological issues that remain pertinent when assessing an outcome of non-response. Finally, I will discuss the significance of exploring the therapist experience, focusing specifically on professional identity and wellbeing.

Psychotherapy

Traditionally, psychotherapy is viewed as remedial; an intervention that intends to remove or ameliorate significant levels of distress (Duncan, Miller, Wampold & Hubble, 2010). Wampold (2001) defines psychotherapy in the following way and distinguishes psychotherapy from other types of helping relationships:

'Psychotherapy is a primarily interpersonal treatment that is based on psychological principles and involves a trained therapist and a client who has a mental disorder, problem, or complaint; it is intended by the therapist to be remedial for the client's disorder, problem, or complaint; and it is adapted or individualized for the particular client and his or her disorder, problem, or complaint'. (Wampold, 2001, p.3)

There is now a wealth of efficacy and effectiveness evidence demonstrating that the majority of therapy recipients experience change (Lambert, 2010). Such findings suggest that psychotherapy is more effective than many evidence based medical practices (Wampold, 2007).

Multiple definitions of change

Amidst the evidence stating that therapy is a beneficial intervention are some crucial methodological issues that are necessary to address. Firstly, the complex issue of defining change in therapy is discussed. Client change has been an important, yet elusive, concept since the origins of therapy outcome research. In general terms, change refers to an improvement that has occurred during therapy; however, a shared operational definition is missing. Trans-theoretical understandings of change are available (e.g. the corrective experience model by Castonguay and Hill, 2012) and

considered by many to provide a more fundamental understanding of change. Despite this, it is more common for therapists and researchers to define change based on their theoretical orientation.

The main theoretical influences on contemporary individual therapy practice are the psychodynamic approach, the humanistic approach, and the cognitive-behavioural approach. Gold and Stricker (2011) state that psychodynamic therapists tend to evaluate their interventions using concepts such as ‘character change’ (a reduction in the unhelpful patterns of responding) and ‘insight’ (an increased understanding of one’s psychological experience). Alternatively, the humanistic model of therapy views the therapeutic relationship as potentially curative, in that it provides the client with a new and emotionally validating experience. Within this secure and validating relationship, the client is able to explore aspects of themselves that cause distress and subsequently develop a greater understanding of themselves (Watson, 2011). The cognitive behavioral model of therapy emphasises the role that thinking plays in a client’s etiology. Therefore, the interventions seek to reduce distress and enhance adaptive coping strategies by changing unhelpful beliefs and providing new strategies for processing information (Lambert, 2013). As a result, there is a variety of model specific terms such as ‘symptom reduction’ and ‘personality modification’ used within the literature to describe the changes that take place in therapy (Roussos, 2013).

Measuring change

There are two issues with model specific definitions of change. Firstly, there are fundamental differences between each model of therapy that create problems regarding consistency within the outcomes research. Consequently, the evidence demonstrating the benefits of therapy is based on a large number of studies that are defining change and therapy outcomes differently. Secondly, the definition of change is often limited by the theoretical framework in which it exists (Roussos, 2013). Using narrow and strict definitions of change can neglect other important aspects of change that are meaningful to the client, although not necessarily to the model.

The definitional problems are further complicated by the validity and reliability issues surrounding the measurement of change. Even if there is a consensus about change in therapy, for example ‘character change’, objectively defining and measuring this abstract concept is very complex. Additionally, if clinicians draw on models to define change and success, the measures must also be model-specific.

Attempts to develop these measures seem to result in a number of measures that other clinicians do not want to use, and which are not evaluated well. A number of researchers have explored the outcomes studies over the years in order to highlight the many measures used to assess change. One such example is a review by Froyd, Lambert, and Froyd (1996) which examined 348 studies published in 20 journals between 1983 and 1989 and found a total of 1,430 different outcome measures. Researchers often address the definitional issues around client change by using multiple definitions and multiple measures. In fact, most contemporary studies tend to include more than one outcome measure in order to obtain a multi-dimensional view of outcome (Lambert, 2013).

In addition to the large number of outcome measures, there are also challenges regarding the selection of the type of measure most appropriate for assessing change. For example, it is well known that individuals seek out psychotherapy for a variety of reasons; for some, symptom reduction may be unrealistic or simply not a priority. For these clients commonly used measures such as the Clinical Outcomes in Routine Evaluation (CORE; Evans et al., 2000) to assess multiple symptoms, or mono-trait tools to measure a single trait such as the Beck Depression Inventory (BDI; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961) are less suitable. Although psychometrically sound, these measures have been described as arbitrary metrics (Blanton & Jaccard, 2006) that may not translate into a client's real world functioning (Kazdin, 2001). In addition, these measures may fail to capture certain therapy goals. For example, change that is meaningful to the client may be operationalised as becoming more accepting and able to cope with a particular difficulty, rather than a reduction in symptoms, which in many cases is unrealistic and unachievable.

No one definition of therapy change or outcome is superlative, although there are perspectives, definitions, and measures (e.g. BDI and CORE) that tend to be more commonly used in clinical practice and preferred within the research literature. The increasing use of these measures provides an opportunity to aggregate and compare across studies, therefore assisting in the development and validation of therapy. However, Wampold (2001) claims that the routine application of these measures, along with other factors, is shaping therapy (an interpersonal endeavor) into an intervention that resembles a medical treatment. For example, locating the problem within the individual, quantifying their distress for diagnosis, evaluating the intervention using symptom-based measures and using medical evaluation methods to form the basis of

our evidence. Each of these factors significantly influences the delivery of therapy and the ways in which outcomes are measured and defined. Wampold argues that client change should incorporate a range of factors, not just symptom relief. For example, a good client outcome may be an increased acceptance and/or ability to cope with a particular difficulty. A symptom-based outcome measure would fail to capture the success of an intervention that manages to achieve this goal.

Additional concerns are highlighted by Hill and Lambert (2004) who suggest that quantitative methods of measuring change can marginalise the client's voice and prevent us from correctly understanding change and what it means to the individual client. Instead, they recommend the use of qualitative outcome measures that capture the client's voice and asks them to define change and whether the outcomes are meaningful. Idiographic measures offer useful ways of tailoring the intervention to each individual client and their therapy goals (Sales & Alves, 2012). Unfortunately, the status of these client centered measures continues to be questioned and many believe that the effective individualisation of client goals remains an ideal, rather than a reality (Hill and Lambert, 2004). Ogles (2013) appears to acknowledge both sides of the argument and highlights the need for clinicians and researchers to find reliable and consistent ways of incorporating both qualitative and quantitative methods.

Different perspectives of change

Without a clear definition of change, when therapists, researchers and clients talk about change, it is easy to assume that they are all talking about the same concept, but actually our understandings can vary (Roussos, 2013). Strupp and Hadley (1977) postulate that the outcome of a therapy is very much dependent on who you ask. They suggest that the client, the therapist, and society in general often hold very different opinions about what represents a desirable outcome. According to the authors, society tends to view psychological wellbeing in terms of predictability and conformity to social norms. This view differs to that of the individual client, who is more likely to refer to a subjective sense of wellbeing (e.g. feelings of happiness and contentment). Alternatively, the therapist may be guided by their preferred model of therapy. As a result, it seems reasonable to suggest that when adequately assessing a therapy outcome, services must consider each perspective. Strupp and Hadley (1977) offer the Tripartite model as a method for gathering information from those considered to hold a vested interest in the outcome of the therapy. The premise of the model is that each perspective is valid and

important, therefore a shared satisfaction amongst the client, the therapist and society represents the best-rounded evidence of a successful outcome (Kazdin, 1999).

Another pertinent issue is that therapy outcomes can change over time. For example, the effects of therapy may take some time to emerge following the end of the therapy and consequently will not be captured by the standard pre and post measures typically implemented by most services. (Werbart, Below, Brun & Gunnarsdottir, 2015).

Consequently, questions remain about who decides whether or not a therapy has been effective, and the timing of this decision.

The amount of change

If we assume that an agreed definition of change that is meaningful to all those with a vested interest in the outcome has been used, along with an outcome measure that was able to capture change in relation to the aims of the therapy, then a question still remains about how much improvement is enough to signify a successful outcome (Green & Latchford, 2012). According to Jacobson and Truax (1991) it is possible to say whether the change captured by an outcome measure is reliable (not due to chance) using the Reliable Change Index (RCI). Reliable change is calculated by dividing the difference between the pre and post treatment scores (how much change has occurred) by the standard error of the difference between the two scores (how much the measure varies due to chance). Once reliable change is identified, the question of whether the change represents an improvement in the 'real world' of the client remains. Jacobson and colleagues offer guidance based on outcome scores and the distribution of these scores in relation to the populations of people who fall within the normal and the clinical ranges. They suggest that clinically significant scores determine whether the treatment effect has a genuine and noticeable effect on the individual. According to the authors, clinical significance demonstrates an amount of change that indicates a move from the dysfunctional range into the normal functioning range. From a societal and clinical perspective this is certainly a satisfactory outcome (Kazdin, 2001). Yet, how meaningful such changes are to the individual client is less clear. It is important to remember that the value of clinically significant change lies in the ability of the outcome measures to capture change in relation to the aims of the therapy. Therefore, it is crucial that services and clinicians use appropriate measures that are capable of capturing change that is meaningful to the client (Kazdin, 2001).

These discussions are particularly relevant within a profession that is moving towards the formal monitoring of client progress via the routine collection of symptom-based outcome measures (Lambert, 2013). Within this context, the success of an intervention is often defined by the amount of change captured by outcome measures, which may or may not be relevant to the client, the therapist or the aims of the intervention.

Expectations of therapy

Our evidence base is largely influenced by efficacy studies that unsurprisingly make the strongest claims regarding the benefits of therapy. The difference between efficacy studies and actual clinical practice is acknowledged by Ward (2013), who recommends that therapists interpret outcome data with a degree of caution. For example, there is a clear disparity between the evidence based claim suggesting that approximately two thirds of clients improve with therapy (Lambert, 2013), compared with recent practice based outcome figures showing IAPT improvement rates of fifty per cent (Layard & Clarke, 2014).

The goals of therapy vary across clients and may include the reduction of problematic symptoms, improving relationships with others, becoming more effective at work, or to resolving other problematic life experiences (e.g. bereavement). Although these goals are all different, the expectations of the client consistently involves a strong feeling of hope that therapy will help them achieve their goal. There are times when the client goals are unrealistic and it is the role of the therapist to skillfully help the client identify alternative and more achievable goals.

Expectations regarding the benefits of therapy are significant to the current study for the following reason. Success-focused research and questionably high claims regarding client outcomes may significantly impact the therapist experience of client non-response. For example, the therapist may enter therapy with unrealistically high expectations of success, struggle to set realistic goals, and make unhelpful comparisons between their own therapy outcomes and those suggested by the literature.

Factors associated with change

The process research has highlighted two possible areas concerned with change in therapy: techniques and the relationship. Although the literature suggests the importance of both, often the debate has resulted in a more adversarial stance between the techniques and the relationship (Goldfried, 2013).

Within each model of therapy are different techniques (e.g. transference interpretations and thought challenging) that are used to create change. In addition, the therapeutic relationship is used in a variety of ways. For example, the psychoanalytic approach claims that the relationship acts as a vehicle for unconscious repetition of previous attachments. In contrast, the humanistic approach suggests that an effective relationship provides the client with a new and emotionally validating experience (Lambert & Ogles, 2004). The differences between the therapies are referred to as the specific principles of change. It is also useful to think about the more general principles of change. Goldfried describes the general principles of change as “occurring at a level of abstraction between the more specific techniques that are used during the session, and the more general theoretical conceptualisations of why such techniques may be important” (p.867). He concludes that between these two levels, one may find the general principles of change that encompass each different theoretical orientations and their associated techniques. These principles are referred to as the common principles of change and can include:

1. The shared belief that therapy can be helpful.
2. An effective therapeutic relationship.
3. Helping the client become aware of the factors (within themselves, others, environment) that contribute to their problems.
4. The facilitation of corrective experiences.
5. The encouragement of continued reality testing.

The common principles of change are trans-theoretical and may be used by any model of therapy, and may be implemented with a variety of therapeutic techniques.

When therapy fails

The issue of therapy failure is part of a broader issue of change and how therapy outcomes are defined, therefore, the issues around definition, measurement, timing, different perspectives, and expectations of therapy remain pertinent. Consequently, a lack of change in therapy is very challenging to define and measure (Lambert, 2013). As noted earlier, change in therapy has multiple definitions and the same can be said for therapy failure. Therapy can fail in a number of ways and consequently there are a range of therapy outcomes that seem to fall under the general rubric of therapy failure. These include client dropout, premature termination, partial change, slow change, deterioration, relapse following a successful treatment, and non-response (Lambert, 2011). Each of these outcomes represents a different phenomenon and therefore yields a variety of different experiences and implications. Compounding the issues around definition are other elements that must be taken into consideration when assessing a negative outcome of therapy. For example, often clients begin therapy on a downward trajectory that is very difficult to stop. Some clients are significantly impacted by difficult life events (e.g. bereavement or unemployment) during the course of the therapy. There may also be a proportion of suicidal clients who are prevented from taking their own lives, despite not showing overall progress. This may be seen as a sign of success, albeit one that is difficult to assess.

It is estimated that a third of clients do not improve with therapy (Lambert, 2013) and approximately 5-10 per cent of clients get worse after therapy (Lambert & Ogles, 2004). The current study focuses specifically on a subset of therapy failure; client non-response. Lambert refers to non-response as those occasions where the client has “more or less been untouched by the treatment” (p.414). Similarly, Linden (2013) defines non-response as “a lack of improvement in spite of treatment” (p.288). Estimates of those clients who report non-response vary from as low as 14% (Lorentzen, Hogland, Martinsen and Ringdal, 2011) to as high as 60% (Hansen, Lambert, & Forman, 2002). The discrepancy between the figures can be understood, in part, by the ambiguity of defining and measuring change (or lack of) in therapy.

The complexity of the therapeutic process makes studying client non-response very challenging. Commonly used outcome measures tend to be designed for capturing the positive effects of therapy, rather than the negative effects (Barlow, 2010). Furthermore, these outcome measures capture specific aspects of change and often demonstrate varying outcomes (Mohr, 1995). In addition to the issues around

measurement, Timulak (2010) highlights the difficulties of teasing apart those less helpful events in therapy that are so often embedded within helpful events. Furthermore, therapy outcomes (successful and unsuccessful) are strongly influenced by theoretical orientation. For example, a psychodynamic therapist may evaluate an intervention in which a great deal of symptom change has occurred as a failure, alternatively, they may decide that an intervention where little symptom change has occurred as a success. To understand this, it is important to recall the primary goals of a psychodynamic intervention; insight and character change (Gold & Stricker, 2011).

Factors associated with client non-response

Most of the outcomes literature has focused heavily on the evidencing of the positive impacts of therapies, rather than exploring the less successful interventions. Consequently, the literature tends to discuss the factors associated with client change, rather than the factors associated with a lack of client change. Although most of the outcome findings are not specifically related to non-responders, one may assume that the findings on successful outcomes are applicable to non-response. In the sense that, if the presence of certain factors (e.g. belief in the rationale of the therapy) promote change, then the absence of these same factors (e.g. a lack of belief in the rationale of the therapy) is likely to prevent change from occurring.

A research interest in client non-response is starting to emerge, however, as yet the available literature remains somewhat limited. The following section gives an overview of some of the factors that have been found to be associated with therapy failure. The *Journal of Clinical Psychology: Special Issue* explored a number of case studies where clients failed to respond during therapy (Lampropoulos, 2011). The case studies offer a useful, yet subjective view of the client's experience from the therapist perspective. The main findings are clustered under the following headings: client factors, and therapist-relationship factors. This is not an exhaustive list of factors associated with client non-response.

Client factors

Ravitz, McBride & Maunder (2011) related the following client characteristics to poor IPT treatment response: personality traits, attachment difficulties, self-definition versus related with others, history of trauma, and autonomous motivation. From a psychodynamic point of view, Gold and Stricker (2011) implicated the following client

characteristics with therapy failure: severity and chronicity of psychopathology, personality disorders, problems with impulse control, a lack of psychological mindedness, a tendency to attribute problems externally, and a high need for direction and structure within therapy. Within humanistic therapy, Watson (2011) associated therapy failure with client affect regulation difficulties, poor narratives, impaired agency, high levels of shame, negative attitudes towards therapy, and a lack of social support. In cognitive behavioural therapy, patient acceptance of the therapy rationale and compliance with homework assignments (Addis & Jacobson, 2000), hopelessness at the start of the intervention, and negativity about controlling symptoms have all been associated poorer outcomes (Westra, Dozois, & Boardman, 2002). Despite the different models, these examples suggest some commonalities when therapists discuss the client factors associated with non-response.

Therapist/relationship factors

According to Ravitz and colleagues, there are a number of therapist factors that are associated with therapy failure in IPT. These include, adherence, misdiagnosis, inaccurate formulation, flexibility, attunement and empathic responsiveness. Watson (2011) highlighted the therapist's empathic attunement and their skills in establishing good therapeutic relationships. An inability to remain flexible and modify treatments that are not progressing was also implicated, along with heightened levels of anxiety and self-doubt. Gold and Stricker (2011) suggested that overt displays of boredom, irritation, a lack of empathy, and rudeness can undermine the clients expectation that the therapist is interested, caring, competent, and concerned about them. According to the authors, these experiences are likely to cause the client to feel rejected and less able to benefit from the therapy.

Difficulties in the therapeutic relationship seem to be a central, if not the primary source, of therapy failures. Research has consistently shown that the early establishment of an effective therapeutic relationship is highly predictive of a successful therapy outcome (Horvath et al., 2011; Safran & Muran, 2000). For clients with histories of early loss, interpersonal trauma or insecure attachment styles, establishing effective therapeutic relationships can be difficult (Bordon, 1994). According to Gold and Stricker, the therapist's inability to monitor, manage and resolve ruptures is closely related to therapy failure. Recognising and resolving enactments is also important, along with an ability to respond non-defensively to the client's anger and hostility.

Even with the apparent theoretical differences, many of the findings are concordant with the preceding research-orientated therapy outcome findings, suggesting that the factors associated with therapy failure are trans-theoretical and concordant with the factors associated with improvement.

Identifying client non-response

Lambert (2007) asserts that to reduce negative effects in therapy, therapists must first be able to identify them. Researchers have suggested that the therapist's ability to recognise those clients who are at risk of non-response continues to be an area of concern. In the absence of a more meaningful way of identifying client progress, it is common for therapists to rely solely on their clinical intuition (Hannan, 2005) and preliminary research findings indicate that clinicians have limited abilities in predicting deterioration in clients and often overestimate the success of an intervention. Hannan conducted a study to highlight the potential difficulties of making such judgements. The clinical judgement of 48 therapists was measured against an algorithm so a comparison could be made regarding their abilities to correctly predict client deterioration. Despite an awareness amongst clinicians that approximately eight per cent of clients are worse off by the end of psychotherapy, clinicians optimistically predicted that only three out of 550 clients would deteriorate. In fact, 40 of the 550 clients deteriorated and the clinicians correctly identified only one of them. The algorithm used a statistical prediction method based on a database gathered from many previous administrations of the outcome measure used in the study. The algorithm correctly predicted 36 of the 40 clients that went on to deteriorate. However, it was not perfect in predicting outcome and over-estimated deterioration. The findings highlight the challenges faced by therapists who rely solely on clinical judgment when identifying clients who are at risk of deteriorating with psychotherapy. The predictive data, used in collaboration with clinical judgement is more likely to be accurate, although there are sources of variation and error present within both.

Hatfield, McCullough, Frantz, and Krieger (2010) conducted a similar study exploring psychologists' ability to identify client deterioration. In this study they defined client deterioration by the reliable worsening across pre and post scores on the Outcome Questionnaire-45 (OC-45). An awareness of the deterioration is explored by the examination of the psychotherapy notes of 70 clients who had demonstrated a reliable worsening with psychotherapy. The findings revealed that when using clinical

judgment alone, only 21% of clinicians identified and recorded in their notes that the client had deteriorated during psychotherapy. It is important to state that within a context where defensible record keeping and shared records are necessary, the opportunities available to therapists to record their speculative impressions are perhaps limited.

These studies focus on the more severe experience of client deterioration, rather than non-response. As previously stated by Lambert (2011) it is important not to conflate the different phenomena. Client deterioration represents a more severe category of client response, in that the individual experiences a worsening of symptoms. As non-response is a relatively under-researched area, we do not know whether the findings can be generalised to the experience of non-response. However, one may predict that a client who remains 'untouched' by psychotherapy, rather than harmed would be even more difficult for therapists to identify.

The client and therapist perceptions

Efforts to understand the times when clients do not change with therapy are further complicated by the fact that clients and therapists typically offer different explanations for why therapy fails (Piselli, Halgin & Gregory, 2011). Murdock, Edwards and Murdock (2011) used the Attribution Theory as a framework for exploring psychologists' experience of clients who terminate psychotherapy prematurely. Attribution Theory claims that people make explanatory attributions to understand the world around them and to seek reasons for the outcome of a particular event (Heider, 1958). Using questionnaires, the study asked 73 psychologists to list the reasons why clients terminated prematurely from psychotherapy. Half of the sample was asked to reflect on their own clinical cases, while the other half reflected in general terms. Findings revealed that those psychologists asked to report on their own clients were more likely to offer external reasons to explain the premature termination, compared to those who focused on clients in general. Consistent with earlier studies (e.g. Hunsley et al, 1999), the findings demonstrate the tendency for therapists to use protective attributions when making sense of the outcomes of the interventions they provide.

