EXPERIENCES OF NON-IMPROVEMENT IN PSYCHOLOGICAL THERAPY: A QUALITATIVE STUDY OF CLIENT-THERAPIST DYADS

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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: Building on from the small body of research that has investigated client and therapist experiences of non-improvement in psychological therapy, this study aimed to investigate how client-therapist dyads experience therapy in which the outcome measures suggest no significant change has taken place, and explore the themes that emerge from these accounts regarding the interpersonal process of these therapies.

Method: Three client-therapist dyads from NHS secondary care psychological therapies services who ended therapy with standardised outcome measures in the 'no reliable change' range took part in semi-structured interviews about their experiences. Their accounts were transcribed and analysed using Interpretative Phenomenological Analysis (IPA).

Results: The themes of each dyad were presented in detail in the style of a case study series. The overarching theme of dyad 1 was 'a risk worth taking', which was comprised of the subthemes 'feeling safe enough to explore', 'beginning to heal the wound' and 'being left with conflicting feelings'. The overarching theme of dyad 2 was 'dipping a toe in the water', which had the subthemes 'fragile alliance', 'struggling towards collaboration' and 'ambivalence at the end'. The overarching theme of dyad 3 was 'reacting to threat', which had the subthemes 'starting with irreconcilable demands' and 'pulling away and leaning in'. From the group analysis of the three pairs, the master theme 'a mixed bag' was developed, which had the following four subthemes: 'opening up', 'closing off', 'growing' and 'struggling'.

Discussion: For the participants in this study, experiences fell on a continuum of change and non-improvement, with subjective experiences being more complex and contradictory than the outcome measures suggested. The quality of the therapeutic relationship and engagement in therapy varied across the dyads. The findings are discussed in relation to the existing research on non-improvement and theoretical literature relevant to this subject. The strengths, limitations and clinical implications of the study are considered, along with recommendations for future research.

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CHAPTER ONE: INTRODUCTION

Although the efficacy of psychotherapy is well-established, the existing literature suggests that a considerable proportion of clients do not improve significantly on standardised measures of outcome (Hansen, Lambert & Forman, 2002; Lambert, 2013; Wampold, 2001). Current evidence puts the prevalence rate of non-improvement at somewhere between 14-60% of clients experience, with estimates varying depending on how it is defined and measured (Carr, Saules, Koch & Waltz, 2017; Evans, Connell, Barkham, Margison, McGrath, Mellor-Clark & Audin, 2002; Gyani, Shafran, Layard & Clark, 2013; Hansen et al., 2002; Lorentzen, Hoglend, Martinsen & Ringdal, 2011; Stiles, Barkham & Wheeler, 2015). The small number of qualitative studies that have explored client and therapist experiences of therapy in which there is no change have been useful in highlighting some of the processes that may be implicated in non-response, such as client non-disclosure and difficult relational dynamics during therapy (Hopper, 2015; Radcliffe, Masterson & Martin, 2018; Werbart, von Below, Brun & Gunnarsdottir, 2015; Werbart, von Below, Engqvist & Lind, 2018).

However, given that client and therapist perspectives have so far been studied in isolation, the level of agreement regarding the factors and processes that influence the final outcome within individual dyads is unclear. In addition, despite the fact that standardised outcomes measures are widely used in clinical trials and clinical practice to evaluate the effectiveness of psychotherapy, it is unclear what a lack of change on a standardised measure means in real terms and how outcome scores compare with clients' and therapists' subjective experiences of meaningful improvement or lack of improvement in therapy (Hill & Bauman, 2013; McElvaney & Timulak, 2013).

In order to develop a more comprehensive understanding of non-response, the aim of the present study is to explore how clients and therapists who have worked together experience and make sense of therapy in which the standardised outcomes measures do not demonstrate a significant improvement. This introduction begins by considering the complexities of defining and measuring change in psychological therapy, including the benefits and limitations of standardised outcome measures. The factors associated with different types of therapy outcome are outlined and the distinction between non-response

and harmful therapy is discussed. The findings from existing qualitative studies on client and therapist experiences of non-response are then summarised and evaluated.