This self-serving bias functions as a protective strategy and describes an individual's tendency to attribute successful outcomes internally, and unsuccessful outcomes externally e.g. the client improved with psychotherapy because I am a good therapist;

the client did not improve with psychotherapy because they did not try hard enough. Self-serving attributions protect the individual's self-esteem or their self-image when the outcome of an experience does not match preconceived expectations (Campbell & Sedikides, 1999). The study by Murdoch and colleagues demonstrates the value of using Attribution theory to make sense of the therapist experience. Further use of Attribution theory in the study of therapists' experience of their own client's non-response to therapy is warranted.

The client experience

Heatherington, Constantino, Friedlander, Angus and Messer (2012) claim that there is an important and encouraging increase in the research exploring the client's perspective of therapy. Such research provides a wealth of important information regarding the client's beliefs and understanding of the therapeutic process and the individual nature of the client experience. Most recently, Radcliffe (2015) explored the subjective experience of eight clients who had completed a course of therapy and felt that they had not improved. An IPA methodology was employed to allow an in depth exploration of participants' experiences. This study highlighted that participants often attributed their difficulties to difficult and traumatic experiences, usually in childhood. These individuals displayed a largely negative sense of self and were conflicted between seeking therapy to help with their problems, and feeling undeserving or unable to be helped. During therapy, their issues felt overwhelming and shameful and as a result, were often not disclosed. This resulted in the needs of clients remaining unmet and, often, their negative beliefs about themselves reinforced. The current study attempts to build on Radcliffe's findings by exploring the other under-researched aspect of non-response, the therapist experience. The study described a challenging client experience that deeply impacted their sense of self and evoked feelings of shame. There is evidence to suggest that the therapist experience of non-response may also be difficult.

The therapist experience

The literature discussing the therapist experience appears to have focused on the more severe and overt categories of therapy failure, such as client suicide (e.g. Knox, Burkard, Jackson, Shaach & Hess, 2006) and consequently there remains a gap in the literature regarding how therapists experience other outcomes of therapy, including client non-response. Studies suggest that the client and the therapist often hold different perspectives regarding the outcome of therapy. These different perspectives suggest

differences in the ways that the intervention was experienced and therefore support the rationale for exploring both viewpoints. Radcliffe (2015) has recently explored the client experience of non-response, however, the therapist experience is unknown. Since therapy is a collaborative endeavor and therefore creates an experience for both the client and the therapist, it is important to capture the therapist experience. The relevant literature points towards two areas of potential importance when exploring the therapist experience of client non-response: Professional identity and wellbeing. It is possible that therapists may experience client non-response as a personal failure and there is evidence to suggest that this is certainly true for clients (Radcliffe, 2015). Professional identity and wellbeing are introduced in the following sections.

Professional Identity

Though rarely discussed in the literature, client non-response may negatively impact the therapist's approach to future clients, professional development and personal wellbeing. According to Friedman and Kaslow (1986) therapists commonly perceive a dominant part of their identity as being a 'healer' and unsuccessful efforts to help others can threaten this concept. When faced with a lack of change the combination of a dominant healer identity, along with implicit expectations for client change may result in a professional identity crisis. Personal characteristics and qualities may be used to explain the outcome, rather than learnt psychological theories and interventions (Watkins, 2012). This may cause the therapist to view the outcome as a personal failure and question whether they have what it takes to help others (Bruss & Kopala, 1993). Therapist's self-esteem is often closely tied to their ability to help others and unsuccessful attempts to help may threaten their sense of self-worth (Ogrodniczuk, Joyce & Piper, 2005). Perhaps the lack of research into the therapist experience of non-response can be attributed to therapists' tendency to be less open when discussing either their difficulties or their negative responses to clinical work (Wolf, Goldfried & Muran 2013). Mash & Hunsely (1993) suggest that the reluctance to discuss ineffective treatment outcome may be rooted in the belief that ineffective treatment is linked to therapist incompetence and inability to help others.

Therapist Wellbeing

According to Maslach (1978) a lack of change in clients or discrepancies between therapeutic expectations and clients' improvement can increase the risks of burnout. Burnout refers to the emotional exhaustion that frequently occurs amongst individuals who work directly with people. Burnt-out individuals lose their energy, positivity and purpose. Although, burnout can happen in many professions, helping professions may be at particular risk. Burnout is a syndrome of emotional exhaustion (feeling emotionally drained), depersonalisation (developing negative attitudes and feeling towards clients), and reduced personal accomplishment (feelings of competence and success in work) (Maslach & Jackson, 1981). Farber (1982) interviewed sixty psychotherapists about their experiences of burnout. Most therapists cited a lack of therapy success as the most stressful aspect of their work. According to Orgodniczuk et al., (2005) the loss of pleasure and satisfaction associated with negative therapy outcomes can leak into the personal lives of therapists. Recurring experiences of negative outcomes that are poorly managed can chip away at the feelings of professional satisfaction and ultimately contribute to burnout (Pekarik, 1985). The majority of therapists interviewed by Farber felt that support systems (e.g. supervision and accessing support from colleagues) were essential for maintaining their psychological wellbeing.

The importance of understanding the therapist experience

The majority of research efforts continue to focus on evidencing the effectiveness of psychotherapy, some attention is currently being paid to deterioration in therapy (e.g. Castonguay et al., 2010; Lilienfeld, 2007), whilst non-response continues to be overlooked. The therapy outcome figures provide compelling evidence for the benefits of therapy, yet, they also suggest that therapy will not always result in client change. Most therapists agree that some people may never benefit from therapy and that not all forms of therapy work for all people. Given the definitional and methodological complexities, non-response is likely to be more common than the literature suggests. The limited studies examining non-response tend to focus on the predictors or the characteristics of non-responders, often using quantitative methods with predefined categories. The research focusing on the client experience of non-response is scant and there is currently nothing about the therapist experience of non-response. In many ways the extent of client non-response can be reduced, however it is unlikely that it can ever be totally eliminated. The experience poses potential threats to the therapist's

professional identity and well-being; suggesting that non-response may create a significant and possibly detrimental experience for the therapist, personally and professionally.

Currently, there is minimal guidance available to therapists who experience non-response as a psychotherapy outcome. An understanding that is grounded in the experiences of therapists provides the foundation for which recommendations around support strategies can be made.

AIMS

This study aims to explore the therapist experience of client non-response by answering the following research questions:

- 1.** How do therapists describe their experience of providing therapy to a client who does not improve?
- 2.** How do therapists understand their experience of providing therapy to a client who does not improve?
- 3.** How do therapists manage their experience of providing therapy to a client who does not improve?

CHAPTER TWO: METHOD

This section presents the rationale for the chosen methodology and provides an explanation for the rejection of alternative methods. It will also outline the research design and procedures, including the study inclusion criteria and data collection methods.

Methodological approach

The limited studies exploring less desirable therapy outcomes have often used indirect data and predetermined categories, therefore, neglecting the real lived experience of both the therapist and the client. Qualitative methods allow an examination of the lived world of the participants, which is essential when trying to capture a detailed understanding of a complex and multi-layered experience (Willig, 2008). Quantitative methods were therefore not considered appropriate for addressing the research questions.

Alternative qualitative methods considered

Grounded Theory (GT) is typically the main alternative method for researchers considering IPA and therefore was considered for this study. GT was originally developed in order to offer qualitative researchers a much needed clear, systemic and sequential guide (Glaser & Strauss, 1967). GT exists in a number of forms and is used frequently across disciplines where it is neither experiential nor psychological, although it can be used in this way. Constructivist grounded theory is considered the most widely used version within psychology. Indeed the constructivist version offers a flexible process and a clear epistemological position, in contrast with other versions. GT researchers often hope to develop a theoretical-level account of a specific phenomenon and this requires larger sample sizes than those typically used in IPA studies.

There are many similarities between IPA and GT, both have a broadly inductivist approach to inquiry and offer an explanatory framework for which to understand the psychosocial phenomena under investigation. Given that IPA requires a smaller sample size, it is likely to offer a more detailed and nuanced account of the lived experience of a small number of individuals, along with an emphasis on the similarities and difference between the participants. By contrast, a GT study of the same experience would likely aim for a more conceptual explanation using a larger sample in which the individual accounts are used to illustrate the theoretical claim. This study aims to capture the

subjective experience of a small number of participants; therefore IPA is considered a more suitable method for answering the research questions.

Discourse Analysis (DA) was also considered as a potential method. DA is concerned with language-in-use and with how individuals accomplish personal, social, and political endeavors through language (Starks, 2007). DA argues that language and words are meaningless; it is through the shared and mutually agreed use of language that meaning is created. Therefore, language both constructs and mediates our understanding of reality. The current study is fundamentally interested in exploring lived experience, rather than how discourses have influenced the experience and how language is used. For these reasons DA was not considered an appropriate methodology for the current study.

Interpretative Phenomenological Analysis

Interpretative Phenomenological Analysis (IPA) provides a methodological framework for gathering and analysing the experiential data. IPA is a qualitative approach that allows the examination of how individuals make sense of significant life events (Smith, Flowers & Larkin, 2009). The phenomenological underpinnings of IPA allow the experience to be explored in its own terms, rather than using predefined categories. IPA researchers are particularly interested in those occasions when the everyday flow of life's experience takes on a particular significance for an individual. Experience is a multifaceted concept, IPA researchers aim to engage with the more 'comprehensive units' of experience; where individuals begin to reflect on the significance of what is occurring. IPA falls somewhere on the positivist/relativist continuum and assumes that the personal significance and understanding of an experience often reveal underlying psychological constructs (Smith, Flowers & Larkin, 2009).

During IPA, the researcher is required to take on an active role. Once the story of the participant has been told; the researcher is then required to try and make sense of it. Access to the experience is reliant on the story that is told; therefore the researcher is required to engage with a double hermeneutic process: the act of trying to make sense of the participant making sense of the experience. IPA is idiographic in nature and therefore committed to the detailed examination of the individual's experience.

Smith et al suggest a small and homogenous sample for an effective IPA study. The small sample size allows the researcher to capture in depth the experience of each individual, whilst exploring the similarities and difficulties between each case. The

idiographic approach focuses not only on subjective experiences but also their place within a context, with an appreciation that individuals and thus their experiences are not separate from the world; rather they are experienced in relation to the world. Data is usually collected by semi-structured interviews where an interview schedule loosely guides the process, whilst allowing the participant to tell their story. Analysis is described as an iterative and inductive cycle (Smith, 2007), typically drawing upon the stages outlined in the following table:

Table 1: IPA Analysis Strategy (Adapted from Smith et al., 2009).

IPA Analysis stages
1. The close, line by line analysis of the experiential claims, concerns, and understandings of each participant.
2. Identification of emerging patterns themes within the experiential material, emphasising areas of similarity and difference, commonality and nuance within the single case and then across the participants.
3. Development of a ‘dialogue’ between the coded data and psychological data in order to begin the interpretative account.
4. Development of a structure or framework which illustrates the relationships between the themes.
5. An organisation of the data that demonstrates transparency around the process from start to finish.
6. The use of supervision and collaborative practice to ensure plausibility and coherence of the interpretations.
7. Full narrative, supported by transcript extracted. Presented theme by theme and supported by a table or diagram.
8. Reflection on one’s own perceptions, conceptions and processes.

These stages do not represent a linear route and there is much room for creativity. IPA researchers are encouraged to be innovative in their ways of approaching the process (Smith et al., 2009). As discussed in the literature review, Radcliffe (2015) provides an excellent example of the usefulness of IPA for exploring the client experience of non-response. The richness of those findings provides further evidence for the appropriateness of utilising IPA within the current study.

Critique of IPA

Willig (2009) highlights the role of language as an important limitation regarding IPA research. The phenomenological underpinnings of IPA mean that researchers often work with descriptions of an event or situation indicating that language acts as the vehicle by which participants communicate their experiences. Given that phenomenology is interested in hearing about actual experience, the IPA researcher must assume that language enables participants to adequately capture and communicate the experience. The value of the research therefore relies on the representational validity of language. A key criticism of IPA is the claim that language constructs, rather than describes reality. More specifically, the language used to describe an experience represents a particular version and the same event can be described in many different ways. Therefore, critics of IPA research suggest that studies analyse the ways in which individuals talk about their experiences, rather than the actual experience itself.

IPA acknowledges that any insights gained from the analysis are the product of the researcher's interpretations (Willig, 2008). Therefore, it can be argued that the researchers own stance and conceptions shape the representation of the participant's experience. IPA recognises the necessity of a reflexive attitude and encourages researchers to become aware of and own their perspectives in order to provide readers with the kind of transparency that allows them to draw their own conclusions on the validity of the findings (Smith et al., 2009). However, critics doubt the researcher's ability to disregard prior knowledge and interpret from an open minded perspective (Finlay, 2008). Smith et al, (2009) asserts that IPA interpretations are always presented tentatively and must be firmly rooted in the participant's direct quotes, with the aim of making the process as transparent as possible.

The following guidance is provided by Elliot, Fischer & Rennie (1999) and considered relevant for the current study:

- 1. Owning one's own perspective:** Describes the researcher's assumptions and values relating to the research topic and demonstrating an awareness of how these may influence the interpretation of data and findings.
- 2. Situating the sample:** Refers to the key features of the participants, including any relevant demographic characteristics.
- 3. Grounding in examples:** Refers to the importance of using of examples to support and evidence the way the researcher has analysed the data e.g. direct quotes to support themes.
- 4. Providing credibility checks:** Recommends using a number of processes by which categories, themes and accounts are checked for credibility.

The broad principles acknowledge the importance of exploring the more subtle and intricate features of qualitative research and offer a variety of ways to establish and maintain quality. Such guidance helps to address some of the limitations of IPA and it is suggested that researchers adhere to quality assurance checks (e.g. Yardley, 2008; Elliott, Fischer & Rennie, 1999). These guidelines have built on the existing principles of good practice in qualitative research and provide guidelines especially relevant for qualitative investigations in psychology and social sciences. Smith et al (2009) highlight the fundamentally creative process of IPA and state that as useful as quality guidelines are, they need to be flexibly applied. Both sets of guidelines are applied flexibly within the current study and described in further detail in a later section.

Research Design

As outlined above, this study utilised a qualitative design. IPA was used as the methodological framework for approaching the research and analysing the experiential data.

Sampling and recruitment

Participants were recruited from two large NHS trusts. Ethical approval was required for each separate trust. The Research & Development Departments were contacted separately. In parallel to the ethical approval pathways, the heads of Adult Psychological Therapy Services were contacted in order to both discuss the research proposal and request preliminary approval to recruit psychological therapists from their

services, following full ethical approval. Once ethical clearance was obtained, an initial email containing information about the study and the opt-in procedure was cascaded throughout the department to all clinical psychologists and psychotherapists (Appendix 2). The email provided a telephone number and an email address through which participants could opt-in. The email explained that by opting in the participant consented to be contacted to arrange an interview time and date. Participants were asked to review their completed caseload from the last twelve months and select a client they had finished working with and felt able to speak about in detail.

In total thirteen potential participants responded to the initial email and were screened using the following inclusion/exclusion criteria.

Inclusion

- Qualified psychological therapists and/or clinical psychologists
- Currently employed by the NHS
- Provide 1:1 psychological psychotherapy to adult service users
- Able to discuss in detail a completed non-response case from the last 12 months

Exclusion

- Trainee psychological therapists and/or clinical psychologists.
- Not employed by the NHS.
- Professionals who do not work 1:1 with service users.
- Retired professionals.

One participant was screened out during the initial email contact and five either declined to participate or did not respond to a follow up email. A total of seven participants consented to be part of the study and interviewed at their place of work.

Ethics

Ethical approval was granted from the Leeds Central Research Ethics Committee (Appendix 6) and the study was registered with the relevant NHS Research and Development Departments (Appendix 7 & 9). The ethical issues identified and addressed within these applications included.

Participant distress: Describing experiences of providing psychotherapy to clients who do not improve could cause emotional distress. In preparation for this, I ensured that each participant was aware of this potential risk during informed consent. Participants were advised that they could take a break or withdraw from the study without explanation if necessary. Following the interview, I checked-in with participants regarding their interview experience and the state of their emotional wellbeing.

Disclosure of unethical practice: The information sheet advised participants that the information they provided would be kept strictly confidential, except in the case of a disclosure of gross professional misconduct. At the beginning of each interview participants were reminded of the interviewer's responsibilities with regards to confidentiality and professional conduct (in which case, concerns would be discussed with project supervisors and if necessary the appropriate NHS and professional authorities would be informed).

Confidentiality: When describing specific examples of clients who did not improve with psychotherapy, participants may have disclosed specific details in relation to themselves, their clients and/or colleagues. Confidentiality was maintained using a number of strategies. Firstly, participants were asked to provide a pseudonym in order to maintain anonymity during transcribing and during the write-up. Following each interview, participants had one week to contact the researcher with any concerns regarding the content of interview. All data, including audio recordings, was stored using the password-protected university server and deleted from the recording device once the recording had been transferred. Extracts of the data shared with the research team for analysis and quality checks were anonymous in order to maintain confidentiality. It was possible that issues around confidentiality may have influenced recruitment (e.g. the decision to take part) and in order to control this potential participants were made aware of all anonymity and confidentiality procedures via the information sheet prior to taking part in the study (Appendix 3).

Data Collection

Non-response was defined as an outcome in which the client does not improve or deteriorate; they remain untouched by the intervention. Given the conceptual issues regarding therapy outcome, it was important to clearly define non-response in order to elicit experiences of non-response. Furthermore, we did not wish to impose a specific definition onto the participants or influence the experiences they decided to share.

Therefore, all participants had provided a therapeutic intervention to a client that had ended prior to taking part in the study.

An interview schedule (Appendix 5) was developed in collaboration with the study supervisors. This was then piloted with three individuals known to the researcher; two interviewees were psychologists in clinical training and the third was a qualified colleague with direct experience of providing psychotherapy for a client who did not improve. This data was not included in the final dataset because the interviews focused on gathering feedback on interviewer style, rather than comprehensively capturing the participant experience.

Feedback was gathered following all pilot interviews and minor changes were made to the wording of some of the questions. Although participants had a range of experiences of providing psychotherapy that they felt had not benefitted the client, it was agreed that participants would use one particular case as the focal point of the interview to allow for an in-depth exploration of experience. Other interventions and more general experiences were discussed as part of the narrative and provide a context for the specific clinical case discussed.

Interviews lasted between 45 and 78 minutes and were audio-recorded. Immediately after the interview, personal reflections were recorded and referred back to during the analysis stage. A professional transcriber transcribed each interview verbatim. For anonymity, the participant chose a pseudonym and any names (of services, areas, colleagues) used during the interview were removed.

Data Analysis

Individual Analysis

Analysis began on the individual level and followed the processes for analysing data suggested by Smith et al., (2009). Firstly, transcripts were checked for accuracy whilst listening to the original interview audio-recording. Following this, the transcripts were read and re-read in order for the researcher '*to immerse oneself in the original data*' (Smith et al., 2009, p.82). The researcher noted first impressions, reflections and observations on the transcript.

As part of this process, data was divided into the following sections according to content and for ease of differentiating more relevant parts of the data:

- Demographics and job/recruitment information
- Descriptive data (descriptions of what happened)
- Experiential data (participant's experience of what happened)
- Use of language (considered strong, interesting, confusing etc.)
- Opinions (general opinions given)

A comprehensive and detailed set of notes was produced to allow for review and help consistency. The initial comments included a range of descriptive (e.g. key words or phrases used by the participant), linguistic (e.g. use of metaphor, intonation, laughter and repetition) and interpretative (e.g. early attempts at a more conceptual understanding of what matters to the participant) notes. At the end of this phase a detailed and comprehensive set of notes was produced and assigned to the data. General information was drawn out of each interview to create a pen portrait for each participant. The aim of the pen portrait was to allow the reader to embed the participant's experience within the wider context in which it occurred. Information about the participant's professional role and service, their definition of change, how it is captured and achieved is presented.

The next phase of analysis involved the development of emerging themes. The experiential data was then divided up into 'meaning units' (Smith et al., 2009, p.83) and comments were assigned to each unit. There is no guidance on what is considered a meaning unit and the types of comments that should be assigned to it. However, it is suggested that the researcher attempts to reduce both the transcript and the researcher notes into 'discrete chunks of transcript' (Smith et al., 2009, p.91) by breaking up the flow of the interview and re-organising the data. Initial notes were turned into concise statements of what was important. These statements are intended to speak to the psychological essence of the data; capturing the participants lived experience, whilst reflecting an abstract and conceptual understanding (Appendix 11). Individual themes that emerged were gathered in a document so that all emerging concepts could be viewed together, thus allowing overlaps and relationships to be identified (Appendix 10). Each individual analysis was completed before moving onto the next transcript. Smith and colleagues emphasise the importance of treating 'each case on its own terms,

to do justice to its own individuality' (Smith et al 2009, p.100). Therefore, researchers must attempt to set aside the ideas emerging from the analysis of earlier cases, in order to allow new themes to emerge with each case. These processes resulted in both themes and sub-themes that aimed to capture the essence of the individual's experience. This process was then repeated for each participant. The entire individual analyses are not included within this document, although individual themes are summarised in the pen portraits.

Group Analysis

Having coded each transcript in the individual level analysis, I then focused specifically on the sections where the participant spoke specifically about their experience of non-response in order to answer the research questions posed and to provide a group analysis.