Defining and measuring change in psychological therapy

A key issue for research investigating non-response is how it should be defined and measured (Lambert, 2013). The concept of non-response is inextricably linked with the concept of change in psychotherapy; although it is widely accepted that change is the primary goal, ideas about what ought to change and how to capture these changes varies considerably between different research paradigms and models of psychotherapy (Hill & Bauman, 2013; Slade, Amering & Oades, 2008; Wampold, 2013). Definitions of good outcome are heavily influenced by dominant discourses on the nature of psychological distress and socio-cultural norms about what it means to be well; as Strupp (1963) argues, what is considered normal or healthy "varies with the time, place, culture, and expectations of the social group" (Brown, 1995; Hill & Bauman, 2013; Valsiner & Van der Veer, 2000). The medical model has had a long-standing influence on how psychological problems are understood, treated and researched. This model assumes that psychological distress is characterized by a particular set of symptoms, that a treatment can be applied to alleviate these symptoms and that clients will experience this as a sufficient response to treatment (McLeod, 2011; Rose, Evans, Sweeney & Wykes, 2011).

Standardised outcome measurement and psychological therapy research

In line with this, meaningful change is often operationalised as a reduction in scores on standardised measures of psychological symptoms taken before and after therapy (Hill & Baum, 2013; Hiller & Schindler, 2011; McLeod, 2011). There are two main types of standardised measure that are used in psychotherapy outcomes studies: single-trait measures that target a particular mental health problem, such as the Beck Depression Inventory (BDI) and Patient Health Questionnaire (PHQ-9), and pan-diagnostic 'core battery' measures, such as the Clinical Outcomes in Routine Evaluation (CORE) and Outcome Questionnaire (OQ-45), which aim to provide an overview of general psychological functioning (Barkham, Margison, Leach, Lucock, Mellor-Clark, Evans & McGrath, 2001; Beck, Ward, Mendelson, Mock & Erbaugh, 1961; Kroenke, Spitzer & Williams, 2001). In addition, there are also outcome measures that are specific to particular therapeutic models; for example, measures targeting concepts such as psychological flexibility and assimilation of problematic

experiences (Hayes, Strosahl, Wilson & Bissett, 2004; Stiles, Elliot, Liewelyn, Firth-Cozens, Margison, Shapiro & Hardy, 1990). The diversity of outcome measures employed in the research literature limits the comparability of findings across studies, making it more difficult to gauge response and non-response rates (Kazdin, 2009; Lorentzen et al., 2011).

In addition, psychotherapy outcomes can be analysed at two different levels: group level response and individual response (Hiller & Schindler, 2011; Rubin & Lutz, 2017). To date, most treatment outcome studies, such as Randomised Control Trials (RCTs), have relied on the comparison of treatment group mean scores on standardised measures, using a test of statistical significance and effect size statistic to demonstrate whether those receiving a psychological therapy experienced an improvement on average and what the size of the improvement was (Ogles, Lunnen & Bonesteel, 2001; Shean, 2014; Kazdin, 2001; Rubin & Lutz, 2017). Although this method can be used to give an indication of whether or not a psychological therapy is effective for the average participant, it is does not tell us anything regarding the variability of therapy outcomes; that is, the proportion of clients who improve or not based on a pre-determined threshold for improvement, such as the proportion of participants falling below the clinical cut off (Hiller & Schindler 2011; Jacobson, Follette & Revenstorf, 1984; Lambert & Ogles, 2009; Wise, 2004). Furthermore, it is unclear what a statistically significant change in self-reported symptoms means in clinical terms (Hill & Baum, 2013; Kazdin, 1999; Shean, 2014; MacLeod, 2017).