The group analysis involved looking for patterns, connections or relationships across the experience of the participants. This involved printing out each coded individual transcript and then looking across them. Following this, an attempt was made to move towards a higher level of theoretical interpretation, under which individual themes may fall. The super-ordinate (all-encompassing) themes intend to capture the essence of the participants' shared experience, whilst individual variability of experience is demonstrated by the sub-ordinate (more specific) themes.

Quality checks in IPA

To ensure the quality and reliability of the findings I referred to the guidelines developed by Yardley (2008) and Elliott, Fischer & Rennie (1999). Credibility checks were conducted in order to decide whether the interpretations were reasonable and grounded by evidence within the data. During supervision, I shared the coded transcripts, reviewed and discussed interpretations, emerging themes, participant pen portraits and a large document of participant quotes supporting the group themes.

Peer supervision was also sought throughout the analysis process and the first attempt at mapping all group themes together was discussed at our Qualitative Research Methods Support Group. The first draft of the results chapter with the full list of themes and extensive number of illustrative quotes for each theme was discussed with my research supervisors.

Situation of Self in Research

Before moving on to present the results of the analysis described above, it is important to restate the significance of the role of the researcher in the interpretation of the data. The researcher can never maintain a neutral stance. Instead there should be a scrutiny of their role in the process of gathering new knowledge in relation to the position they are gathering it from (Mason, 1996). Elliot et al (1999) suggest a transparent and reflexive starting point, therefore I have provided an email that I sent to my thesis supervisors following a reflexive interview during a supervision session where I was asked to do the one thing that I was expecting my future participants to do - reflect on my own experiences of providing an intervention to a client who did not improve (Appendix 1).

Table 2: Use of researcher reflexivity.

Extract from email	Commentary	Current thoughts
<i>'I do have my own experience of working with a client who did not get better and it was a really challenging experience for me'.</i>	This quote emphasised my role as a researcher who is researching an experience that I have myself experienced. It was important that I acknowledged the advantages and disadvantages associated with this position. My own experience will undoubtedly have created assumptions that are likely to shape how I interpret the experiences of others.	On reflection, I think that being open about my own experiences did encourage participants to be more open and honest about their experiences. Participants seemed to appreciate that I shared my own experiences.
<i>'I felt extremely sad, powerless, isolated and disheartened by the profession and my role within it. I even considered leaving the course'.</i>	This quote suggests that my experience deeply impacted me on both a personal and a professional level. Thoughts about leaving the profession imply that I was fearful of further similar experiences and blaming of the profession.	It has been a great privilege hearing about the challenging experiences of other therapists and I have found this process both informative and restorative.

<p><i>‘When you asked me this morning about my experience, it caught me off guard’.</i></p>	<p>My language suggests that the topic is something that I was trying to defend against. The term ‘caught off guard’ suggests that I may have felt more comfortable discussing the topic if I had been more prepared and able to protect myself. The language also implies that I felt my supervisors were attacking me in some way. This experience is likely to impact my interviewing style, particularly recognising my own anxieties.</p>	<p>Developing an understanding of my own experience and the experiences of my participants has increased my confidence and comfort around the topic of non-response.</p>
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Writing up

The names of participants have been changed to ensure anonymity and any identifying details, such as places of work, etc., have been omitted. In the results chapter, where verbatim extracts are used to support the theme the extracts have been edited for readability and minor hesitations (e.g., repeated words, “uh” etc) have been omitted. Each extract has been identified by the participants’ pseudonym. Themes and sub-themes appear in italics within the text of the results.

CHAPTER THREE: RESULTS

The findings from the analysis will be presented in a number of separate sections. Firstly, a table showing participant information is presented. Following this individual pen portraits provide contextual information about each participant and a reflexive paragraph of my own experience of each interview. The group analysis will then be described: a summary of the main themes representative of the group of participants, with the use of supporting extracts from participants, to illustrate the themes connection to participants' lived experiences. The themes will then be presented in a table to demonstrate their prevalence amongst participants. Further analysis using the Drama Triangle is then presented in a table format.

Table 3: Participant characteristics.

Participants	Gender	Years qualified	Orientation	Service
Sol	M	Less than 5	Psychoanalytic/Cognitive analytic	Forensic Psychology Service
Fiona	F	Less than 5	Integrative, CBT, Schema	Specialist Forensic Psychology Service
Wendy	F	5-10	CBT – 3 rd wave	Older People's Psychology and Therapy Service
Barry	M	5-10	Systemic and integrative	Early Intervention Team
Dave	M	More than 10	CBT and Interpersonal therapies	Secondary Care Adult Mental Health Services
Fred	M	More than 10	Behavioural and Cognitive therapies	Secondary Care Adult Mental Health Services
John	M	Less than 5	CBT	Mental Health Access Team

Participants

Four Clinical Psychologists and three psychological therapists were interviewed about their experiences of providing a therapeutic intervention to a client that did not improve. All participants were UK trained and post-qualification experience ranged from 1 to 26 years. All participants were recruited from Adult Psychological Service across two different trusts. Each participant chose their own pseudonym.

Pen portraits

Pen portraits for each participant include a description of the type of work they do, the models they use and the client presentations typically seen, as well as a paragraph outlining their general opinions of and attitudes towards unsuccessful interventions. Whenever quotes from interviews with participants are used to support their pen portrait this will be highlighted in *italics* and quotation marks.

Participant 1: Sol

Sol was the first person to respond to my email invitation to take part in the study. He decided to take part for the following reasons *'I'm really interested in what actually happens in the room and when it actually happens that leads to change and what change is as well, and why we expect people to change'*. Sol felt that these questions were particularly pertinent within forensics, where he is often faced with the dilemma of what commissioners would like psychotherapy to achieve versus what psychotherapy can realistically achieve. Sol explained that the majority of therapeutic interventions are concerned with risk management, specifically reducing the risks of violence. The goal of reducing client distress using psychotherapy is less frequent, mainly because the majority of patients are highly medicated and avoidant. Sol defined therapeutic success as someone moving from a position of denial to a position of acceptance, in terms of their distress and difficulties. *'It's not so much that I hope to solve people's problems in therapy or help them to solve their problems, it's more that I hope people come to believe that consulting others, being with others and asking for support can help in whatever way'*.

Interestingly, Sol explained that his definition of meaningful change has changed since working in forensics. As a trainee, Sol believed that meaningful change occurred when two people talked for long enough in order for an internalisation of the therapist to occur. Once this happens, the patient is then able to draw from the helpful and benign dialogue that they have internalised. Since working in forensics, Sol said *'the abstract*

process of internalisation is much more difficult than I hoped'. The service defines therapeutic success by a reduction in violent acts or harm to self. Sol felt that this definition fit loosely with his views: *'I suppose I believe that if people are able to communicate their distress in different ways they're less likely to have to rely on violence as a way of managing their emotions'*. Therefore, an outcome showing a reduction in harm to self or others may indicate the individuals increased ability to communicate distress in more functional ways. All of the clients that Sol works with have at some point committed at least one violent act. Substance misuse (historical or active) and *'interpersonal trauma, ranging from neglect to abuse'* is present in almost every client history. Sol spoke about the overwhelming resistance to engage with psychological therapy he encounters and attributes this resistance to *'an enormous amount of denial of distress, vulnerability, and highly complex difficulties in the majority of patients'*. Sol added that *'a diagnosis of paranoid schizophrenia is common and most often accompanied by a personality component, whether diagnosed or not. Patients are often highly medicated with anti-psychotic and/or anti-anxiety medication'*.

I instantly liked Sol and experienced him as warm, intelligent and capable. He was interested in the research topic and had clearly thought a great deal about the client he discussed. Sol described himself as someone with a great desire to be helpful and useful. My experience of Sol was consistent with his descriptions of himself and throughout the interview I experienced from him an eagerness to make sense of his experience and be a helpful research participant. Sol's individual themes included disillusionment, paralysing feelings of impotence and satisfying others.

Participant 2: Fiona

Fiona thought that *'failure'* occurs in all professions and wondered *'if it may be more challenging for clinicians who invest a great deal in wanting to help other people'*. She highlighted some of the challenges for measuring change, *'those kinds of formal measures (BDI or BAI) aren't validated for the population I worked with so I wouldn't be looking for change using them'*. Fiona said that her definition of meaningful change varies from client to client and is often dependent on the context of the service. With regards to client complexity, Fiona said the following, *'I think people's needs are often so extreme that you have to work much more with the presentation and what you see as opposed to those sorts of formal measures'*. Fiona said *'there isn't really a typical client presentation'*, although client's presentation is always complex and commonly includes *'mental illness, learning difficulties and personality disorder'*. Fiona said that

client offences vary and range from *'rape, child sex offences, murder, to GBH'*. Despite some common themes, Fiona felt that *'the clients were all very different, and their presentation was usually very different too'*. Fiona spoke in depth about one particular client whom she worked with for twelve months. The work was psycho-educational and aimed to help the client to understand his crime and his illness.

I was fascinated by the specific nature of her work and often found myself deviating from the interview schedule. I appreciated Fiona's candid approach to the interview and I admired her decision to be honest about her motivations and struggles, rather than giving answers that may have presented her in a more positive light. Fiona's major individual themes were ambivalence about the service, feeling judged and avoiding of uncomfortable feelings.

Participant 3: Wendy

Wendy decided to take part in the study because she has *'worked with a number of clients who have not made progress in therapy'* and felt comfortable sharing her experiences. Wendy defines meaningful change in terms of *'wellbeing'* and looks for self-reported evidence that the client is living *'a value-based life'*. The service she works in requests that clinicians use the CORE-34 at least once a month with their clients. In addition, Wendy uses outcome measures specific to Acceptance Commitment Therapy (ACT) and mindfulness e.g. the Valued Living Questionnaire. Wendy said *'I wonder about those clients who report feeling better and my feeling that nothing has really changed for this person or that shortly after discharge they will be back to square one'*. Wendy felt that there were within her clinical work *'twenty per cent of clients that did not improve'*. In her experience the clients that aren't going to do well tend to drop-out, *'I tend to have clients that either drop out very early on at session 1 or 2 or they complete a whole course of therapy and improve'*. Wendy felt comfortable with the idea that twenty per cent of her clients do not improve with therapy and wondered if these clients needed something that she was unable to offer. She said, *'Perhaps someone else can do something differently with them or perhaps they can get it from someone else in their life'*. Wendy also thought that the timing of the intervention is a *'crucial factor'* for deciding the overall effectiveness of therapy. Wendy shared realistic views about the potency of therapy and acknowledged that *'it is not possible to help everybody'*. She felt that the successful experiences of providing therapy balance out those inevitable occasions when people do not improve. Wendy did not think that there was a typical client presentation; sometimes client problems were

quite straightforward e.g. moderate depression or a first episode of panic and could *'easily be seen in primary care'*. Most clients have *'more complex presentations, with longstanding mental health difficulties and co-morbidities'*. Wendy said that clients commonly present with *'issues around bereavement, end of life or ageing'*. When asked why she decided to speak about this client, Wendy said the following;

'She's one of those clients that I felt most despondent about, one of those clients that I felt didn't improve from relatively early on and she was someone I felt difficult to let go of despite the lack of improvement so that's why I chose her'.

The interview with Wendy was one of the shortest interviews that I conducted. During the interview I felt a sense of discomfort, both within myself and from Wendy. I found myself feeling quite uneasy asking the interview questions, as though I was asking Wendy to think about something that she didn't want to think about. After the interview I was quite disappointed at myself for not adapting and finding a way to help Wendy feel comfortable. I also felt quite annoyed at Wendy for 'a less satisfying' interview experience. The main individual themes for Wendy were feeling drawn in, feeling disempowered by the client and feelings of guilt.

Participant 4: Barry

Barry spoke about ideas from critical psychology and positioned himself as *'quite critical of the mental health system in general'*. In particular, he is sceptical about psychology *'marketing itself as some kind of solution to all the world's problems'*. Barry is not completely damning of the profession and thinks that psychological interventions can be useful in some ways. However, he believes that *'empathy, understanding and compassion are the main ingredients for helping people and it doesn't necessarily take a professional to provide such things'*. Barry believes that psychological distress is caused by *'social factors such as political influences, poverty, unemployment, racism and so on'*. Such systemic understandings have contributed to his idea that client distress is *'often far beyond the remit of what any therapist can achieve working with an individual, a family system or even a social system'*.

Barry provides therapeutic interventions to people who are presenting for the first time with experiences like *'voice hearing, paranoia, seeing distressing visions'*. He defines meaningful change in the following way.

'It's some kind of a subjective feeling of wellbeing; increased moments of happiness, improved relationships, connecting more with others, the ability to make choices of

when to trust and when not to, rather than a more global view that people cannot be trusted. An understanding of why people feel the way that they do, even if this does not necessarily result in changes to their situation or experiences.'

Barry measures change using the client's subjective report of social and individual functioning. His social constructionist views mean that he is interested in *'the changing ways that people use language to talk about their lives'*. The service defines therapy outcomes using post-intervention employment status, self-harming behaviour and the client's discharge destination. More formal measures that capture the amelioration of symptoms are not considered relevant within this service. For example, the service does not attempt to reduce symptoms such as voice hearing but aims to help people find better ways of coping with them.

Barry was surprised to hear the research finding that only a third of clients do not improve with psychotherapy. He expected the figure was actually higher in clinical practice and questioned the validity of the research.

'I guess if you look at a lot of the research it doesn't show long-term outcome, so I think on a very immediate level someone is going to respond to someone who is empathic and understanding and that's probably going to help in some way but whether it has any long term impact I would say it is even less that would improve long-term'.

These views may be influenced by the highly complex clinical population that Barry works with. The typical client presents *'with multiple problems, ongoing social stressors, chaotic backgrounds and often a lot of historical or active drug use'*. Due to service pressures, there *'is a tendency to classify clients based on whether or not they are psychotic and the medical understanding of psychosis often determines whether or not people can access support'*. Barry believes that this clinical population experiences *'difficulties accessing psychology due to their complex presentations and lack of psychological-mindedness'*. Barry strives to work with people *'irrespective of their difficulties and accepts that only some of them are going to be able to respond to the work'*.

When asked why he had decided to discuss this particular client, Barry stated that he tends to remember *'the ones that he had relational difficulties'* and said, *'When someone doesn't improve it's almost a chink in the armour; a bit of a dent to your self-identity or self-image so I think there is that aspect to it'*.

I found Barry very engaging and enjoyed hearing his views. I found his sense making efforts both thoughtful and realistic; he is clearly a very reflective individual who takes seriously the complexities of people's lives and difficulties. The main individual themes arising from Barry's interview were feelings of frustration, acting in uncomfortable ways and disillusionment with the profession.

Participant 5: Dave

Since qualifying Dave has worked at *'the more complex end of client work'* and consequently clients not improving is something he feels *'very familiar with'*. Dave spoke about discussions he has had with colleagues regarding the difficulties of achieving change with certain clients. However, when asked specifically about his own experiences of providing an intervention to a client that does not improve he said *'I've not really thought about it specifically like that'*. Dave said the following about why he agreed to take part in the study *'I thought it sounded like an interesting project, I like to support research. Most studies that I hear about if I think I might have something to offer or I could be a participant, I know what it's like recruiting people it can be a bit soul destroying'*. Dave said the following about defining change in psychotherapy, *'I try to be as client-focused as possible and look at what my clients would define as progress and whether they think it has been achieved'*.

Dave spoke about the difficulties involved in defining change and thinks that it is partly a problem of *'mental health services that are based on the medical model, where the idea of symptom reduction is the goal. Sometimes it might not be about actual reduction in symptoms, it might be making them feel at ease about the symptoms that could be a meaningful shift for someone'*.

Furthermore, Dave felt that symptom-based outcome measures *'can be quite insensitive to shifts'* within the clinical population that he works with. Dave explained that *'they tend to be better with a primary care type client group rather than the more complex'*. Dave can work with clients for up to two years, which he felt *'is quite a long time compared to other services or CMHT type services'*. Although Dave considered two years as quite a *'luxury'*, he also thought it created a dilemma for the therapist, who must decide *'how long do I keep going before I think well actually I'm not getting much change here'*. Dave did not think there was a typical client presentation and said *'the clients I see present with a range of complex psychological difficulties'*. He attributed this to the lack of exclusion criteria within secondary services.

'We tend to get people with psychosis or long-term serious mental illness and we also get the chronic affective disorders like depression, anxiety and often you find personality difficulties, if not disorders. High levels of abuse, childhood abuse whether sexual, physical or emotional neglect and there will often be substance abuse'.

Dave stated that this client's experiences of extreme childhood neglect were some of the worst he had experienced and he certainly felt *'the emotional hit of the story'*. Despite the client's difficulties, Dave thought that this client could *'benefit from psychological therapy and suggested a more interpersonal approach'*.

Dave had forgotten that we had arranged an interview date. However, he had a cancellation and we were able to proceed. Dave had not been able to prepare for the interview in the same way that the other participants had and subsequently he struggled to speak about a specific case or describe his own experience in depth. My interview with Dave felt similar to my interview with Wendy, in the sense that although both had volunteered to take part in the study, I felt that I was asking them to talk about things that they didn't necessarily wish to talk about. Throughout the interview, I experienced a resistance from Dave that made it more difficult to explore and make sense of his experience. Dave's individual themes were emotional fatigue, managing personal and professional boundaries, and feeling drawn in.

Participant 6: Fred

Fred stated that he does not define meaningful change within his therapeutic work, instead *'he helps the client define the changes that will be most meaningful to them'*. He then uses this collaborative definition *'to monitor and frame the success of the therapy'*. Fred acknowledged the importance of *'marrying up the needs of both the therapist and the client when decided on treatment goals, for example ensuring that the desired changes are clear, concrete, achievable and measurable'*. Fred relies on client self-report and occasionally seeks out *'a third party opinion'* e.g. the mother or the partner of a client.

Fred was sceptical regarding the research finding that a third of clients don't improve with therapy and thought that the figure was an *'underestimation'*. He attributed this to the differences between efficacy and effectiveness studies and thought that in his experience *'treatment success rates are more like 50 per cent'*. Fred didn't think there was a typical client presentation, although there are several common themes within secondary care in general. Namely, *'personality disorders (the emotionally unstable*

are most common), a lot of anxiety, depression, psychosis (less common) OCD with co-morbidity, joint diagnosis and risk issues'. Referrals come from the mental health access team, where they typically offer 16 psychotherapy sessions, subsequently the more complex presentations are moved on to secondary care where there are currently no treatment limits. According to Fred, the lack of treatment limits mean that the length of treatment 'varies hugely'. He thought that the shortest piece of work he had completed (not including drop outs) was around twenty-two sessions and the longest was over a hundred sessions. At this point Fred made reference to the topic of my study.

'It's not necessarily that I've got this carefully worked out treatment plan that says it will take 20 sessions of cognitive therapy and then ten session of mindfulness. It doesn't work like that its very much seat of the pants sort of stuff, I'll find myself responding to contingencies and I think that's fine'.

I admired the courage that Fred showed when sharing his struggles about the piece of work. So often we put distance between our own experiences and those of the people we work with. Perhaps this is both helpful and necessary in the sense of boundaries and self-preservation, but when Fred spoke about his own struggles I experienced his vulnerability. The individual themes of Fred's interview were personal vulnerability, fearing criticism and struggling to end.

Participant 7: John

John was the final participant to be interviewed. John's interest in research motivated him to take part on the study and he thought the research topic was interesting.

'I thought oh good it's something different and I thought at the top I thought it looked interesting as well. I want to try and help people get better and I get a bit pissed when people don't. It'd be interesting to find out what more I could do, what I could do different'.

John looks for evidence of client change using both questionnaires and client report. He explained that *'the service commissioners request a battery of questionnaires in order to demonstrate the effectiveness of the service'*. However, John stated that he *'looks beyond the numbers'* and is more interested in hearing from the client what has changed for them.

'I've had tons of sessions with a client and I've managed to get her to iron, for her that was a major success, the scores were rubbish and just as high, she was just as miserable but she was ironing. We both counted this as a success, you know that was the most that we could do and I thought that was brilliant'.

John defines meaningful change depending on what the client wants to achieve. He told me that the treatment goals are always SMART (specific, measurable, achievable, realistic and timely) and client-led. He spoke about the importance of recognising the small successes of an intervention.

"The woman with the iron wanted loads of stuff but I was able to say well maybe let's try and get you to the shop. By the end of the sessions she had managed to do the ironing and I said well you know it's better than you were doing before, better than 3 months ago, let's just take it as a win. Don't take it as a negative that you've failed let's take it as a win and that's what we did". John agreed with the research findings that a third of clients don't get better with psychotherapy and felt that the statistic *'probably reflected his own clinical practice'*. When asked why he had decided to discuss the particular client, he said.

'Because this is the only one I could think of, the easiest but if I'd spent more time thinking I probably would've chosen now, this other client who rings a bell, but this one was better learning; I got more learning out of this one than the other one'.

He described seeing clients with varying combinations of *'both physical and mental health co-morbidities, namely post-traumatic stress disorder, chronic fatigue, fibromyalgia, ME and a range of mental health problems'*. The service treatment limit is 16 sessions, unless the client presents with depression in which case the limit is increased to 20 sessions. John thinks that the treatment limit *'fits well'* and argues that if a lack of change is noted at session eight or nine then it is appropriate to start asking questions.

'We've got to start questioning is the therapy right? Or is it right for the client? Do they want it?.... yeah so 16 is fairly good because if they haven't made some sort of progress then it's either a case of stepping up or discharge, something along those lines'.