In response to the limitations of group level analysis and the need to quantify concepts such as improvement and non-response, psychotherapy research has increasingly focused on individual outcomes (Harvey, 2014; Lambert, 2013; Wise, 2004). There are two main methods for determining individual response to psychotherapy: clinically significant change and reliable change. For change to be considered clinically significant, the client's score on a given measure at the start of therapy must fall within the clinical range and their score at the end of therapy must fall within the non-clinical range (Jacobson & Truax, 1991). In this sense, clinically significant change reflects a return to 'normal' functioning and levels of distress, as determined by the external standard of clinical and non-clinical population means (Jacobson, Follette & Revenstorf, 1984; Jacobson & Truax, 1991; Wise, 2004). Reliable change refers to changes in scores that are statistically reliable; that is, change that is unlikely to be a product of the unreliability of the measure (Jacobson, Follette & Revenstorf, 1984; Jacobson & Truax, 1991). The Reliability Change Index (RCI) is used to

calculate this; where a measure is less reliable, a greater difference between the pre and post-treatment scores is required for the change to be considered statistically reliable (Jacobson, Follette & Revenstorf, 1984; Jacobson & Truax, 1991; Wise, 2004). According to Jacobson, Follette, Revenstorf, Baucom, Hahlweg & Margolin (1984), an improvement in scores that both falls outside the range explained by measurement error and falls within the range of scores typical of the non-clinical population "can be considered unequivocally as a treatment success" (Jacobson et al., 1984, p.498).

When both reliable change and clinically significant change analyses are performed, there are 4 possible outcomes: complete recovery (reliable and clinically significant change), reliable improvement (reliable change met, but clinically significant change not met), no reliable change (neither reliable change or clinically significant change met) and reliable deterioration (a worsening of symptoms outside the range that could be explained by measurement error) (Jacobson & Truax, 1991). The generation of these categories has allowed researchers to explore the proportion of clients experiencing a range of outcomes; however, the reliable and clinically significant change paradigm is not without criticism. It has been highlighted that symptom change is just one aspect of client improvement and that the analysis of other relevant variables, for example quality of life, may suggest a different outcome (Kazdin, 1999). Furthermore, it is unclear what impact, if any, a shift in scores from the clinical to non-clinical range has on the client's everyday experience (Blanton & Jaccard, 2006; Kazdin, 2001).

Standardised outcome measurement in mental health services

In addition to the increasing interest in the range of outcomes experienced by clients in psychotherapy outcome research, growing emphasis has been placed on the use of routine outcome measurement in clinical practice (Boswell, Kraus, Miller & Lambert, 2015; Crawford, Robotham, Lavanya, Patterson, Weaver, Barber et al., 2011; Macdonald & Fugard, 2015; Rao, Hendry & Watson, 2010; Thornicroft & Slade, 2014; Unsworth, Cowie & Green, 2012). In 2001, the Department of Health document 'Organising and Delivering Psychological Therapies' advised that services ought to use standardised outcome measures routinely (DOH, 2001; Rao et al., 2010). In 2005, the National Institute of Mental Health (NIMH) embarked on a 2-year programme to implement routine outcome measurement in NHS psychological therapies services, and mental health services more generally (NIHM,

2005; Unsworth et al., 2012). By 2008, the Department of Health had stated that NHS services were required to collect routine outcome measures for the purposes of audit. Within Improving Access to Psychological Therapies (IAPT) services, standardised outcome measures are enshrined in routine clinical practice and play a key role in the commissioning of services; the minimum data set standard requires that standardised measures of depression and anxiety are completed at 90% of contacts and that 50% of clients achieve clinically significant change at the end of therapy (DOH, 2008).

At present, the use of specific outcome measures is not mandatory in secondary care psychological therapies services, but is considered best practice; for example, within the Guidelines for Clinical Psychology Services (BPS, 2011). The increasing emphasis on routine outcome measurement in policy and best practice guidelines necessitates that psychological therapy services engage with outcome measurement and it is often anecdotally reported that the use of outcome measures is increasing, although the evidence regarding the uptake rate is scant (Barkham, Mellor-Clark, Connell & Cahill, 2006; Kelly, 2010; Macdonald & Fugard, 2015; Rao et al., 2010; Unsworth et al., 2012). However, one study reported that in 1999, 50% of 220 NHS services contacted claimed to collect pre and post therapy outcomes data routinely, although how this data is used by services is less clear (Mellor-Clark, Barkham, Connell & Evans, 1999). Similarly, a study of CORE-OM data in 64,610 clients of primary care psychological therapies services, prior to the development of IAPT, found that both pre and post intervention data was available for 40% of clients (Bewick, Trusler, Mullin, Grant & Mothersole, 2006). The available evidence on the use of routine outcome measurement, particularly in secondary care services, is dated and it seems likely that the current uptake rate is higher given the emphasis on outcomes in recent policy documents. It also remains unclear how services are using the data they collect (Jacobs, 2009; Kelly, 2010).

Potential benefits of routine outcome measurement in clinical practice

It has been argued that for therapists to improve their outcomes and reduce the likelihood of non-response, they need to be able to identify clients who are at risk of a poor clinical outcome or dropping out of therapy (Lambert, 2007). However, the findings from several studies suggest that therapists are not adept at predicting clinical outcomes. For example, one study compared the ability of therapists to make accurate judgements regarding

which of their clients were at risk of deteriorating with that of an algorithm that used historical outcomes data to make statistical predictions (Hannan, Lambert, Harmon, Nielsen, Smart, Shimokawa et al., 2005). The algorithm was able to correctly identify 36 out of 40 clients who would go on to deteriorate in therapy, whereas the therapists identified only 1 out of 40. Although this study focused on deterioration rather than lack of change, these findings suggest that access to clinical outcome data during therapy could be important in allowing therapists to intervene when a client is at risk of a poor outcome. Similarly, another study investigated the ability of therapists providing group therapy to accurately predict the final clinical outcome of their clients, using Jacobson & Truax's (1991) 4 categories of reliable and clinically significant change (Chapman, Burlingame, Gleave, Rees, Beecher & Porter, 2012). However, there was no significant relationship between the therapist predictions and the actual client outcomes.

A growing body of research suggests that regular use of outcome measures can have a positive impact on clinical outcomes (Amble, Gude, Stubdal, Andersen & Wampold, 2015; Lambert, Whipple, Vermeersch, Smart, Hawkins, Nielsen et al., 2002; Lambert & Shimonkawa, 2011; Lutz, De Jong & Rubel, 2015; Krageloh, Czuba, Billington, Kersten & Siegert, 2015; Rubin & Lutz, 2017; Simon, Lambert, Harris, Busath & Vazquez, 2012). A meta-analysis of 9 studies that compared conditions where therapists were provided with regular feedback regarding client ratings of their current symptoms and the therapeutic alliance with treatment as usual found that reliable deterioration was reduced by 50% in the feedback condition (Lambert & Shimonkawa, 2011). Furthermore, a review found that 17 out of 25 studies on the impact of regular outcome measurement reported a significant positive effect on 'not on track' cases; that is, clients who were not experiencing the improvement that the feedback system predicted would be evident if the client were to finish therapy with a good outcome (Krageloh et al., 2015). Similarly, a large multi-site RCT found a small-moderate effect in favour of therapist feedback ($p=.027$, $d=0.32$) (Amble et al., 2015). However, these results were not supported by a similar study of 259 clients, which found that therapists receiving a warning signal regarding lack of change or deterioration did not significantly improve the final outcome (Amble, Gude, Ulvenes, Stubdal & Wampold, 2016).

In addition, the generalisability of the studies in this area to the NHS context, particularly with regards to secondary care, has been questioned, as most of these studies

rely on samples from university counselling services in the US, which differ significantly in the severity of their difficulties and their socio-economic background (Davidson, Perry & Bell, 2015). A systematic review of studies investigating the impact of continuous outcome monitoring on clinical outcomes demonstrated that, whilst those with highest levels of need and degree of complexity still benefit somewhat, the effect sizes are much smaller (d=.12 and d=.30 compared to d=.7) (Davidson, Perry & Bell, 2015; Simon et al., 2012). In contrast, a recent study found that whilst 'positive' feedback from outcome measures (decreased symptoms) was associated with positive final outcomes, 'negative' feedback appeared to contribute to poorer final outcomes amongst clients with the severest difficulties (Errazuriz & Zilcha-Mano, 2018). Further research is clearly needed to clarify which clients, or therapists, are most likely to benefit from the regular use of outcome measures and the most helpful ways to feed this information back.