John was the final participant to be interviewed. My enthusiasm for the interviewing process had dwindled and I was looking forward to moving on to another stage of the research process. I wondered if my lack of enthusiasm impacted the interview which

lasted only 47 minutes. Throughout my interview with John I found myself reacting strongly to some of his statements and the language he used. I noticed feeling quite protective of the client he discussed and concerned about what sounded like a rather ‘anti-therapeutic’ experience. I wondered if John’s anxiety was perhaps responsible for some of the insensitive language he used to describe his client and her difficulties:

“I was a bit pissed off and frustrated because the amount of effort I put in, I thought right you’re going to get it both barrels, you’re going to get the A grade, I’m going to get this sorted now, come on I can do this, we can do this, I can do this, we can do this”. John’s main individual themes were minimising client difficulties, feelings of frustration and a lack of empathy.

Client complexity

The following table represents the therapist reported client difficulties and evidences the complex and multifaceted difficulties that each client presented with. Difficult early experiences were common, as were dysfunctional family relationships. Relational, psychological and social difficulties characterised the lives of each client. Each client had their own unique goals for therapy and expressed a strong desire to use therapy to make sense of their experiences and improve their quality of life.

Table 4: Therapist reported client difficulties.

Client	Gender	P.H Condition	M.H Condition	Previous unsuccessful therapeutic intervention	Challenging social context	Dysfunctional current relationships	Using Medication	Early abuse
1	M		X	X	X	X	X	X
2	M	X	X	X	X	X	X	
3	F	X	X		X	X	X	
4	M		X	X	X	X		X
5	M		X		X	X		X
6	F	X	X	X	X	X	X	X
7	F		X	X	X	X	X	X

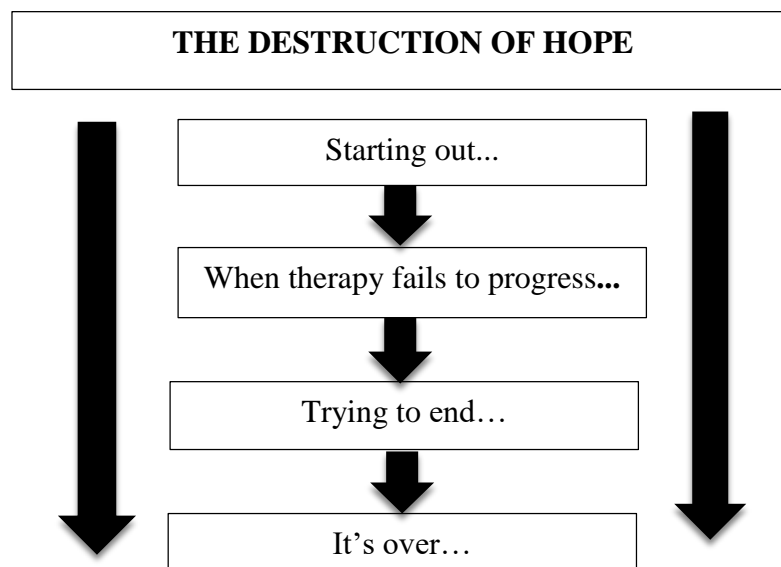
Group Analysis

The first section outlines the direct experience of the participants, and remains closer to the data set. Themes were developed in the order in which participants told their stories and therefore represent a timeline of the therapist experience. Efforts have been made to ensure that the quotes derive across the sample and therefore represent the voices of all participants. Super-ordinate themes are in bold, and sub-themes are in bold *italics*.

Participant experience of client non-response

There is one over-arching theme that incorporates 15 super-ordinate themes and 15 sub-themes. The complete list of themes is presented in a table (see Table 6). The over-arching theme draws together the essential aspects of the therapist journey. Each super-ordinate and sub-theme is presented and illustrated with participant's quotes. Participants themes and sub-themes are organised using four non-experiential labelled stages.

Figure 1: Model showing the over-arching theme and the stages of participant's journey.



Starting out...

Satisfying demands

Aiming to please

In each case, participants described pressures to achieve change with the client they discussed. Some of the participants referred to organisational pressures, along with a felt sense that these organisations were not particularly interested in how realistic achieving change with the client was or what it involved.

'There are service and wider organisational pressures, commissioning pressures to change people, however you go about that. People don't particularly want to know, they just want you to change people'. (Sol)

'In that service particularly there's a lot of pressure on people being seen to improve, whatever that might mean'. (Barry)

'No matter how challenging someone was, you'd work with them and that was the expectation with this client'. (Fiona)

Pressures to achieve change with the client discussed were also experienced from the clinical team in which some of the participants were embedded.

'Being the only psychologist and being the person who has the highest salary etc. there's almost this danger of people putting me on this pedestal, of well you can do this complex piece of work as if everything I touch turns to gold'. (Barry)

'No matter who you are a psychologist, a nurse, a teacher....whatever, there's a certain amount of come on what do you know about working with this person...almost an earn your stripes situation'. (Fiona)

The pressure to achieve change in therapy was also generated by client expectations and/or client feelings of desperation.

'He said that he had no choice [but to do therapy] as he could not continue to live as he had done for the past thirty two years'. (Dave)

'He'd been previously working with an assistant and I think he was just delighted, a little bit narcissistic but delighted to finally have a doctor...as though I could do something more'. (Fiona)

'I felt like she wanted me to wave a magic wand'. (Wendy)

Seeking success

Each participant began the therapy with a strong desire to help the client. Some described internal pressures to succeed in therapy with this particular client.

'I arrived as a newly qualified in October and immediately just started the work with this chap, I thought you know I need to affect some change with people, I need to demonstrate that I can actually do this job'. (Sol)

'I'm personally inclined to be a bit perfectionistic and to want to do well, I have high standards for myself and to want to achieve all the time...this was an opportunity for me to make a success'. (Fiona)

Generating hope

Minimising the client difficulties

For some of the participants there was a sense that the client's complex difficulties were underestimated. One participant described a rushed assessment process.

'I saw her on the Thursday she started treatment on the following Tuesday, so yeah you're starting treatment, you're suitable so let's have ya. It happened very fast, much faster than with others'. (John)

Another participant mentioned the client's willingness to attend therapy as the main criteria for therapy.

'I knew it wouldn't be easy, but I often joked that my basic qualm of whether I put someone through therapy is whether they say they want to do it and they turn up'. (Dave)

Others spoke about underestimating the interpersonal difficulties of the client.

'She'd not had mental health problems before but she'd had an awful lot of complex relationships and difficulties within her life and I'd not really asked enough about that and got an understanding'. (Wendy)

'As someone who acknowledges the real impacts of people's lives, to think that after forty odd years of bad relationships that he's going to develop some sort of wonderful

therapeutic relationship with me and that he's going to improve over the course of the year we worked together was actually unrealistic'. (Barry)

Positive self-belief

Although not explicitly stated in most cases, most participants entered the intervention with a positive sense of self, alongside implicitly held beliefs around expectations of change. Some participants positioned themselves as capable of achieving an outcome that other colleagues either could not or would not attempt.

'I'm willing to give something like this a go. I remember thinking it's an off putting situation for a lot of people and they would just run a mile'. (Fiona)

'I suppose I appreciated that for someone like him, quite paranoid, having worked in rehab and recovery where it might take you a year to engage with somebody, I guess I was willing to work on that and give that time in a way that maybe some of my colleagues wouldn't have done'. (Barry)

One participant was critical of previous therapeutic attempts and presented his intervention as the solution to the client difficulties.

'I was saying well you've had loads of the wrong therapy and this is the first time you will have the right therapy'. (John)

Two of the participants spoke about aspects of their professional environments that are encouraging of a sense of grandiose; causing them to feel the need to prove themselves.

*'In the service there's almost a sort of specialness and almost entitlement around the service, even the professionals feel quite special about being involved in the service'.
(Fiona)*

'Within the team I'm the one with the biggest salary and revered in some ways or referred to as the psychologist that does their magical thing'. (Barry)

Anxiety

Size of the task

Some of the participants recalled feeling anxious about the client's difficulties and the challenge of providing a useful therapy.

'I had feelings of well what am I going to do with her?' (Wendy)

'I certainly had a sense that he would be very difficult to make significant progress with, I think partly aside from everything the length of time he'd been suffering with these difficulties you know for thirty two years and the severity of the emotional neglect.

I suppose my experience told me that it wasn't going to be easy'. (Dave)

'I felt anxiety about the size of the task'. (Fiona)

'I remember thinking that I'd bitten more off than I can chew'. (Fred)

'We kind of identified right at the beginning that forming an attachment with me, a therapeutic attachment, would be very difficult for him, very frightening and a struggle for him'. (Dave)

About the relationship

Some of the participants recalled feeling anxious about their relationship with the client. One participant described experiences of conflict.

'One of the eruptions that we had was relatively early on, I had this overwhelming sense of something there and I put it towards him about his behaviour and he took it as that I didn't believe him about anything, so he stopped coming for a couple of weeks'.

(Barry)

Some participants experienced a sense of resistance from the client.

'She didn't say very much you had to drag it out of her, anything you had to drag it out of her'. (John)

'I just thought there's no relationship developing here, there's not really a trusting open relationship developing here and that was immediately a bad sign'. (Sol)

One participant spoke about this feeling that the client was attending therapy to please others, rather than for himself.

'He had told me during the therapy that part of him felt like he wanted to carry on with the therapy for me because he didn't want to let me down, rather than a sense for himself'. (Dave)

Self-doubt

Participants recalled feelings of self-doubt which at the time they attempted to deny and/or ignore.

'If I was actually being honest with myself, I would've realised then that I wasn't really doing anything helpful early on I think'. (Sol)

'There was a little voice in me that was saying he's anxious, he's worried and at what point do we say enough'. (Fiona)

'It was very early on when I was starting to think this isn't going like I think it should do'. (Barry)

'Repeatedly I felt that I shouldn't be working with her, that I wasn't doing her any good and yet I carried on'. (Fred)

'It was reasonably clear that there wasn't going to be a productive therapeutic outcome from reasonably early on but I persevered'. (Sol)

When therapy fails to progress....

Anger

Most participants spoke about experiencing significant feelings of anger and frustration.

'My level of anger reflected how hard the work was'. (Fiona)

'I felt a bit pissed off really'. (John)

'I would find it immensely frustrating'. (Barry)

'I felt an impotent anger, an anger at myself and him for not getting anywhere'. (Sol)

For one participant, the feelings of anger were pervasive and resulted in personal and professional impacts.

'I was starting to feel a lot angrier in general at work, and then feeling angrier about work outside of work as well'. (Sol)

Some of the participants described feeling uncomfortable about their feelings anger and tried hard not to bring such feelings into the therapy room.

'I was so aware about how frustrated I would get with a person I would try and almost rein myself in at times'. (Barry)

'I'd quite often do all the running around, I'd do all of the heavy lifting it's almost like I'd do the behavioural assessments for you, I'll go outside and don't you worry I'll do all your exposure work for you; you just sit there or go to the toilet'. (John)

Some participants redirected their feelings of anger and found more acceptable ways of venting e.g. at home, to colleagues, in supervision.

'There's a psychology office and you can just vent sometimes your frustration, in a safe environment which was really helping too'. (Sol)

'I used supervision to vent some of my frustrations and some of the difficulties I was having with that person'. (Barry)

Others turned on themselves and a harsh self-critical voice was heard.

'So there you go again you great lump, there you go again not knowing what to do, letting things run and not taking control'. (Fred)

Inadequacy

Each participant experienced difficult feelings of inadequacy.

'I felt inadequacy as a therapist and that I wasn't getting it right, that I'm not very good at engaging people. That I just wasn't getting my technique right somehow'. (Sol)

*'I felt quite inadequate that she wasn't getting better and I wasn't being effective'.
(Wendy)*

For some there was an idea that other therapists would manage the situation better.

'I suppose my most prevalent thought was, why can't I manage like all the other therapists can?' (Fred)

Desperation

In most cases, significant feelings of desperation led participants to work harder and put more effort into the therapy.

Trying harder

'I showed and did my magic tricks and pulled out all of the tricks out of the hat'. (John)

'I was desperately trying to be therapeutic, to be the therapist and it just was not going anywhere'. (Barry)

'I tried everything; exposure and response prevention, cognitive behavioural therapy, REBT, and EMDR. I remember thinking I've got to try harder'. (Fred)

'There was a real chronic frustration, exasperation but then in me, alongside an almost a desperation to do something'. (Sol)

Acting out

For some, feelings of inadequacy and desperation resulted in behavior that felt uncomfortable.

'I think if anyone I leaned on the interpreter, it was good practice to sit in the room after the patient had gone and talk about how it had gone. But I sometimes was aware I was asking for her reassurance and her approval of what I was doing, I felt a little bit conscious of that at times'. (Fiona)

'If he had some kind of crisis going on I felt secretly, this sounds awful but secretly delighted and I felt much more comfortable dealing with that. It was very tempting for me to move towards this other stuff that I found more gratifying'. (Fiona)

'I then felt the need to do therapeutic things outside of the therapy which is really out of the ordinary for me. I'm normally really quite boundaried with patients' (Sol)

Trying to end.....

Helplessness

Some of the participants experienced feelings of helplessness.

'I just felt defeated. (Fred)

'I felt quite powerless'. (Dave)

Others described humiliating experiences of being the target of the client's hostility.

'I was struggling to find myself within that work and I think it was affecting my confidence quite a lot. I felt very bullied by that client'. (Barry)

'She would say and do things that would make me feel quite inadequate'. (Wendy)

'It just feels like he's putting two fingers up at you the whole time'. (Sol)

Vulnerability

Fearing criticism

Most participants feared criticism about the lack of client progress and subsequently chose not to access support from others.

'I remember thinking that my supervisor might think that I haven't done a good enough job with her'. (Wendy)

'I thought my supervisor would say pull yourself together, get yourself sorted'. (John)

'There was a fear that I would be found out and that I don't know what I am doing'. (Fred)

One participant feared criticism from a co-worker.

'We had an interpreter present, which was an additional issue I think when it's not working well because you're really conscious of what that person thinks'. (Fiona)

Accessing support

Some participants spoke about more positive experiences of accessing support when they were feeling vulnerable.

'I had a really lovely relationship with my supervisor and we would laugh, not at the patient, or the lack of progress but about how hopeless it feels when you're working in that setting and that you're not getting anywhere and the futility of it. I think all you can do sometimes is laugh and I did find it validating that we were having a laugh at how hopeless our jobs felt at times'. (Fiona)

'I remember talking to my supervisor and saying I need to talk about him because I haven't felt the need to talk about him, so there was almost this sense of that he was getting lost'. (Dave)

'I used supervision a lot I suppose...working through feelings, working through the reality of what could happen and what might be able to change, trying to look at technique, different models etc'. (Sol)

Giving up

Many of the participants recalled feeling defeated.

'Towards the end I was much more inclined to sit back and just let her talk'. (Wendy)

'I just kind of let her run with it and I had no idea about how I get control back'. (Fred)

'He was easy to forget about, I could have just seen him once a week and then put him out of my mind until it was time to see him again'. (Dave)

'I don't remember speaking about her because I probably thought well I've only got four sessions, it'll be fine, and it'll be ok'. (John)

One participant described an experience of 'cutting-off' from the client.

'Once I've decided that something is broken, then it's broken and I'm not going to try and repair it'. (Fred)

Many of the participants recalled overwhelming experiences of fatigue.

'I found it really wearing. It was the hardest thing I did in the week. I was really tired when I came out of those sessions'. (Fiona)

'It was a little bit draining and I didn't get a lot of reward from it the same way that I might have done from working with other clients'. (Wendy)

*'I tried really hard and I used to leave sessions feeling drained and feeling crap'.
(John)*

For some, the experience had a profound impact on the sense of self.

'I felt responsible for the failure of therapy'. (Fred)

'It's just feeling that I don't have the ingenuity, the imagination or the brass neck to say anything at this point because I've got nothing worth saying'. (Fred)

Feeling drawn in

Many of the participants described difficulties ending the intervention.

'Despite the lack of improvement, she was someone I felt difficult to let go of'. (Wendy)

'There was a sadness that I was one of his main social contacts and that had come to an end'. (Barry)

'I felt like I was just leaving her at a point that wasn't good for her and it did feel like I was just abandoning somebody'. (Wendy)

'There was a strong desire to not let him go'. (Dave)

'I remember thinking I can't let her down by just saying I'm sorry I'm not good'. (Fred)

'I was unwilling to discharge, even though I should have been'. (Fred)

Self-protecting

The language used by some participants suggests that a more negative view of the client emerged, along with the use of self-serving and protective attributions regarding the lack of success.

'I felt a bit annoyed with her really, that she should have been doing that work really. She could have been, even though she had been through an awful experience but could have been making more of her life'. (Wendy)

'He would actively sometimes I think attack people who are trying to help. I think there are some people that don't want to be helped'. (Sol)

'If I am honest at the end I was probably thinking that he wasn't being the perfect client and that he wasn't making the changes that he needed to and that I wanted him to'.

(Barry)

It's over....

Relief

After the therapy ended immediate relief was recalled by most of the participants.

'I think I felt a relief that I was stopping banging mine and his heads against the wall'.

(Sol)

'I do remember a massive sense of relief when I did actually end it with him'. (Barry)

'I was sad when we ended, but there was a sense of relief'. (Wendy)

'There was an element of relief that I was no longer working with someone that complex'. (Fiona)

Guilt

Most participants felt guilty about the way they felt or behaved towards the client.

'There's guilt that I tried to continue to work with him for so long and that the feelings I had, impacted on him at that time'. (Sol)

'I've felt a lot more guilt because I think about how I felt about him at the time and I don't, he doesn't deserve that, you know he's been through, as have some many of the chaps he's been through a horrific history and so of course he doesn't deserve for anyone to feel that way about him'. (Sol)

'There's a part of me that hopes that the way I acted didn't make it more painful for him'. (Dave)

Loss

Many of the participants felt that the experience provided an important reminder regarding the dangers of over-investing in the idea that they can help solve long-standing and complex client difficulties.

Feeling wounded

'I think sometimes it's helpful to be reminded that I like anyone else struggle with certain bits of work and I think all you can do is reflect on that'. (Barry)

'It's been a self-discovery that I can't heal everybody'. (John)

For one participant, feelings of dissonance between the idealised self and the actual self were experienced.

'I had a certain lack of patience that I don't think I communicated but it makes me feel a bit bad about myself because it's something that I don't easily tolerate and I think as a therapist, you'd like to think of yourself of someone that is patient and empathetic'.

(Fiona)

One participant recalled the lasting impact of the experience on his identity.

'When people don't improve it's a bit of chink in the armour, a bit of a dent to your self-identity or self-image or something'. (Barry)

Disillusioned

For many of the participants, the experience left them questioning the influence and ability they have when trying to achieve change in therapy.

'I think psychological therapies are only ever going to be so helpful because people exist in this world of problematic social stresses and relationships that are far beyond our influence'. (Barry)

'I just don't view therapy as a magic bullet at all now, I really don't, and I don't see it as a fantasy solution to things'. (Sol)

'I've realised that CBT isn't the silver bullet, it's not going to cure everybody, it's very useful for a lot of people but it's not the be all and end all'. (John)

For some participants these feelings of loss reminded them of the importance of not taking sole responsibility for their client's wellbeing.

'I think it's trying to take that away those layers of self-grandeur. To remind myself that I'm not the only person in this situation, I'm not the only context in this person's life'.

(Barry)

'I've learnt a lot more about the importance of working as a team. You know in a very, in a very real felt way rather than a theoretic way. A desire to put my faith in the team and generally to work with the team, to think with the team and to do with the team'.

(Sol)

'I think they will or won't get better with or without my help and this reminds me that I am no longer responsible for another person's wellbeing'. (John)

Re-generating feelings of hope

About the therapy

Despite the difficulties, many of the participants experienced feelings of hope that the intervention hadn't been a total failure.

'I grappled with the idea that maybe he had got what he wanted, and maybe he had got something out of our work'. (Dave)

'I am hopeful that she did get something from it, she had started to do more'. (John)

Outside of the therapy

Others recalled feeling hopeful that the client would find what they needed outside of the therapy room.

'Another feeling is of a kind of a hope for him that outside of therapy through occupation engagement that accommodation, robust accommodation and occupation engagement are the way forward for this chap. In other words giving him something to live for, rather than asking him to look at what he has to lose is the way forward'. (Sol)

'I just hope that either she is alright or that she got some sort of resolution of the things that were troubling'. (Wendy)

'I feel really fond of that patient and I really hope he can move on'. (Fiona)

Some of the participants described feeling hopeful about the learning experience and the implications for future clients.

'I suppose from my point of view I've got learning from it and it's changed what we do, it's changed what I do'. (John)

'I learnt a lot more about the importance of working as a team. You know in a very, in a very real felt way rather than a theoretic way'. (Sol)

'There's another patient who very much reminds me of a younger version of this chap, who I think people are really hoping we can help earlier and my therapeutic strategy has been so different'. (Sol)

Table 5: Breakdown of participant responses.

The journey	Master themes	Sub themes	Sol	Fiona	Wendy	Barry	Dave	Fred	John
Starting out....	Satisfying demands	Aiming to please	X	X		X	X		X
		Seeking success	X	X					
	Generating hope	Minimising the challenge			X	X	X		X
		Positive self-belief			X		X		X
		Anxiety	The size of the task		X	X		X	X
	When therapy fails to progress....	Anger	About the relationship	X			X	X	
			Self-doubt	X	X		X		X
Inadequacy			X	X	X		X	X	
		Desperation	Trying harder	X	X		X		X
Trying to end.....	Helplessness	Acting out	X	X					
			X	X	X	X	X	X	
	Vulnerability	Accessing support	X	X		X			
		Fearing criticism		X	X			X	
	Giving up			X	X		X	X	
	Feeling drawn in				X	X	X	X	
Self-protection		X		X	X				
It's over.....	Relief		X	X	X	X			
	Guilt		X	X	X	X	X		
	Loss	Feeling wounded			X		X		
		Disillusioned		X			X		
	Regenerating hope	About the therapy					X		
		Out of the therapy		X	X	X			

CHAPTER FOUR: DISCUSSION

The aim of the present study was to explore the therapist experience of client non-response. Data was collected through semi-structured interviews and analysed using IPA in order to address the following research questions:

1. How do therapists describe their experience of providing therapy to a client who does not improve?
2. How do therapists understand their experience of providing therapy to a client who does not improve?
3. How do therapists manage the experience of providing a therapy to a client who does not improve?

The findings from the analysis are examined in relation to the literature already discussed and the relevant wider literature. This section then provides a critical evaluation of the research method with a particular focus on its strengths and limitations; clinical implications and suggestions for future research are made.

Summary of findings

The findings offer an account of seven therapists' experience of client non-response, an experience not currently captured within the therapy literature. Although each participant in the study described a unique experience, their experiences distilled into a core narrative, encompassed by the over-arching theme of *'the destruction of hope'*. The experiential themes were organised across a four-part journey; *'starting out'*, *'when the therapy fails to progress'*, *'trying to end'*, and *'it's over'*. It was clear from the narratives that at the start of the intervention, participants experienced a combination of internal and external pressures to achieve change with the client. Participants recalled feeling anxious about the size of the task and their ability to establish and maintain a therapeutic relationship with the client. Participants appeared to manage these pressures and anxieties by generating a sense of hope around the therapy. Hope was created in two ways; participants minimised the client difficulties and held positive self-beliefs regarding their ability to provide a successful intervention. As the therapy continued without success, participants began to experience significant feelings of inadequacy, anger and desperation. Challenging feelings of inadequacy were managed by *'doing more'* and *'working harder'*. Towards the end of the therapy, participants spoke about feeling *'helpless'* and wanting to *'give up'* on the client. Each participant experienced

significant difficulties ending the therapy; they felt drawn into a relationship with the client and feared criticism from colleagues. Consequently, most participants found it difficult to access support or talk openly about their struggles with the client. After the therapy, participants recalled immediate feelings of relief that the therapy and their relationship with the client had ended. Feelings of personal and professional loss were described by all participants who felt that they had '*bought into*' the idea that therapy was the solution to the client's difficulties. Participants felt guilty for the times that they blamed the client for not getting better. Each participant engaged in an important re-evaluation of the therapy and identified some elements of success within the intervention. Some participants accepted that the therapy may not have been the correct intervention for the client and expressed hope that the individual would find resolution in other areas of their life. Others felt grateful for the learning experience and were hopeful that they would be better prepared and able to work effectively with future clients who may be at risk of not improving during therapy.

I will now discuss the key findings in relation to the literature outlined in the introduction and the relevant wider literature. Participant quotes are in *italics*.

Key finding 1: A lack of corrective experiences

The Corrective Experience Model (CEM) offered a useful theoretical framework for understanding participant's attempts to make sense of the lack of change in therapy. With hindsight, participants spoke about the problems they experienced within the therapeutic relationship and felt that they had fallen into unhelpful ways of relating to the client and consequently not provided corrective opportunities. Indeed, the stories told by participants did not appear to include accounts which might clearly be seen as including corrective experiences. Castonguay & Hill (2012) define a corrective experience as an occasion in which a person comes to understand or experience an event or a relationship in a different and unexpected way. This can include emotional, relational, behavioural, or cognitive events. They suggest that although corrective experience can occur in all aspects of life, the therapeutic relationship can provide an important context within which CE's occur. For example, clients presenting with relational difficulties may benefit from feeling validated and supported, especially when this has not been part of the client's past experiences. Alternatively, when therapists are unintentionally invalidating or rejecting, the interactions may replicate the dysfunctional

interactions that clients have had in the past, often resulting in anti-therapeutic effects (Castonguay et al, 2010).

Key finding 2: Unrealistic internal and external expectations

Unrealistic expectations are considered to be a common feature within modern healthcare systems where the demands far outweigh resources (Crigger, 2004). This resonated with some participants who recalled feeling as though they had no choice but to provide therapy to the client. They perceived organisational pressures to engage the client and continue the work regardless of the difficulties or the apparent lack of change. One participant said, *'There are service and wider organisational pressures, commissioning pressures to change people, however you go about that. People don't particularly want to know, they just want you to change people'*. (Sol)

Each participant discussed a highly complex client; this is typical given the high rate of complexity in clinical samples (Kessler, Chiu, Demler, & Walters, 2005). From the start of therapy, participants either experienced barriers to therapeutic progress or a sense that it was not progressing well (e.g. resistance from the client or a sense that the client did not want to be in therapy). Each participant identified that the client they talked about had communicated their desperation, along with unrealistic expectations that therapy was the solution to their difficulties. Rather than managing these unrealistic client expectations, participants appeared to respond to the client's feelings of desperation by desperately wanting to help them. As we know, the role of the therapist is to establish effective therapeutic relationships with others and, more often than not, to act as a 'care-giver'. Leiper and Casares (2000) found that compulsive care-giving attachment patterns were present within a sample of 196 British clinical psychologists. Psychotherapy literature tends to focus on the attachment style of the client seeking out therapy and the subsequent impacts on the therapy. Given that therapy is an interpersonal experience between two people (Wampold, 2001) it is important to explore and understand what both the therapist and the client are bringing to the relationship. There are studies to suggest that the therapist attachment style influences their approach to the work and the difficulties experienced in the therapy (Leiper & Casares, 2000). Strong care-taking and rescuing tendencies appeared to be present amongst the current sample and influenced the therapy experience (e.g. continuing to offer care in spite of the evidence of non-response and finding it hard to end the therapy). One participant alluded to his rescuing tendencies with the client and

said the following, *'I gave him more chances to re-engage than I might have done with others'* (Dave).

Some participants spoke passionately about their views concerning the right of access to therapy for all, regardless of complexity. It seemed that for many of the participants denying or withdrawing care to the client was not an option. External demands and expectations were compounded by the participant's internal expectations. Some of the participants spoke about what they considered to be *'a perfectionistic streak within them'* and *'a high need to achieve'*. Others recalled feeling as though this challenging piece of work could be an opportunity to demonstrate competence and achieve something that others could not. In the words of one participant, *'this was the person's opportunity and chance to move on and this was a chance for me to make it successful.'* (Fiona). Participants retrospectively acknowledged their role in creating and perpetuating the illusion that therapy would be the answer to the client's problems.

Key finding 3: The role of hope

A strong finding across all cases was the participants' early feelings of hope in spite of their awareness of the difficulties. The significance of hope is highlighted by Wampold (1992) and said to account for 15 per cent of therapy outcome variance. Hope is created by the client's assessment of the therapy rationale and both the client and the therapist positive feelings about its healing potential. Lambert (1996) claims that hope and optimism are necessary and protective; allowing the therapist to remain engaged and committed in spite of client non-response. According to Lambert, adopting this optimistic stance is helpful for both therapists and the clients. For example, the more success therapists see in their clients then the more satisfied they are in the job. Participants seemed to artificially maintain feelings of hope in the face of the evidence and their own experience. Lambert asserts that overestimating outcomes and using protective attributions allow necessary distortions for therapists who must search for success even when clients are overall not changing. At the start of the therapy, hope and optimism were generated by participants in two ways. Firstly, each participant reflected on the ways in which they underestimated the client's difficulties, particularly, the client's long-standing interpersonal difficulties. Secondly, participants held the belief that they were special and could make a difference to this client in spite of the odds or of other people's previous failed attempts. One of the participants referred to this as the *'magical healing identity'* that is often perpetuated and even encouraged by

colleagues who *'put psychology on a pedestal'* and clients who enter therapy with a belief that therapy is *'the solution to their difficulties'*. Some quotes appeared to imply that participants were striving for the respect of their team members especially given the wish to be seen as deserving of a relatively higher salary. With the benefit of hindsight, participants recognised their role in generating misplaced hope.

Key finding 4: Difficulties within the therapeutic relationship

Each therapy relationship described in the non-response had different qualities which the therapist subsequently linked to the non-response. What united them, however, was the impact that the client had on the participant, which in all cases was very strong. As we know, the therapy relationship is a powerful indicator of therapy outcome and said to account for 40 per cent of variance (Wampold, 2001). According to Horvarth et al (2011) early difficulties in the therapeutic relationship are associated with a negative therapy outcome. Some aspects of the way the relationship and the therapy began later resonated with the outcome of non-response. Several therapists noted that their clients were particularly prone to feeling hurt or rejected due to histories of abuse or trauma. Safran and Muran (2000) assert that clients with traumatic histories may be more vulnerable to experiencing difficulties in the therapeutic relationship. Traumatic histories were reported in every case and participants were often left feeling anti-therapeutic or persecutory when well-intentioned attempts to talk about the here and now of the therapy relationship left the client feeling hurt or rejected. One participant said, *'I'd find it very difficult to talk about those kinds of relational issues with him because he would see it as a real threat or insult'* (Barry).

Key finding 5: Experiences of unresolved impasse

Participants were often left with an experience of stuck-ness that resonated with an experience of unresolved therapy impasse. A therapy impasse refers to a therapeutic stalemate that therapist and client may or may not be aware of (Nathanson, 1992). Unresolved moments of stuck-ness were described by each participant. Two of the participants used powerful metaphor to communicate their experiences of feeling stuck and unable to move forward.

'I was stopping banging mine and his heads against the wall' (Sol)

'It was more like we were just arguing without arguing'. (John)

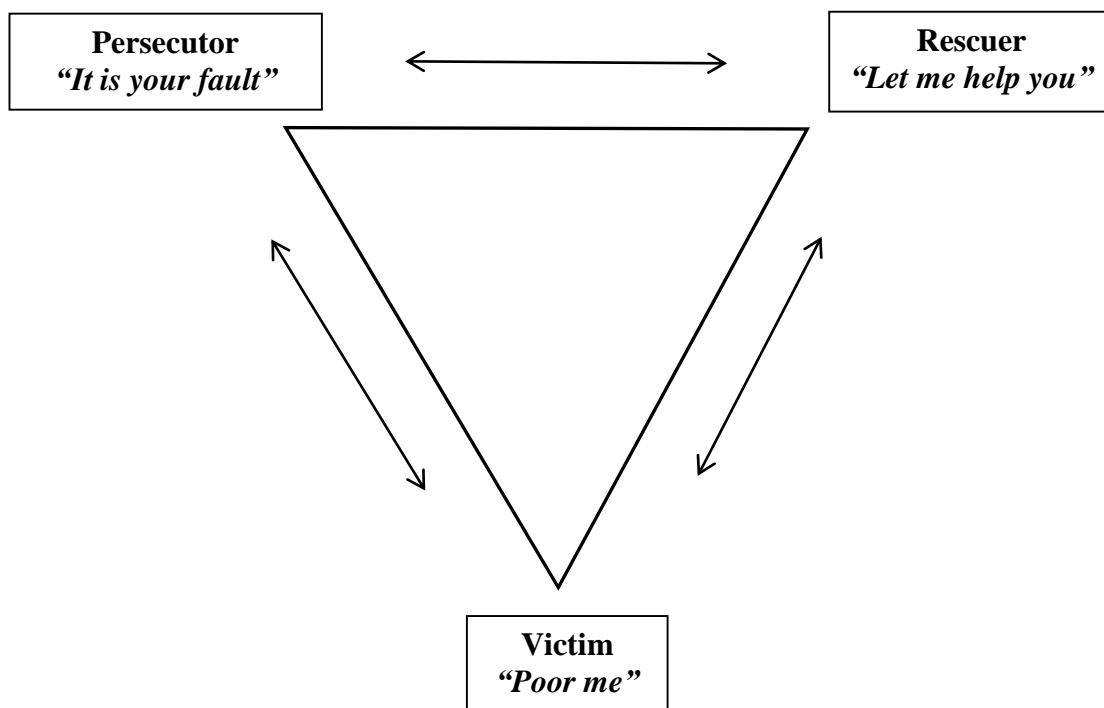
Although not the same as an overall experience of non-response, the experiences of impasse provided the participants with evidence that the therapy was not progressing and threatened their sense of competence and self-efficacy. As the therapist is involved in the impasse it is very difficult for them to view it objectively and supervision is crucial for effectively managing and resolving experiences of impasse. Another way of managing an unresolved impasse may be for the therapist to give up on the client and accept that they cannot help the client (Leiper & Kent, 2001). Each participant described an experience of giving up on their client. One participant said, *'I ended up saying to her I can't help you'* (Fred). Leiper and Kent suggest that if an impasse endures over time the therapist's feelings of incompetence can accumulate and evolve into beliefs about being a fraud. In this state the therapist may feel like the intervention they are providing is a farce, whilst feelings of helplessness and despair consume the therapy. Shame is considered to be a key response following the recognition of an impasse (Nathanson, 1992). Therefore the therapist's experience of therapy failure is influenced by how they manage feelings of shame. According to Leiper and Kent, locating blame within the client is one of the most tempting and dangerous aspects of an impasse as it can lead to the therapist demanding more of the client therefore undermining the safety of the therapy. Within the current study it was common for participants to blame their clients for not getting better towards the end of the therapy. As mentioned previously, participants felt anti-therapeutic and persecutory for doing so. During an impasse, therapists may attempt to overcompensate for feelings of inadequacy by becoming more rigid and dismissive of the client's feedback or the signs of therapy failure. With hindsight, each participant experienced significant feelings of guilt about concerns that they pushed the client too far and ignored signs that they were struggling. Many of the participants described feeling paralysed by their sense of guilt and consequently became passive and helpless within the therapy relationship. This experience appears to link well with the therapist experience of impasse (Leiper & Kent, 2001) and suggests that there were experiences of unresolved impasse present within participant's experiences of non-response.

Key finding 6: The shifting role of the therapist

The traditional IPA analysis produced experiential themes and data from participant's narratives. Following this, a process was noticed and built on to structure the findings. The timeline revealed that often there was more than one experience occurring at one time point. These experiences were varied and often conflicting both across participants

and within. The Drama Triangle offered a useful framework for structuring and making sense of how these varied and conflicting experiences were present in a way that a thematic list could not.

Figure 2: The Drama Triangle (adapted from Karpman, 1968).



Power dynamics between the client and the participant were apparent from the start of the intervention and appeared to shift throughout the course of the therapy. The Drama Triangle helped understand the shifting experiences; particularly the shifting roles of rescuer, persecutor and victim described by participants (see Appendix 13 for quotes showing the different roles).

Karpman (1968) claimed that this triangle is present within all dysfunctional processes. Each participant referred to occasions where they felt disempowered by the client and victimised within the relationship. When a rescuer moves into a victim role, that individual experiences a loss of power and influence within the relationship. For individuals whose primary role is to rescue or provide care (e.g. a helping professional), it may be very difficult to recognise and accept themselves as being in the victim or the persecutory role. The experiences shared and the language used by the participants suggested that with hindsight participants were able to recognise the shifting and often dysfunctional nature of the interactions, alongside their own vulnerability. Regardless, during the therapy, their dominant coping strategy of denial communicated a desire to

resist feeling like a victim or persecutor and avoid experiencing the uncomfortable feelings of helplessness and inadequacy. One participant said, *'Maybe I could have used supervision to talk about it in a bit more of a real way. And more sitting with those feelings of hopelessness and despair and feeling deskilled and like you're letting the patient down in some way'* (Fiona). Similarly, identifying with the role of the persecutor who overcomes feelings of helplessness and shame by over-powering others was also very challenging for the participants. Most of the quotes within the persecutory state were related to the therapy ending, which all participants experienced as a struggle. One way in which participants felt they moved from rescuer to persecutor was when they ended the intervention and withdrew their care. In order to end the dysfunctional experience, participants were required to resist their rescuing tendencies and be prepared to be perceived as the persecutor (abandoning and uncaring), characteristics that once again challenge the healing identity. One participant said, *'I was just leaving her at a point that wasn't good for her and it did feel like I was just abandoning somebody'* (Wendy).

Karpman (1968) suggests that The Drama Triangle endures because each participant is using the dynamic to fulfil unspoken (often unconscious) psychological needs. Whilst participants tended to attribute their responses and the ways in which they acted in the therapy to their clients, the narratives did suggest that therapist factors were also relevant. A complex relationship between client and therapist consisting of a dance between the different needs, beliefs and personalities was apparent. For example, Fiona described herself as having a bias towards clients who can understand psychological concepts quickly and discussed the struggles she experienced whilst working with a learning disabled client. These findings resonate with the views of Sussman (1995) who referred to the human vulnerabilities of every therapist. He spoke about the 'helping professions syndrome' whereby therapists can project their own needs onto the client, whilst experiencing a sense of hostility about their own previous experiences and a sense of envy towards the client who is able to ask for help. The therapist's desires to feel competent, valued and useful are communicated in every story told by participants. Their stories suggest that neither the therapist nor the client received what they wanted from the intervention. Clients expressed hope that therapy would improve the quality of their life and therapists hoped to demonstrate competence and boost their self-esteem. This finding is particularly interesting when discussed in relation to the study carried out by Radcliffe (2015). Her findings showed that clients who experienced non-

response were left feeling that they did not receive what they wanted and their needs remained unmet. The non-response outcome reinforced clients' believing themselves worthless, a failure and wrong, as they felt they had failed at therapy. There appears to be a parallel experience between the client and therapist, whereby both are desperately working against their fears around competence, capability, failure and self-worth.

Key finding 7: Significant feelings of inadequacy

According to Bandura (1977) there is a direct link between performance and self-evaluation. Therefore, therapists will feel good about themselves mainly when they have accumulated experiences of success during therapy. Questioning one's competence appeared to be a significant aspect of the participant narratives and seems most likely explained by the lack of success within the therapy. The following participant quote supports this assertion, *'There were not many successes in there and there were not many moments when I felt great as a therapist'* (Fiona). Participants reflected on their attempts to manage challenging feelings of inadequacy by desperately trying to 'do more'. In the words of one participant, *'I suppose thinking about it now I was desperately trying to be therapeutic, to be the therapist and it just wasn't going anywhere'* (Barry). In their accounts participants indicated how the experience of non-response was experienced within their own personal context and the personal meaning it had for them. They talked about the experience within a broader picture of themselves as competent and able therapists, suggesting that the experience of non-response undermined their sense of self. It was clear from the narratives that all of the participants had invested a great amount in the therapy and they were deeply concerned about making a difference for the client.

Each participant recalled significant feelings of inadequacy and incompetence throughout the therapy, particularly at the beginning. These feelings may be the result of the internal attributions used by participants to explain the non-response (e.g. it is my fault, I am not trying hard enough). An alternative understanding is offered by the concept of countertransference. Countertransference refers to the therapist's unresolved areas of difficulty (Gelso & Hayes, 1998). Client experiences of helplessness and hopelessness may have triggered feelings of incompetence in the participant through the process of identification and caused participants to blame themselves for the non-response. Counter-transference is also generated by complementary therapist responses. According to Kiesler (2001), depending on how much the therapist represents a

significant person to the client, he or she will experience complementary inner responses similar to those experienced by other persons in the client's life. Kiesler highlights the importance of the therapist's ability to disengage from complementary responses in order to interact with the client in a different way than other significant individuals in the client's life, thus facilitating opportunities for corrective experiences. One participant said, *'I suppose my sadness was about repeating the cycles and repeating the patterns and that I hadn't been able to stop the repeating of the pattern or a relationship ending in an unsatisfactory way for him.'* (Dave). In practice, this study highlights how difficult this can be and participants often described feeling anti-therapeutic or persecutory when they tried to respond to clients in a non-complementary style.

Key finding 8: Participants feared criticism from others

Some participants were keen to access support and reassurance from others (colleagues and supervisors) throughout the difficult experience, whilst the majority feared criticism or felt let down by their supervisors. Increased levels of stress and perceived threat are associated with experiences of potential failure due to the negative responses anticipated from the patient, colleagues, and society (Covell & Richie, 2009; Crigger, 2004; Wagner, Harkness, Hebert & Gallagher, 2012). Participants spoke about their experiences of stress and threat.

'I think there's always some sort of self-surveillance that goes on in modern healthcare where you're always trying to compare yourself to some complicit norm, whether you're seen as efficient or good at your job, probably get enough of that from my own kind of self-critique but there is always that level of self-surveillance, self-monitoring and justifying to myself whether to keep seeing this person or not.' (Barry)

One participant was unable to access appropriate support due to the fear that he would be criticised and his job would become endangered.