Criticisms of using standardised measures to evaluate outcomes

As in the research literature, disagreement regarding how to define and measure a good outcome in mental health services is rife and the equation of lack of improvement on measures of symptoms with treatment failure has been widely criticized (Hill & Bauman, 2013; Lakeman, 2004; Macdonald & Fugard, 2015; Thew, Fountain & Salkovskis, 2015; Thornicroft & Slade, 2014; Trivedi & Wykes, 2002; Slade, 2006). Numerous researchers and clinicians have highlighted the potential discrepancy between the recovery model, which emphasises individuality and the possibility of a meaningful life in spite of mental health difficulties, and standardised measures of outcome, which emphasise symptom reduction and reinforce ideas of illness and cure (Browne, 2006; Hill & Bauman, 2013; Lakeman, 2004; Macdonald & Fugard, 2015; Pilgrim, 1999; Slade, 2006; Thornicroft & Slade, 2014).

For example, it has been argued that the use of standardised outcome measures, particularly with clients with the most severe or longstanding difficulties, such as those who may attract the diagnoses schizophrenia and personality disorder, is an oppressive act that works only to perpetuate and ratify the dominance of the medical model at the expense of service-users who are unlikely to achieve a complete 'remission' of symptoms and whose personal stories of recovery may go unacknowledged (Browne, 2006; Garland, Kruse & Aarons, 2003; Lakeman, 2004). In addition, it has been noted that various interpersonal processes may shape clients' use of outcome measures and thus further limit their validity;

for example, clients may use them to communicate their feelings about therapy ending or they may feel pressured to give their therapist positive feedback (McLeod, 2011).

Several studies have demonstrated that although symptomatic improvement may be an important facet of recovery, changes in symptoms do not always feature in clients' discussions about their hopes for therapy and why their therapy was significant (Binder, Holgersen & Nielsen, 2010; Crawford et al., 2011; Levitt, Butler & Hill, 2006; McLeod, 2011; Rose et al., 2011). For example, a study exploring the experiences of clients classified by the RCI as a good outcome (reliable improvement or clinically significant change) and those identified as a poor outcome (no change or reliable deterioration) found that there were considerable similarities in the benefits of therapy reported by both groups (McElvaney & Timulak, 2013). Furthermore, a qualitative study of client perspectives on a 'good outcome' found that clients emphasised that recovery is an on-going and continuous process rather than a specific end point (Moltu, Stefansen, Nøtnes, Skjølberg & Veseth, 2017). The clients in this study highlighted the importance of self-acceptance, becoming more adept at using coping strategies when distress arises and having an understandable narrative through which to conceptualise their distress as key factors in a good outcome. Similarly, Binder et al (2010) found that increased self-acceptance and understanding, as well as the improvement of symptoms, were central to the clients' beliefs about what constitutes a positive outcome. These findings suggest that outcome measures that reflect these values, as well as more traditional ideas of recovery, may be more meaningful and useful to clients, therapists and researchers. In addition, these studies caution against making assumptions about clients' experiences of therapy on the basis of standardised measures in their current form.