'There's fear that if I'm found out and these days in the NHS no one's job is secure and they're going to find out that I don't know what I am doing. We've got a reconfiguration coming, who knows if I'll survive it...or that my clinical supervisor would say to me, you're spending too much time with this person, we've got waiting list and you've got to discharge her.' (Fred)

For each participant, the experience of non-response caused them to think and act in ways that provoked feelings of anxiety and shame. According to O’Conner et al (2011) the decision to be open about experiences of failure is often hindered by the culture of blame and scapegoating that is prevalent in Western society and may help us understand why accessing supervision was difficult for some of the participants. Kluft (1992) posits that therapists may be reluctant to make effective use of supervisors due to feelings of guilt and shame in relation to a sense of failure. Radcliffe (2015) suggests that the client experience of non-response was also significantly influenced by their reluctance to discuss personal difficulties that evoked feelings of failure and shame. The difficulties that participants have speaking about the non-response in supervision suggest the presence of a parallel process. A parallel process in the supervisory relationship refers to the times when the interpersonal processes between the client and therapist are reflected in the relationship between the therapist and supervisor (Searles, 1955). According to McNeill and Worthen (1989) the parallel process is an unconscious identification with the client and may represent the therapist’s attempts to tell the supervisor what the problems are in therapy. Doehrman (1976) referred to the inevitable dynamics of power and evaluation with the supervisory relationship and suggested that the supervisee may react to the supervisor in a similar way to how the client is reacting to them. Reluctance to access supervision was described by the majority of participants. One participant said, *‘I suppose maybe the therapy might have benefitted if I had brought him to supervision’* (Dave). Others felt either let down by their supervisor or that they could have used supervision in a more productive way;

‘While I did find it validating that we were kind of having a laugh at how hopeless our jobs felt maybe while we were doing that we could have been talking in a bit more real way about it....sitting with those feelings of hopelessness and despair and feeling deskilled and like you’re letting the patient down in some way, maybe that’s what we should have been talking instead of sitting around and laughing’ (Fiona).

Key finding 9: Participants used a range of functional attributions

Studies have suggested that therapists’ awareness and knowledge of client non-response are often impaired by the protective attributions often used to explain negative therapy outcomes (Hunsely, 1999; Murdock, Edward & Murdock, 2011). These studies captured the therapist’s attributions at one time point (following the intervention). The current study retrospectively explored participants’ attributions throughout the therapy.

The findings show that participants made different attributions (not all protective) at certain points in time. The changes in attributions fit with the stages of the participant journey. Participants initially blamed themselves, then the client and finally, factors external to the therapy (e.g. the service, the profession, society). In the early stages of the intervention, participants recalled making internal attributions to explain apparent non-response. Participants blamed themselves and consequently managed feelings of inadequacy by trying to work harder. According to Zickgraf (2015) it is common for the therapist to respond to client non-response by working harder and doing more. By locating the problem within themselves, participants were able to maintain a sense of control over the outcome and avoid negative views of the client or the therapy from emerging. One participant said, *'I felt like I wasn't getting it right, that I'm not very good at engaging people. That I just wasn't getting my technique right somehow, that there was something wrong with how I was approaching the work in general'* (Sol). At the end of the therapy, participants began to use more protective attributions.

'She should have been doing that work really. She could have been, even though she had been through an awful experience she could have been making more of her life had she done the work that was available to her'. (Wendy)

'There was a tendency for me to get frustrated with him because he wasn't being the perfect client. He wasn't making the changes that he needed to and that I wanted him to'. (Barry)

Protective or self-serving attributions function as a protective strategy and infer that therapists were feeling exposed, threatened and vulnerable. Self-serving attributions are most commonly associated with negative events (Malle, 2006) and refer to a naturally occurring self-protective strategy used by individuals faced with an outcome that poses threat to their self-image (Campbell & Sedikides, 1999). Explanations for negative personal outcomes have been studied in a variety of settings (e.g. academic achievement and interpersonal stress). In each context the findings indicate that a higher level of self-esteem is maintained after a failure when the perceived cause is external rather than internal. Given the difficult emotions found to be associated with the experience of non-response, it is likely that participants used self-serving attributions to protect their sense of competence and well-being. Participant's attributions after the therapy ended protected both the client and the participant and located blame within the profession or service that required the participant to work with such a complex client.

'His distress was far beyond the remit of what you can do with individual work or even family and social systems'. (Barry)

'The problems weren't his they were the systems'. (Sol)

'In so many ways this client was completely let down by the system'. (Fiona)

Key finding 10: An experience of personal and professional loss

After the therapy ended, participants were able to develop more perspective and engaged in a re-evaluation of the therapy. Some participants were able to identify more positive aspects that challenged the non-response outcome. Others accepted that therapy may not have been the most appropriate intervention for the client and felt hopeful that the client would find some sort of resolution outside of the therapy room.

Feelings of personal and professional loss were communicated by most of the participants. For these participants the therapy failure reminded them that therapy is not always going to be the solution to people's problems. Participants accused the profession of falsely marketing itself as the solution to people's problems. These participants acknowledged their role in *'buying into'* the idea of therapy omnipotence and subsequently over-estimating their own ability to influence the lives of their clients.

Participants felt guilty about the way they thought about or behaved towards the client. One participant said, *'He did not deserve that, you know he's been through, as have so many of the chaps he's been through an horrific history and so of course he doesn't deserve for anyone to feel about him in that way, but I did and people do'*. (Sol)

With hindsight, participants were able to recognise the self-serving attributions about the therapy outcome and felt remorseful for the times that they blamed the client for not getting better.

Key finding 11: An experience of not being able to heal

According to Friedman and Kaslow (1986), when therapists are faced with a lack of client change their dominant healer identity is challenged. Subsequently, personal characteristics and qualities may be used to explain the lack of progress, rather than learnt psychological theories and interventions (Watkins, 2012). In all seven cases, participants attempted to make sense of the initial non-response by exploring their own shortcomings. This has been highlighted as an unhelpful and potentially detrimental

strategy commonly used by therapists faced with client non-response. Using this strategy led some participants to view the non-response as a personal failure and they consequently questioned their ability to help others. One participant said, *'I felt quite inadequate that she wasn't getting better and I wasn't being effective'* (Wendy). Many of the participants believed that other therapists would have coped better and found ways of achieving change with the client, *'I suppose my most prevalent thought was, why can't I manage like all the other therapists can?'* (Fred). This upward social comparison represents an interesting shift from the beginning of the therapy whereby most participants positioned themselves as able to achieve what others could not.

Key finding 12: The risks of burnout

Lack of change in clients or discrepancies between therapeutic expectations and client's improvement can increase stress levels and the risks of burnout (Maslach, 1978).

Participants' experience was marked by a range of challenging emotions that endured over a period of time. These challenging emotions were especially evident in the later stages of therapy where participants' feelings of fatigue and helplessness were evident, along with a desire amongst participants to give up on the client. The previous feelings of anger and frustration were replaced by feelings of helplessness and participants were left feeling vulnerable and insecure. According to Maslach, burnout consists of three subscales for measuring separate aspects of burnout: Emotional Exhaustion (feeling emotionally drained), Depersonalization (developing negative attitudes and feeling towards clients), and Personal Accomplishment (feelings of competence and success in work). Feeling drained, developing negative feeling towards the client and feelings of incompetence were key aspects of each participant's experiences. It seems as though the personal attributions made by the participants (e.g. it is my fault the therapy is not working) were carried outside of the therapy room impacting their personal and professional lives e.g. not wanting to come to work and increased feelings of anger outside of work. It is suggested that knowledge, skills, and experience counter feelings of inadequacy and incompetence (Therriault & Gazzola, 2006). However, the findings of the study captured a different scenario whereby the most profound and global statements about inadequacy were experienced by the two most experienced therapists. This may suggest the potentially accumulating impact of client non-response when it is not managed effectively.

CHAPTER FIVE: STRENGTHS AND LIMITATIONS

This section will critique the research, outlining both the strengths and limitations of the study.

Research design

Although other approaches were explored, IPA was considered the most appropriate design for exploring the novel area under investigation. Within the limitations discussed below, IPA appeared to fit well with the aims of the research and allowed a detailed exploration of the experience of a relatively homogenous group of participants. This qualitative methodology provided a discovery-orientated approach in an under-researched area, allowing data to emerge from the participants, rather than predefined concepts.

This was my first experience of using IPA and it is therefore important to acknowledge and take ownership of my limited experience. According to Smith et al (2009) an effective IPA researcher demonstrates the following qualities; flexibility; patience; empathy; determination; persistence; curiosity; and the willingness to enter into, and respond to, the participant's world. I found this set of qualities quite demanding and it is highly likely that at times I fell short on any one or a combination of these qualities. Strategies for mitigating my lack of experience included the ongoing support and guidance from my research supervisors. I also attended a regular qualitative research support group and peer supervision.

Sample and recruitment

A strength of the recruitment strategy was that it yielded a relatively homogenous group of psychological therapists working in the NHS, working with adults delivering individual psychotherapeutic interventions. The findings reflected some commonalities in the experiences across the whole sample, the findings of which can be of interest and potentially applicable to all psychological therapists of varying theoretical orientations. The small sample could also reflect a limitation of the study and raise the need for caution in interpreting the findings. One could argue that the findings are applicable to all but specific to none. Particularly, given that the sample represents a very small minority of those participants who were invited to take part in the study. Transferability concerns are commonly raised in association with qualitative studies which tend to explore experience using a small sample. It is important to remember that the overall aim of this study was not to find conclusions about the therapist experience of client

non-response. Such aims cannot be achieved by this type of study. Instead, the current study focused on an in-depth analysis of the experience of several therapists in order to try and understand something about their experiences. Consequently, statements about the generalisability of these findings cannot be made.

It is also important to consider the qualities of those participants who decided to take part in the study, compared to those who did not. When explaining their decision to take part, most of the participants recalled their own difficult research recruitment experiences and expressed a desire to help with the study. Others shared an interest in the topic and felt as though they had something to contribute. The findings of this study suggest that the participants were quite significantly affected by their experience. It is important to acknowledge that there may be another group of therapists who shared a similar experience of client non-response, yet felt much less affected by their experience and therefore did not feel they had anything to say in an interview. The findings of this study suggest that client non-response can be a difficult topic to discuss and it is also possible that potential participants may have felt uncomfortable with the idea of discussing their experience. This is speculation; however it is worth taking into account the characteristics of those who responded, and considering how these may have influenced the findings. This sample may also indicate a self-selection bias, in that participants chose to talk about the experience because of a sense of security or confidence in talking about their personal struggles or anxieties. This might also have the potential to narrow the general applicability of the findings to those who are already comfortable acknowledging and discussing therapeutic non-response. It remains unclear how those participants who prefer not to share their experiences (i.e. the majority), experience therapeutic non-response; they may, for example, avoid the topic due to discomfort or anxiety.

Interviews

This study relied on the data collected by a semi-structured interview; therefore experience was communicated through language. Since this study is interested in the therapist experience of non-response we must assume that participants were able to accurately express their experience using language. According to Willig (2008) the words we use construct and describe a particular version of that experience. An experience can be described in a variety of ways, therefore suggesting that this study may have gathered a specific version of the experience rather than the direct lived experience. Further questions are asked about an individual's ability to use language to

capture the nuances of their emotional and physical experience. During the interview participants were asked to retrospectively describe their feelings, thoughts and behaviours. It is likely that these descriptions were difficult to produce.

Finally, the nature of the topic was likely to elicit stories that may have portrayed participants in less favourable ways and it is possible that participants may have given safe or socially desirable accounts of their experience. Labelle, Campbell and Carlson (2010) discuss the factors interfering with the accuracy of self-reports, such as impression management and repressive coping styles. Despite these concerns, all participants appeared to talk openly about their experiences, particularly views and experiences that may have placed them in a less favourable light. The interviews allowed participants to explore their experiences within a private and contained environment. I was also able to experience first-hand the participant's body language, tone of voice and expressed emotion.

Analysis

It can be argued that the data analysis did not lend itself to examining how organisational, client and therapist factors shaped the experience of non-response. For example, while the sampling strategy employed was a convenience and not a purposive strategy, participants were employed in a range of organisational settings in which the goals of therapy would likely vary in patterned ways, as would the complexity of client difficulties dealt with. From the vignettes too, participants varied in terms of their clinical experience – from relatively inexperienced to very experienced therapists. Whilst the analysis did include certain aspects of how the environmental factors impacted the experience (e.g. organisational expectations), further exploration of how such factors shaped patterns of variation in respondents' experience would have provided a more in-depth analysis. It is also important to mention the use of a process orientated presentation of data that is more commonly associated with a grounded theory approach (Miles & Huberman, 1994). Therefore, a grounded theory approach may be a more appropriate method for building on the process which I developed to structure my findings.

The findings represent my interpretation of the interview material through a personal engagement in both the interview and the analysis process. Whilst robust credibility checks were routinely applied throughout the research process, the validity of the themes and the ways in which they accurately represent the participant's experience can

also be judged by the reader. There are a number of guidelines for assessing quality or validity in qualitative research. Smith et al (2009) suggest that researchers are guided by the criteria set out by Elliot et al (1999) and/or Yardley (2008). The guidelines offer broad and inclusive criteria that can be applied to research, regardless of theoretical orientation (Smith, Flowers & Larkin, 2009). The following table outlines the criteria set out by Elliot et al (1999) and how I have attempted to address them within the current study.

Table 6: Credibility checks.

Guideline	Steps carried out by researcher
Owning one's perspective	I completed an initial reflexive interview in order to explore my own experience of non-response and my assumptions around the topic. I kept a reflective journal throughout the process and audio recorded my reflections following each interview.
Situating the sample	I have included a detailed pen portrait for each participant. The pen portraits provide a context for the findings.
Grounding in examples	The pen portraits and group analysis are evidenced with direct quotes throughout.
Providing credibility checks	Full transcripts and sections of data were shared and commented on to allow credibility of emerging and final themes. In addition to individual quotes, tables have been provided so the reader can see the participant's individual themes (Table 6).

As this is qualitative, interpretative research it is inevitable that my own assumptions will have played a role in the development of themes and the model. The study findings aligned with many of the expectations I held following my own experience of non-response. For example, it was anticipated that participants would describe experiencing a sense of failure, report that the non-response challenged their sense of competence and left them with feelings of guilt. Alignment between researcher expectations and study findings can raise questions about the potential influence of a researcher bias. However,

I am confident that the findings are trustworthy due to the rigor of the research method and my efforts to be aware of my biases when analyzing the data.

Clinical Implications

Therapy is an activity that engages core aspects of both the therapist and the client. Therefore, it is likely that an outcome of non-response may incur emotional costs for both, including financial costs for services. The findings of this study, I believe, are useful primarily for therapists working across a range of psychological therapies, in particular in relation to cases where they are concerned about a potential non-response therapy outcome. Clinical supervisors may also benefit from a greater understanding of the therapist experience of non-response when supporting clinicians. An increased awareness amongst therapists, supervisors and services is likely to have a positive influence on how the successful identification and management of clients at risk of non-response. Therefore, this potentially reduces non-response outcomes and/or positively impacts the client experience of therapy.

Hope

Hope was a key concept throughout the therapist experience. Indeed, generating hope is considered to be a core task of therapy (Frank & Frank, 1991). The current findings indicate that whilst the therapist's feeling of hope allowed them to remain resilient and committed to the intervention; they also prevented them from using more effective strategies for managing client non-response. Lambert asserts that these feelings of hope and optimism can lead to therapist blind spots and make it difficult for them to identify and subsequently manage client non-response. Findings suggest that participants relied primarily on their clinical judgment when making therapy decisions. Although participants appeared to value and trust their clinical experience and judgment, there is a growing body of evidence suggesting that tracking client's progress can assist clinical practice and improve outcomes (Lutz et al, 2006). Lambert et al (2003) demonstrated that providing the therapist with feedback on the client's progress improves outcomes and suggests that relying on clinical judgment to identify those clients that are not progressing is insufficient. Therefore, therapists may consider introducing measures that function to track the change in their clients. For example, the feedback could have provided participants with evidence and a strategy for addressing the lack of change with the client and exploring the barriers to change in a safe and more objective manner.

Suitability for therapy

With the benefit of hindsight participants felt they had underestimated the client's difficulties and felt that providing therapy to the client may not have been the right thing to do. Therapists may consider conducting systematic and comprehensive assessments for therapy. As part of the assessment process, the therapist could use suitability criteria to screen for any client factors found to be associated with good outcomes, which might introduce the idea of negative outcomes at the start of the therapy. This may be a particularly useful implication for those participants who felt that they had underestimated the client's difficulties and overestimated their ability to withstand the demands of therapy. This finding also raises questions around how we decline therapy to those clients who are assessed as unsuitable in a therapeutic and non-rejecting manner.

Supervision

Reflecting on their experience during the interviews seemed to be both useful and therapeutic for participants. The interviews gave participants the opportunity to have a unique and protected space to share their experience of client non-response. It may be useful for clinical supervisors to incorporate similar opportunities to speak about such difficulties into existing clinical supervision or peer supervision networks. Supervisors may consider introducing a dedicated slot for therapists to explore their emotional responses towards clients within an open, honest and supportive relationship. Including a protected space for non-response case discussions may invite therapists to talk more openly about the cases that are challenging them. The findings suggest that interpersonal experiences such as unresolved impasse, unrecognised rupture and counter-transference featured heavily within the non-response experiences. Supervisors may consider introducing process-orientated models of supervision that focus specifically on the interactions between the client, the therapist and the supervisor. One such example is the Seven-eyed model of supervision provided by Hawkins and Shohet (2012). The model provides a framework for thinking about some of the challenging aspects described by participants. Using the model collaboratively may provide an invitation, as well as an expectation that both supervisor and supervisee will speak openly and honestly during supervision.

Table 7: The Seven Eyed Model of Supervision (Adapted from Hawkins & Shohet, 2012).

Eye	Focus	Example areas to explore within supervision
1	Client	How does the supervisee describe the client (e.g. appearance, movement, posture, gesture, use of language, voice, breathing etc.)
2	Intervention	What interventions have you used? What are your reasons for using them?
3	Client-supervisee relationship	Find a metaphor or a visual image that best represents the relationship Imagine the sort of relationship you would have in different circumstance.
4	Supervisee	How is the supervisee affected internally by the client? Does the relationship remind the supervisee of another relationship?
5	Supervisor-supervisee relationship	Looking for parallel process; the ways in which the supervision relationship resembles the therapeutic relationship e.g. Holding back through fear of criticism.
6	Supervisor processes	Noticing any sudden changes (e.g. boredom, fear, interest etc.) Images that spring to mind.
7	Focus on the wider context	Client context (background, reason for referral, who referred) Context of supervisory relationship (previous experiences, professional differences, power) Supervisor context (biases, stereotypes, personality style)

The value of this framework may vary across different therapy models, and supervisors my wish to seek out guidance that fits with their therapeutic orientation.

Problems opening up and talking about topics that may evoke feelings of shame were found in this study and have also been found in the client experience of non-response (Radcliffe, 2015). Exploring these processes within a supportive supervisory relationship may help the therapist gain a better understanding of the clients difficulties accessing help. Supervisors might consider leading by example and modelling to supervisees by sharing their own exploration of cases that have not gone well, and encouraging supervisees to do the same. According to Hawkins and Smith (2006), effective supervision is able to create a shift in both the therapist's awareness and their clinical practice. Finally, it is also important to acknowledge the therapist's responsibility in both seeking out and making use of opportunities to discuss cases of non-response.

Burnout

In light of the strong emotions evoked as a result of client non-response, it is pertinent to consider the issue of burnout among therapists. As previously discussed, burnout is most commonly defined by the following three dimensions: emotional exhaustion, depersonalisation, and reduced personal accomplishment. Following a comprehensive review of the available literature discussing strategies for preventing burnout, Morse and colleagues (2012) concluded that the issue of burnout continues to be a significant concern within the mental health profession, both in its prevalence and the associated problems for the individual members of staff, the organisations that employ them, and the service users. Despite the authors concerns about the limited studies and their methodological issues, the review was able to draw together a number of useful strategies for reducing the risks of burnout aimed at both the individual and the organisation level.

Some of the strategies suggested by the review (e.g. increased social support, increased internal reward and an increased sense of satisfaction) are particularly relevant for the current study. For example, reduced levels of perceived social support were described by the majority of participants who felt unable to access satisfactory support from their supervisors. A lack of satisfaction from their work was also reported across participants. The moments of success felt by participants felt fleeting and unfulfilling,

overall the intervention was marked by a sense of inadequacy and failure. The stories told by participants revealed difficulties recognising and holding onto the smaller successes of the intervention.

Finally, many of the participants spoke about additional organisational challenges (e.g. increased pressures, idealistic demands and a lack of understanding regarding the impact of the work). According to Francis (2013) these pressures and demands create an environment of fear and low morale where satisfaction and compassion are likely reduced. The risks of a disengaged, isolated and burnt-out workforce are increased and there is less time to explore the personal impacts of the work. Francis suggests that a more open, transparent and candid culture of healthcare is desperately needed. This view is supported by Farber (1982) who suggests that in order to prevent or reduce the risks of burnout, professionals must feel able to express freely, negative attitudes towards their work. Using process-orientated models of supervision that encourage such conversation, alongside organizational initiatives such as The Schwartz Center programme, are recommended. The Schwartz programme attempts to foster a more open and candid environment within healthcare, where professionals are encouraged to speak honestly about the social and emotional strains of the profession (Lown & Manning, 2010). The rationale is that healthcare professionals are able to provide improved care and outcomes when they have a greater understanding of their own experiences.

Further research

Given the lack of research studies on client non-response, one can assert that the most important starting point for future research is to consider this phenomenon as a topic worthy of further exploration. While this study illustrated a potentially novel process through which the therapist experience of client non-response to therapy may be understood, it also brought to light a number of areas which may warrant further research. Further research may wish to establish whether the findings of this study are commonly experienced. An increased understanding of the experience of negative therapy outcomes will complement the limited non-response literature which focuses on methods or strategies for reducing negative outcomes. This literature is very useful however it implies that negative outcomes are to be prevented rather than accepted. This is problematic because even in well-controlled efficacy studies client non-response is common and inevitable. An increased exploration into those times when therapy

does not produce change will tell us a great deal about the experience of therapy and change.

Participants' difficulties talking about their experience of client non-response in supervision was a significant finding. The current study gathered only basic information about the model of supervision received by the therapist and how this may have impacted their experience. Some participants reported more satisfying experiences during supervision and felt better able to access the support available to them. Given the crucial role of clinical supervision it would be helpful to learn more about supervisor orientation and styles that provide greater support during therapist experiences of non-response. This may be different in different services e.g. IAPT. A research focus on the decisions about self-disclosure in supervision and whether supervision can mitigate the challenging experience of non-response would expand the current findings.

Another area worthy of further investigation is the participant's use of self-protective attribution using the Free Association Narrative Interview (FANI) (Hollway & Jefferson, 2008). The FANI methodology is guided by psychoanalytic principles of free association and is designed to elicit specific events laden with emotional meaning. In the current study each participant spoke about one specific and memorable client. This was a client who had challenged them in specific ways and evoked emotion in them that other clients had not. Unlike IPA, the FANI method views participants as defended subjects and uses psychoanalytic principles to explicitly explore the anxieties and defences that affect participants' recollection and meaning of events or memories. The FANI method is particularly useful for exploring emotionally-charged and identity-based issues. FANI researchers are psychoanalytically trained and can therefore gather an understanding of the unconscious processes that influence the therapist experience of non-response.

Conclusions

This study explored the therapist experience of client non-response, a previously under-researched topic. From the therapist account of their experience of non-response, a group journey emerged spanning the intervention and beyond. Therapists described a complex and challenging experience that endured over time and impacted negatively on the therapist's wellbeing and sense of identity. Difficulties defining non-response were

evident and were influenced by the therapist's emotional state and mean-making efforts. This is perhaps unsurprising given the complexities associated with defining therapy outcomes. Internal and external demands greatly influenced the therapist experience and reduced their ability to access helpful coping strategies (e.g. supervision).

The findings suggest that therapists may experience client non-response as a personal failure. We know that defining, measuring and achieving change in therapy is highly complex. The therapy outcome literature discusses the complex phenomena of client change and suggests a range of necessary mechanisms for change, including therapist, client, relationship, and systemic factors. In addition, questions remain regarding the methods of measuring client change, when it should be measured, and by whom. Given the lack of literature discussing non-response, a thorough understanding of the complex process and the associated experience remains limited. Consequently, the findings of the current study highlight the dangers of therapists assuming heightened levels of personal responsibility, not accessing appropriate support and using less helpful explanations for why some clients do not improve with therapy. Therapists may be unaware and alert to their responses and it is important that we continue to find ways that enable therapists to remain reflective and resilient throughout particularly challenging pieces of therapeutic work.

Final thoughts

As outlined in the reflexive email, my interest in the topic started with my own experiences of providing therapy to a client that did not improve. The experience was challenging and consequently I wanted to make sense of my experience by learning about the experiences of others. Like my participants I felt vulnerable and feared judgment from others about my competence and ability. As therapists, we rely on and in a sense, expect our clients to be vulnerable in a therapy room. This study has made me more aware of the times I expect clients to do something that I have felt uncomfortable doing. Striving to understand difficult experiences is anxiety provoking, exposing but also fruitful. I have experienced first-hand the value of engaging with a challenging topic, opening up and being honest. Hearing the stories of my participants has inspired a more open and transparent approach to my work.

ABBREVIATIONS

- ACT: Acceptance Commitment Therapy
- BAI: Beck Anxiety Inventory
- BDI: Beck Depression Inventory
- CBT: Cognitive Behavioural Therapy
- CAMHS: Child and Adult Mental Health Services
- CEM: Corrective Experience Model
- CFS: Chronic Fatigue Syndrome
- CORE-34: Clinical Outcome Routine Evaluation (34 item version)
- CMHT: Community Mental Health Team
- DA: Discourse Analysis
- EMDR: Eye Movement Desensitisation and Reprocessing
- FANI: Free Association Narrative Interview
- GBH: Grievous Bodily Harm
- GP: General Practitioner
- GT: Grounded Theory
- IAPT: Improving Access to Psychological Therapies
- IPA: Interpretative Phenomenological Analysis
- MDT: Multi-Disciplinary Team
- NHS: National Health Service
- PTSD: Post-Traumatic Stress Disorder
- REBT: Rational Emotive Behavioural Therapy
- RCI: Reliable Change Index
- RCT: Randomised Clinical Trial
- SMART: Specific Measurable Achievable Realistic Timely
- OCD: Obsessive Compulsive Disorder

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APPENDICES

Appendix 1: Reflexive email.

Hi supervisors

I just wanted to let you both know that I left supervision this morning feeling a little stirred up. I do have my own experience of working with a client who did not get better and it was a really challenging experience for me. It was during my first placement and I found the situation very difficult. I felt extremely sad, powerless, isolated and disheartened by the profession and my role within it. I even considered leaving the course. I felt like I was just another person who had let this client and her family down. I was sickened by the injustice she had experienced throughout her life and I felt like the intervention I had provided was yet another injustice. I felt guilty for the privilege of never having to endure such cruel life events, narcissistic for thinking I could help and self-indulgent for even considering my own feelings. The thought of more experiences like this one fills me with dread and I have noticed that I have actively sought out placements with less of an emphasis on providing therapy.

When you asked me this morning about my experience, it caught me off guard. I am curious and enthusiastic to understand my experience and the experiences of others, however, at the time there didn't appear to be any time or space to think about my own feelings, and it felt easier to put my defenses up and move on. The responses I did receive only perpetuated the difficult feelings I had. I do not think I have really come to understand my own experience. Perhaps, I have unconsciously detached from my thesis topic, so I don't have to think about how I felt. Subsequently, I have wanted to view the thesis as just another academic piece of work, another box to tick....but maybe it is much more than that. The course constantly encourages us to put ourselves under a microscope and I find this very overwhelming. I suppose I was hoping that the thesis would not require me to do the same thing –silly me!

On a positive note my learning point is this...I am aware that when I feel overwhelmed I tend to withdraw and shut down....instead of using my energy to avoid thinking about difficult topics, I will try to use my energy to actively think and make sense of these topics, in the hope that they can become less difficult and I can understand them more. My own tricky experiences are a good place to start.

Thanks for the meeting, I appreciate the guidance.

Sophie

Appendix 2: Opt In Email.

Research Study: Therapists' experience of clients who do not improve with therapy

Researcher: Sophie Hopper

Supervised by: Dr Carol Martin & Dr Ciara Masterson

My name is Sophie Hopper and I am in the second year of the Doctorate in Clinical Psychology programme at the University of Leeds. I am trying to recruit participants for my DCLin project. I am interested in the therapist experience of providing an intervention to clients who do not improve. My literature review has identified a lack of research into both the client and therapist experience of a lack of change as a therapy outcome. This is surprising given the finding that approximately one third of clients do not improve with therapy.

The study focus is on subjective experience and how individuals make sense of such experience. Given this, I will use interpretative phenomenological analysis (IPA) to analyse the findings. It is hoped that the study aims will help further the understanding of the therapist experience and client non-response - this is particularly useful given findings that suggest the experience of a lack of change is common.

Taking part in the study would involve meeting with me for an interview. The interview would be at a location that is convenient for you and would normally last about an hour. If you wish there is also have an optional shorter follow-up interview (approximately 2 weeks after the initial interview) lasting 45 minutes. The follow-up interview is designed to allow for further reflection and clarification.

Your participation can make a difference to therapeutic and service practices - In particular, it might result in recommendations for countering a loss of confidence, excessive self-criticism and burnout in psychological therapists.

Should you require more details about the study or wish to participate, please contact me at this email address.

Warm regards,

Sophie Hopper

Psychologist in Clinical Training

University of Leeds



Appendix 3: Participant Information Sheet.

Research study: Therapists' experience of clients who do not improve with therapy

Lead researcher – Sophie Hopper

I would like to invite you to take part in a study exploring the therapist experience of clients who do not improve with therapy. Before you make a decision, I would like to take the opportunity to explain why the research is important and what your participation will involve. Please take the time to read the following information and discuss it with others if you wish.

Who is conducting the study?

The study is being conducted by Sophie Hopper (current second year psychologist in clinical training at the University of Leeds). The research is a doctoral thesis and part of the academic course requirements.

What is the background information and purpose of the study?

Despite the findings that the majority of clients make psychological gains following psychotherapy, there remains a sizeable proportion of clients (approximately one third) who report no gains. Therefore, the experience of providing a therapy to a client who does not improve is common. Despite the prevalence, little research attention is paid to this group of clients. At present, there is also very little research exploring the therapist experience of therapy, regardless of the outcome. This study aims to address the gap by exploring therapists' experiences of providing therapy to clients who do not improve in order to further our knowledge of the experience, particularly how clinicians understand and manage the situation. The therapist experience of client non-response is the focus

of the study, but it may also help to develop our understanding of the concept of meaningful change, which has a range of service and research implications.

Why have I been chosen?

Participants are invited to take part by virtue of their professional role and employment within the NHS. You have been chosen as you fit the criteria of being a psychological therapist or clinical psychologist who provides one-to-one psychological therapy to adults in a consulting room. These criteria were selected as most of the literature on therapy outcomes has been conducted within these settings.

Do I have to take part?

Participation in the study is voluntary. If you do decide to participate, you will be given an information sheet and asked to sign a consent form. You may give consent to interview and then change your mind, or be interviewed but then ask to have your information partially or fully removed from the analysis. Following an interview, if you are concerned about some of the content of the interview I will discuss the following options of partial or full withdrawal from the study:

- Not using specified material in the report as quotes
- Withdrawal of segments of transcript from analysis
- Withdrawal of the recording before transcription starts

In either case, you do not have to justify or explain decisions regarding part or full withdrawal from the study. Please be aware that following an interview there will be a limited period of 1 week for participants to withdraw partial/full consent. After 1 week, transcribing will begin and withdrawal will no longer be possible. .

What would taking part involve?

Potential participants are invited to review their completed caseload and select clients to discuss during one semi-structured interview that is anticipated to take 60 minutes. The clients you select must fulfil the criteria of someone who did not improve with therapy -

in order to discuss in detail your experience of providing an intervention to a client who did not improve. It is important that you review the case data prior to the interview so you are familiar with the client you have chosen to discuss. During the interview, you may use materials as prompts such as your diary, outcomes measures, case notes etc.

Interviews can be conducted at a place of your convenience. Any travel expenses will be reimbursed. Interviews will be audio recorded and anonymously transcribed – participants will be asked to choose a pseudonym that will be used in subsequent analysis and reports. Any personal details or information provided during the interview will be removed from subsequent transcripts and reports.

At the end of the first interview participants will be asked whether they would like to take part in an optional shorter follow-up interview (approximately 45 minutes). The optional second interview intends to give participants and the researcher the time to reflect and the opportunity to clarify some of the content from the first interview. If you would like a follow up interview, it will take place approximately 2 weeks after the initial interview. Participants are NOT obliged to take part in the follow-up interview - it is offered as a supplement to the initial interview.

What are the ethical issues involved?

Data will be stored on an encrypted memory stick and stored on the university's password protected server. Both the recording and transcript will be securely stored. Once the study is written up, the audio recordings will be deleted and the transcripts will be kept securely by the University for three years. You can still take part in the study if you do not agree to your information being stored for future research.

Your participation in the study and all the information you provide will be kept strictly confidential, except in the unlikely case of a disclosure of gross professional misconduct when the appropriate NHS and professional authorities would be informed.

Transcriptions will be anonymised and the pseudonym identified by participants during the interview will be used. If third party information is disclosed during the interview, which makes a client or another member of staff identifiable this will be kept confidential and unidentifiable quotes will be used in the final report. The transcribers will comply with the university's confidentiality contract.

It is unlikely that the interviews will cause significant distress. However, it is important to acknowledge that exploring the therapist experience of clients who do not improve may involve aspects of uncomfortable reflection. Participants will be experienced in managing their own levels of discomfort and it is unlikely that the participant will not be able to manage the interview topics. Other options that I might use in addition will include short breaks and as a last resort a re-arranged interview date.

What will happen to the results of the research study?

The study will be written up into a doctoral thesis. There is also the potential for academic papers and conference presentations as a result. It is hopeful that your contribution to this study will have benefits for psychological services and the wider theory base. If you wish to receive a summary of the findings please ensure that you tick the relevant box on the consent form and leave your preferred email address.

Thank you for taking the time to read this information sheet. I look forward to hearing from you.

Contact details

If you wish to take part or find out any further information about the study, you can contact

Sophie Hopper by e-mail:

umsho@leeds.ac.uk, or at the following address:

Clinical Psychology Training Programme

Leeds Institute of Health Sciences

University of Leeds

Room G.04

Charles Thackrah Building

101 Clarendon Road

Leeds

LS2 9LJ

(01133 432732)

Supervised by:

Dr Carol Martin (c.martin@leeds.ac.uk)

Dr Ciara Masterson (c.masterson@leeds.ac.uk).

(Address and phone number as above)

If you decide to take part, and then have any concerns or complaints about your experience of taking part, you can speak to me in the first instance. I will do my best to address the issue. If you wish to complain more formally, you can do this by contacting Clare Skinner by e-mail: governance-ethics@leeds.ac.uk or at the following address:

Faculty of Medicine & Health Research Office

Room 10.110, Level 10

Worsley Building

Clarendon Way

University of Leeds

Clarendon Road

Leeds

LS2 9NL

(01133434897)

Appendix 4: Participant Consent Form.

Clinical Psychology Training Programme

Leeds Institute of Health Sciences

University of Leeds

Room G.04

Charles Thackrah Building

101 Clarendon Road

Leeds

LS2 9LJ

Research Project: Therapists' experience of providing therapy to clients who do not improve

Lead Researcher - Sophie Hopper

Supervisors – Dr Carol Martin & Dr Ciara Masterson

The purpose of this form is to establish whether you have been given sufficient information about the above research project and understand what is involved if you decide to take part. Please read the statements and tick the applicable boxes.

I confirm that I have read the information sheet (Version 1 - dated 18/07/2014) and had a chance to ask any questions.	
I give my consent for the interview to be audio-recorded.	
I understand that my interview material will be kept confidential (research supervisors will see only anonymised responses as part of research quality).	

I give consent for anonymised extracts of the interview to be used in the subsequent write up.	
I understand that after an interview there will be a limited period of time (1 week) in which participants may withdraw partial/full consent.	
I would like a summary of the findings emailed to the following address.....	
I agree to take part in the above research project.	

Please sign and date on the back of this form

Name of participant:	Date:	Signed:
Name of Researcher:	Date:	Signed:

Appendix 5: Interview Schedule.

Introduction

My name is Sophie and I am a third year trainee. Firstly, I would like to thank you for your interest and participation in the research project. My interest in this topic began with my own experiences of providing therapy to clients who did not improve. My interest led me to research findings that suggest approximately a third of clients do not improve with therapy – therefore I started to realise that the experience of providing therapy to a client who do not improve is common. Currently, there appears to be minimal organised support or guidance to therapists who experience a lack of client change as a therapy outcome. Subsequently, I am keen to hear about the subjective experience of fellow clinicians, particularly how you make sense of the experience and manage any subsequent impacts. I am interested in hearing about your subjective experience; therefore, there are no right or wrong answers.

Pen portrait information

1. Overview of the type of work you do
2. Typically presentation of the clients you see
3. What attracted you to this study?
4. How do you define meaningful change in your clinical work?
5. There are many ways to measure client change, which one do you feel is most helpful for your clinical work?

Main questions

1. Can you tell me about a time you have provided a psychological intervention to a client who did not improve?
 - *At what point did you realise that the intervention was not helping? How did you know that the client had not improved? I am interested in hearing more about that process..*
2. Tell me what you were thinking and feeling during the time you worked with them?

3. Did you decide to do anything different or ‘out of the ordinary’ to your regular practice? What did you do? If no, did you consider doing anything differently?
4. How did you use supervision or other colleagues at this time?
5. Once the work with this client ended, how did you manage the situation?
6. What do you think the personal impact of this experience was? (ST/LT)

On reflection, what sense do you make of the experience now?

7. What is your understanding of the way you felt/responded?
8. What did you learn? Prompt - (about yourself/ particular client/therapy)
9. Looking back, is there anything you wish you could have done differently?
10. What do you think may have led to the client not improving?
11. Research claims that approximately a third of clients do not improve with therapy – what kinds of thoughts/feelings do you have in response to this statistic?

Finally, I am curious to hear why you decided to speak about these particular clients?

Cool down

- Opportunity to say anything that they did not get the chance to say.
- Check-in with them regarding the experience of the interview.
- Re-visit consent and re-iterate the 1-week limit regarding the decision to omit or revise the content.
- Discuss the opportunity for a follow-up interview following an opportunity to reflect.
- Thank participant

Please note

A topic guide will be generated for the second interview based on the content of the initial interview.

Appendix 6: Ethical Approval.



UNIVERSITY OF LEEDS

Faculty of Medicine and Health Research Office
School of Medicine Research Ethics Committee (SoMREC)

Room 10.110, level 10
Worsley Building
Clarendon Way
Leeds, LS2 9NL
United Kingdom

☎ +44 (0) 113 343 4361

28 July 2014

Miss Sophie Hopper
Psychologist in Clinical Training
Clinical Psychology Training Programme
Leeds Institute of Health Sciences
Charles Thackrah Building
101 Clarendon Road
University of Leeds
Leeds, LS2 9LJ

Dear Sophie

Ref no: SoMREC/13/106

Title: Therapists' experience of providing therapy to clients who do not improve: An IPA investigation

Your research application has been reviewed by the School of Medicine Ethics Committee (SoMREC) and we can confirm that ethics approval is granted based on the documentation received at the date of this letter and subject to the following condition(s):

- **Trust R&D approval must be obtained prior to commencement of the research and confirmation of this approval sent to this committee once obtained**

<i>Document</i>	<i>Version</i>	<i>Date Submitted</i>
Ethical_Review_Thesis Version 1	1	21/07/14
Interview schedule Version 1	1	21/07/14
Participant consent form Version 1	1	21/07/14
Participant information sheet Version 1	1	21/07/14
Thesis email invite version 1	1	21/07/14

Please notify the committee if you intend to make any amendments to the original research ethics application or documentation. All changes must receive ethics approval prior to implementation. Please contact the Faculty Research Ethics Administrator for further information (fmhuniethics@leeds.ac.uk)

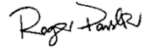
Ethics approval does not infer you have the right of access to any member of staff or student or documents and the premises of the University of Leeds. Nor does it imply any right of access to the premises of any other organisation, including clinical areas. The committee takes no responsibility for you gaining access to staff, students and/or premises prior to, during or following your research activities.

Please note: You are expected to keep a record of all your approved documentation, as well as documents such as sample consent forms, and other documents relating to the study. This should be kept in your study file, which should be readily available for audit purposes. You will be given a two week notice period if your project is to be audited.

It is our policy to remind everyone that it is your responsibility to comply with Health and Safety, Data Protection and any other legal and/or professional guidelines there may be.

We wish you every success with the project.


Yours sincerely

A handwritten signature in black ink, appearing to read 'Roger Parslow'.

Dr Roger Parslow
Chair, SoMREC, University of Leeds

Appendix 7: SWYPT R & D Approval Letter.



South West Yorkshire Partnership 
NHS Foundation Trust

10th November 2014

Ms Sophie Hopper
Psychologist in Clinical Training
The University of Leeds
Charles Thackrah Building
101 Clarendon Road
Leeds
Ls2 9LJ

**Research & Development
Ward 2,
Castleford, Normanton & District Hospital
Lumley Street,
Castleford, WF10 5LT**

**Tel: 01977 605285
Fax: 01977 605298
Email: research@swyt.nhs.uk**

Dear Ms Hopper

Re: Therapists Experience of Providing Therapeutic Interventions to Clients who Do Not Improve: An IPA Investigation

Following the recent review of the above project I am pleased to inform you that the above project complies with Research Governance standards, and NHS Permission has been granted on behalf of Trust management. We now have all the relevant documentation relating to the above project. As such your project may now begin within South West Yorkshire NHS Foundation Trust.

The final list of documents reviewed and approved is as follows:

Document	Version	Date
Protocol	1	1 October 2014
University of Leeds School of Medicine Research Ethics		28 July 2014
Interview Schedule	1	21 July 2014
Email Invitation	1	18 July 2014
Consent Form	1	13 November 2014
Information Sheet	1	18 July 2014
Evidence of Insurance		September 2014
CVs – Sophie Hopper and Academic Supervisors Dr Carol Martin and Dr Ciara Masterson		1 October 2014

This approval is granted subject to the following conditions:

- You must comply with the terms of your approval. Failure to do this will lead to permission to carry out this project being withdrawn. If you make any substantive changes to your protocol you must inform us immediately.
- You must comply with the procedures on project monitoring and audit¹.
- You must comply with the guidelines laid out in the Research Governance Framework for Health and Social Care²(RGF). Failure to do this could lead to permission to carry out this research being withdrawn.

Chair: Ian Black Chief Executive: Steven Michael OBE



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With all of us in mind

- You must comply with any other relevant guidelines including the Data Protection Act, The Health and Safety Act and local Trust Policies and Guidelines.
- If you encounter any problems during your research you must inform your Sponsor and us immediately to seek appropriate advice or assistance.
- Research projects will be added to any formal Department of Health research register.

Please note that suspected misconduct or fraud should be reported, in the first instance, to local Counter Fraud Specialists for this Trust. R&D staff are also mandated to do this in line with requirements of the RGF.

Adverse incidents relating to the research procedures and/or SUSARs (suspected unexpected serious adverse reactions) should be reported, in line with the protocol requirements, using **Trust incident reporting procedures in the first instance and to the chief investigator³**.

They should **also** be reported to:

- The R&D Department
- the Research Ethics Committee that gave approval for the study (if applicable)
- other related regulatory bodies as appropriate.

You are required to ensure that all information regarding patients or staff remains secure and *strictly confidential* at all times. You must ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice (<http://www.dh.gov.uk/assetRoot/04/06/92/54/04069254.pdf>) and the Data Protection Act 1998. Furthermore you should be aware that under the Act, unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.

Changes to the agreed documents MUST be approved by in line with guidance from the Integrated Research Applications System (IRAS), before any changes in documents can be implemented. Details of changes and copies of revised documents, with appropriate version control, must be provided to the R&D Office. Advice on how to undertake this process can be obtained from R&D.

Projects sponsored by organisations other than the Trusts are reminded of those organisations obligations as defined in the Research Governance Framework, and the requirements to inform all organisations of any non-compliance with that framework or other relevant regulations discovered during the course of the research project.

The research sponsor or the Chief Investigator, or the local Principal Investigator, may take appropriate urgent safety measures in order to protect research participants against any immediate hazard to their health or safety.

² Details from:

http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4108962&chk=Wde1Tv

³ SUSARS – this must be within 24 hours of the discovery of the SUSAR incident

Chair: Ian Black Chief Executive: Steven Michael OBE





With all of us in mind

South West Yorkshire Partnership 
NHS Foundation Trust

The R&D office should be notified that such measures have been taken. The notification should also include the reasons why the measures were taken and the plan for further action.

Note that NHS indemnities only apply within the limitations of the protocol, and the duties undertaken therewith, by research staff with substantive or honorary research contracts with this Trust.

Once you have finished your research you will be required to complete a Project Outcome form. This will be sent to you nearer the end date of your project (Please inform us if the expected end date of your project changes for any reason).

We will require a copy of your final report/peer reviewed papers or any other publications relating to this research. Finally we may also request that you provide us with written information relating to your work for dissemination to a variety of audiences including service users and carers, members of staff and members of the general public. You must provide this information on request.

If you have any queries during your research please contact us at any time.

May I take this opportunity to wish you well with the project.

Yours sincerely

Dr Adrian Berry
Medical Director


Chair: Ian Black Chief Executive: Steven Michael OBE



Appendix 8: Letter of Access.



With all of us in mind

South West Yorkshire Partnership 
NHS Foundation Trust

10th November 2014

Ms Sophie Hopper
Psychologist in Clinical Training
The University of Leeds
Charles Thackrah Building
101 Clarendon Road
Leeds
LS2 9LJ

Research Department
Ward 2
Castleford & Normanton District Hospital
Lumley Street
Castleford
WF10 5LT

Tel: 01977 605285
Fax: 01977 605298

Email address: research@swyt.nhs.uk

Dear Ms Hopper

Re: Therapists Experience of Providing Therapeutic Interventions to Clients who Do Not Improve: An IPA Investigation

This letter should be presented to each participating organisation before you commence your research at that site: South West Yorkshire Partnership NHS Foundation Trust.

In accepting this letter, each participating organisation confirms your right of access to conduct research through their organisation for the purpose and on the terms and conditions set out below. This right of access commences on 10th November 2014 and ends on 31 July 2015 unless terminated earlier in accordance with the clauses below.

As an existing NHS employee you do not require an additional honorary research contract with the participating organisation. The organisation is satisfied that the research activities that you will undertake in the organisation are commensurate with the activities you undertake for your employer. Your employer is fully responsible for ensuring such checks as are necessary have been carried out. Your employer has confirmed in writing to this organisation that the necessary pre-engagement checks are in place in accordance with the role you plan to carry out in the organisation. Evidence of checks should be available on request to South West Yorkshire Partnership NHS Foundation Trust.

You have a right of access to conduct such research as confirmed in writing in the letter of permission for research from this organisation. Please note that you cannot start the research until the Principal Investigator for the research project has received a letter from us giving the organisation permission to conduct the project.

You are considered to be a legal visitor to South West Yorkshire Partnership NHS Foundation Trust premises. You are not entitled to any form of payment or access to other benefits provided by South West Yorkshire Partnership NHS Foundation Trust or this organisation to employees and this letter does not give rise to any other relationship between you and South West Yorkshire Partnership NHS Foundation Trust or this organisation, in particular that of an employee.

While undertaking research through South West Yorkshire Partnership NHS Foundation Trust, you will remain accountable to your employer but you are required to follow the

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reasonable instructions of your nominated managers (Dr Peter Spencer) in this organisation or those given on their behalf in relation to the terms of this right of access.

Where any third party claim is made, whether or not legal proceedings are issued, arising out of or in connection with your right of access, you are required to co-operate fully with any investigation by South West Yorkshire Partnership NHS Foundation Trust or this organisation in connection with any such claim and to give all such assistance as may reasonably be required regarding the conduct of any legal proceedings.

You must act in accordance with South West Yorkshire Partnership NHS Foundation Trust policies and procedures, which are available to you upon request, and the Research Governance Framework.

You are required to co-operate with South West Yorkshire Partnership NHS Foundation Trust in discharging its duties under the Health and Safety at Work etc Act 1974 and other health and safety legislation and to take reasonable care for the health and safety of yourself and others while on South West Yorkshire Partnership NHS Foundation Trust premises. Although you are not a contract holder, you must observe the same standards of care and propriety in dealing with patients, staff, visitors, equipment and premises as is expected of a contract holder and you must act appropriately, responsibly and professionally at all times.

If you have a physical or mental health condition or disability which may affect your research role and which might require special adjustments to your role, if you have not already done so, you must notify your employer and each participating South West Yorkshire Partnership NHS Foundation Trust prior to commencing your research role at each site.

You are required to ensure that all information regarding patients or staff remains secure and *strictly confidential* at all times. You must ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice and the Data Protection Act 1998. Furthermore you should be aware that under the Act, unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.

The organisation will not indemnify you against any liability incurred as a result of any breach of confidentiality or breach of the Data Protection Act 1998. Any breach of the Data Protection Act 1998 may result in legal action against you and/or your substantive employer.

You should ensure that, where you are issued with an identity or security card, a bleep number, email or library account, keys or protective clothing, these are returned upon termination of this arrangement. Please also ensure that while on the premises you wear your ID badge at all times, or are able to prove your identity if challenged. Please note that the organisation accept no responsibility for damage to or loss of personal property.

This letter may be revoked and your right to attend the organisation terminated at any time either by giving seven days' written notice to you or immediately without any notice if you are in breach of any of the terms or conditions described in this letter or if you commit any act that we reasonably consider to amount to serious misconduct or to be disruptive and/or prejudicial to the interests and/or business of the organisation or if you are convicted of any criminal offence. You must not undertake regulated activity if you are barred from such

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work. If you are barred from working with adults or children this letter of access is immediately terminated. Your employer will immediately withdraw you from undertaking this or any other regulated activity and you MUST stop undertaking any regulated activity immediately.

Your substantive employer is responsible for your conduct during this research project and may in the circumstances described above instigate disciplinary action against you.

If your circumstances change in relation to your health, criminal record, professional registration or suitability to work with adults or children, or any other aspect that may impact on your suitability to conduct research, or your role in research changes, you must inform the organisation that employs you through its normal procedures. You must also inform the nominated manager in each participating organisation.

Yours sincerely

Lubena Mirza
Research Co-ordinator

Chair: Ian Black Chief Executive: Steven Michael OBE



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Appendix 9: LYPFT R & D Letter of Approval.



Leeds and York Partnership 
NHS Foundation Trust

Our Ref: 2014/531/L

Research & Development
St Mary's House
St Mary's Road
Leeds LS7 3JX
E-mail: sinead.laudsley@nhs.net
Direct Line: 0113 295 2387
FAX: 0113 2954466

Ms Sophie Hopper
University of Leeds
Charles Thackrah Building
Clarendon Road
Leeds
LS2 9LJ

09/10/2014

Dear Ms Hopper

Project Title: Therapist experience of providing therapeutic interventions to clients who do not improve: An IPA investigation

Following the recent review of the above project I am pleased to inform you that the above project complies with Research Governance standards, and NHS Permission has been granted on behalf of Trust management. We now have all the relevant documentation relating to the above project. As such your project may now begin within Leeds and York Partnership NHS Foundation Trust.

The final list of documents reviewed and approved is as follows:

Document	Version	Date
Protocol		1/10/2014
Interview Schedule	1	21/7/2014
Participant Consent Form	1	18/7/2014
Participant Information sheet	1	18/7/2014
REC Approval Letter		28/7/2014
Email Invite	1	18/7/2014

This approval is granted subject to the following conditions:

- You must comply with the terms of your ethical approval (where applicable) Failure to do this will lead to permission to carry out this project being withdrawn. If you make any substantive changes to your protocol you must inform the relevant ethics committee and us immediately.
- You must comply with the Trust's procedures on project monitoring and audit.

improving health, improving lives 

- You must comply with the guidelines laid out in the Research Governance Framework for Health and Social Care (RGF). Failure to do this could lead to permission to carry out this research being withdrawn.
- You must comply with any other relevant guidelines including the Data Protection Act, The Health and Safety Act and local Trust Policies and Guidelines.
- If you encounter any problems during your research you must inform your Sponsor and us immediately to seek appropriate advice or assistance.

Please note that suspected misconduct or fraud should be reported, in the first instance, to local Counter Fraud Specialists for this Trust. R&D staff are also mandated to do this in line with requirements of the RGF.

Adverse incidents relating to the research procedures and/or SUSARs (suspected unexpected serious adverse reactions) should be reported, in line with the protocol requirements, using **Trust incident reporting procedures in the first instance and to the chief investigator.** They should also be reported to:

- The R&D Department
- the Research Ethics Committee that gave approval for the study
- other related regulatory bodies as appropriate.

You are required to ensure that all information regarding patients or staff remains secure and *strictly confidential* at all times. You must ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice (<http://www.dh.gov.uk/assetRoot/04/06/92/54/04069254.pdf>) and the Data Protection Act 1998. Furthermore you should be aware that under the Act, unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.

Any changes to the study must be approved before any changes can be implemented. Details of changes and copies of revised documents, with appropriate version control, must be provided to the R&D Office. Advice on how to undertake this process can be obtained from R&D. Changes to the local study team should also be notified to R&D.

Projects sponsored by organisations other than the Trust are reminded of those organisations' obligations as defined in the Research Governance Framework, and the requirements to inform all organisations of any non-compliance with that framework or other relevant regulations discovered during the course of the research project.

The research sponsor or the Chief Investigator, or the local Principal Investigator, may take appropriate urgent safety measures in order to protect research participants against any immediate hazard to their health or safety.

The R&D office should be notified that such measures have been taken. The notification should also include the reasons why the measures were taken and the plan for further action.

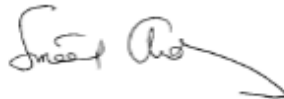
The R&D Office should be notified within the same time frame of notifying the REC and any other regulatory bodies.

Note that NHS indemnities only apply within the limitations of the protocol, and the duties undertaken therewith, by research staff with substantive or honorary research contracts with this Trust.

Once you have finished your research you will be required to complete a Project Outcome form. This will be sent to you nearer the end date of your project (Please inform us if the expected end date of your project changes for any reason). We will require a copy of your final report/peer reviewed papers or any other publications relating to this research. Finally we may also request that you provide us with written information relating to your work for dissemination to a variety of audiences including service users and carers, members of staff and members of the general public. You must provide this information on request.

If you have any queries during your research please contact us at any time. May I take this opportunity to wish you well with the project.

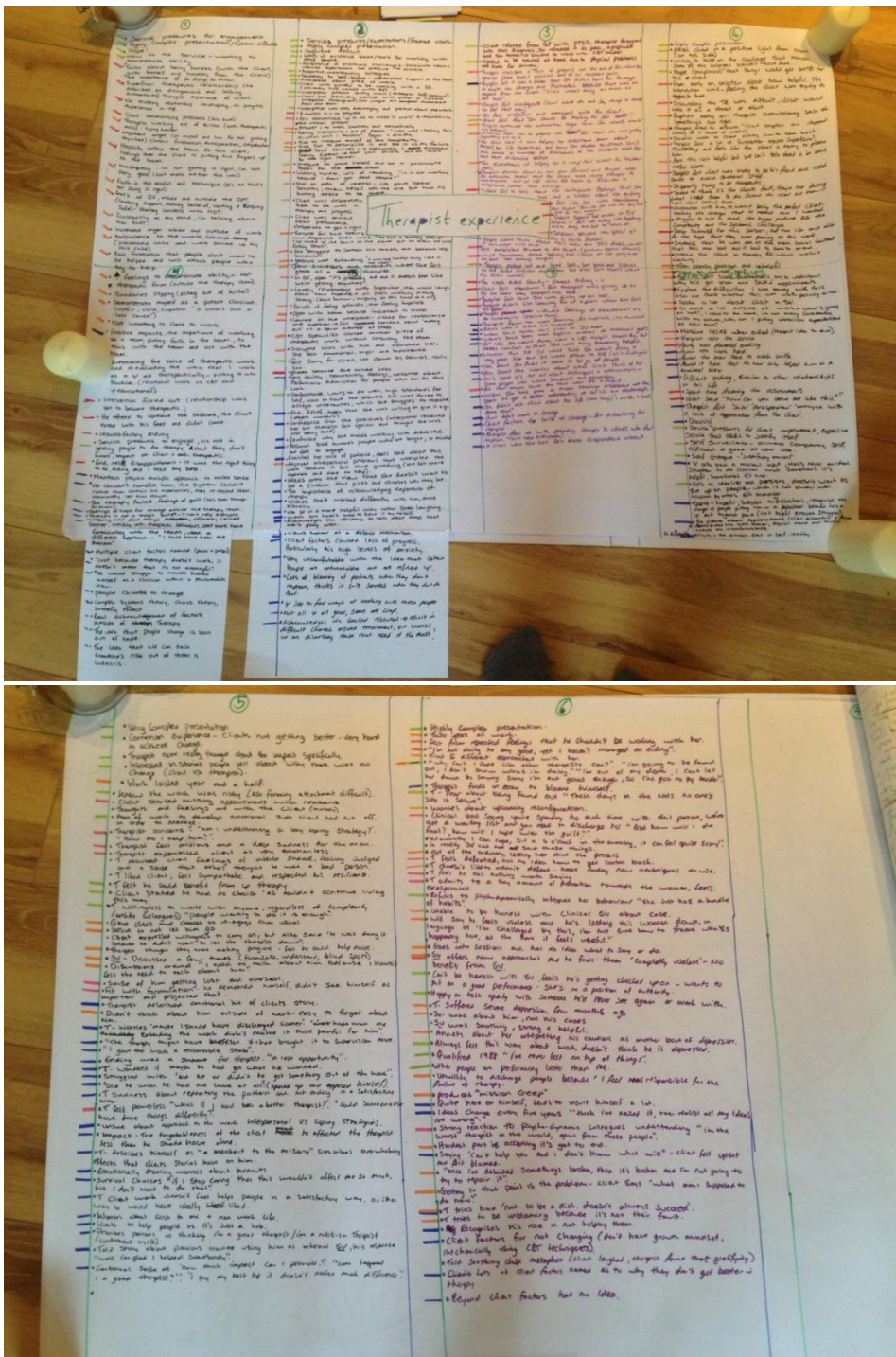
Yours sincerely

A handwritten signature in black ink, appearing to read 'Sinead Audsley', with a long horizontal flourish extending to the right.

Sinead Audsley
Research Governance Manager

cc: Dr Carol Martin, University of Leeds
Dr Jayne Hawkins, LYPFT
Claire Skinner, University Of Leeds

Appendix 10: Searching for master themes across cases.



Appendix 11: Section of individual coded transcript.

F: He kept going psych doctor, it's doctor [mumbling unsure of sentence] and that seemed to be his initial focus so I was like yeah tick the relationship seems to be working fine, but then when we actually started to do the work and we had and interpreter present and which is an additional issue I think when it's not working well because you're really conscious of what that person thinks as [well].

So this guy had worked with a number of other psychologists so I knew she'd be present at all of these different appointments and during the different therapy. So I was kind of like comparing myself to my idea of what previous therapies might have achieved as well and finding that a little bit threatening. So initially she was very encouraging to me and said your relationship seems to be going very [well], and it was probably, wasn't until about three months in perhaps that he didn't seem to be retaining any of the information and that was really the whole point in the intervention so that he was able to present some kind of coherent explanation of why he'd actually come into the service and what he needed to do to actually move out again, but he couldn't seem to hold onto it.

F: I think at times it felt quite demoralising and I think it was quite different in a setting like that I mean I've just come here and working in the community and there's a lot of screening and assessment's to see if someone is suitable for psychology and in that setting you need to work with who you've got really. I didn't have the luxury of saying you're not suitable for psychology because he needs that work to be able to move on and without it he will get stuck at high secure level. So really no matter how challenging someone was, you'd work with them and that was the expectation. So I think the oneness is on you to find a way around the problems and a way of making it work, so you end up taking more responsibility because this is the person's opportunity and chance to move on and this is a chance for me to make it successful.

F: Yeah I think it is a certain amount of pressure. So I think it's more of an internal pressure than an external pressure. I think you think you need to work creatively and

Comment [SH1]: Him revering her was seen as a sign of a good TR?

Comment [SH2]: Feeling watched, judged, her opinion is important...added pressure...worried about not doing well, being criticised?

Comment [SH3]: Fearing how she would compare with other psychs...fearing criticism, threatening – client had lots of previous work and not achieved the aims – realistic? What is repeatedly going wrong

Comment [SH4]: Threatened, fearing criticism

Comment [SH5]: Implies that she became less encouraging

Comment [SH6]: Realisation that it wasn't going well...client factors stated undermining the aims of therapy

Comment [SH7]: Therapy aims

Comment [SH8]: Crushing, detrimental – shared pain

Comment [SH9]: General context – opinion. Making comparison to current work place...trying to make sense of her experience

Comment [SH10]: Satisfying demands, pressure, expectation and responsibility

Comment [SH11]: This is my job and I need to make it work – if it doesn't it is down to me attitude..

Comment [SH12]: Putting more pressure on herself than others do

Comment [SH13]: Opinion and general context

Appendix 12: The rescuer, persecutor and victim roles.

Rescuer role	Persecutor role	Victim role
Rescues when does not really want to	Blames/criticises	Feels victimised, oppressed, helpless, hopeless, powerless, and ashamed
Feels guilty if does not rescue	Deny their vulnerability	Pretends impotence and incompetence
Places their value on what they do for others	Keeps victims oppressed	Looks for a rescuer that will perpetuate their negative feelings
Deny their needs	Rigid, authoritative stance	If remains in the victim position, will prevent self from making decisions, solving problems, pleasure and self-understanding
'Smothering' parent	'Critical' parent	'Dejected' stance

Appendix 13: Examples quotes from participants showing the different roles.

Rescuer	Persecutor	Victim
<i>'I continued to try and see him for so long' (Sol)</i>	<i>'I felt a relief that I was stopping mine and his heads banging against the wall' (Sol)</i>	<i>'It just feels like he's putting two fingers up at you all of the time' (Sol)</i>
<i>'If he had some kind of crisis going on, I felt secretly...this sounds awful but I felt secretly delighted because I could help him' (Fiona)</i>	<i>'I remember thinking this is putting him through an awful lot, at what stage do I say enough?' (Fiona)</i>	<i>'I think there are some people who will actively attack people who try to help' (Sol)</i>
<i>'I think I stayed with her longer than I would have done with any other clients that weren't making progress' (Wendy)</i>	<i>'I was so aware of how frustrated I would get with this person, and I would try and almost rein myself in at times' (Barry)</i>	<i>'She would say and do things that would make me feel quite inadequate' (Wendy)</i>
<i>'I was desperately trying to be therapeutic, to be a therapist' (Barry)</i>	<i>'There were times when he was clearly upset about some of the things I had said and didn't want to come back' (Barry)</i>	<i>'I felt very bullied by this client' (Barry)</i>
<i>'I gave him more chances to re-engage than I might have done with others' (Dave)</i>	<i>'I had a certain lack of patience that I don't think I communicated' (Fiona)</i>	<i>'I felt the emotional hit of his story' (Dave)</i>
<i>'I'm unwilling to discharge people who I should be discharging' (Fred)</i>	<i>'Maybe I should have discharged him sooner, I hope extending it in that way didn't make it more painful for him' (Dave)</i>	<i>'I don't want to make it sound like she manipulated me, but she might have' (Fred)</i>
<i>'I'm a sucker for women that cry, I hate it when women cry and I think to myself right...I'm going to have to do something now aren't I?, I'm going to have to rescue her now, damn it' (John)</i>	<i>'I said I can't help you and I don't know what will. She was upset about this and said she felt blamed, as though I was blaming her for not getting better' (Fred)</i>	<i>'I felt defeated and I had no idea how to get control back' (Fred)</i>
	<i>'She didn't say very much, you had to drag it out of her, anything you had to drag it out of her' (John)</i>	