Client and clinician perspectives on standardised outcome measurement

Related to this, a small number of studies have begun to explicitly investigate service-user and clinician views of outcomes measurement (Crawford et al., 2011; Ionita, Fitzpatrick, Tomaro, Chen & Overington, 2016; Thew et al., 2015; Unsworth et al., 2012). Amongst the concerns reported by service-users were the presence of normative assumptions in measures, such as the importance of close family relationships, and a sense that some measures contain items that are too broad to be meaningful (Crawford et al., 2011; Thew et al., 2015). However, the findings of two studies that compared client and therapist experiences of outcomes measurement in NHS services suggest that clients generally hold

more favourable opinions than clinicians, provided that the measures are properly introduced and referenced throughout therapy (Thew et al., 2015; Unsworth et al., 2012). Both studies reported that some clients felt the use of measures was therapeutic; for example, through facilitating difficult conversations, prompting self-reflection and evidencing change. However, it is important to note the small sample sizes of these exploratory studies and the possibility of self-selection bias; larger studies are required to obtain a more representative view of client experiences and perspectives in particular (Thew et al., 2015).

Idiographic outcome measures

In response to criticisms that standardised outcome measures may not reflect client-defined meaningful change due to issues of sensitivity and specificity, there has been an increasing interest in developing idiographic outcome measures to complement and contextualise standardised measures (Ashworth, Shepherd, Christey, Matthews, Wright & Parmentier et al.; 2004 Barlow & Nock, 2009; Beresford & Branfield, 2006; Green, 2016; Sales, Neves, Alves & Ashworth, 2017). The key difference between standardised and idiographic measures is that with the latter, the items are the measure are tailored specifically to the individual client's difficulties and goals (Green, 2016). Accordingly, the client's scores are compared only to each other, rather than a normative sample. In clinical practice, these measures allow for a more personally meaningful consideration of the impact of therapy on the client and are therefore more compatible with the recovery paradigm (Browne, 2006; Lakeman, 2004; Schrank & Slade, 2007). The personalised feedback enables the therapist to adjust the intervention to individual needs with greater specificity (Evans, 2012; Green, 2016). In research, for instance in single case studies and case series, idiographic measures arguably provide a more nuanced picture of clinical outcomes than standardised outcome measures alone, which may have important implications for the evidence base on psychological therapies (Barlow & Nock, 2009; Kazdin, 2009).

An example of an idiographic outcome measure that is gaining traction is the Psychological Outcome Profiles (PSYCHLOPS) (Ashworth, Shepherd, Christy, Matthews, Wright, Parmentier et al., 2004). This questionnaire provides a space for the user to reflect on and record the key difficulties they experience and the changes they hope to make. Although not suitable for sessional use, it can be administered pre, mid and post therapy. A recent study compared the extent to which the PSYCHLOPS provided information not

captured by the CORE-OM and PHQ-9 in 107 clients from NHS mental health services (Sales et al., 2017). 95% reported at least one item not on the PHQ-9 and 71% at least one item not on the 34-item CORE-OM. Similarly, Ashworth, Evans & Clement (2009) compared PSYCHLOPS responses with the Hospital Anxiety and Depression Scale (HADS) in 114 clients from a primary care clinical psychology service. They found that the PSYCHCLOPS (d=1.61) was significantly more sensitive to change after therapy than the HADS (d=1.15) ($t=5.75$, $p<0.001$). Preliminary studies therefore encouraging regarding the potential of such measures to generate unique, clinically useful information. However, this research is still in its infancy and the uptake amongst clinicians is currently unknown.

Non-improvement in psychological therapy

Definition and prevalence of non-improvement

Given the complexities of defining and measuring change in psychotherapy, it follows logically that the concept of non-improvement is equally ambiguous (Lambert, 2013; Schottenbauer, Glass, Arnkoff, Tendick & Hafter-Gray, 2008). The most recent studies typically define non-improvement as the absence of reliable or clinically significant change (Carr et al., 2017; De Smet et al., 2019; Stiles et al., 2015; Werbart et al., 2019); however, some studies have employed other criteria, such as continuing to meet the diagnostic criteria for the target problem or a failure to achieve a reduction on the outcome measure by a pre-determined percentage, and a significant proportion of studies do not report a non-improvement rate (Cuijpers, Karyotaki, Weiz, Andersson, Hollon & van Straten, 2014; Harvey, 2014; Reuter, Munder, Altmann, Hartmann, Strauss & Scheidt, 2015; Van, Dekker, Peen, van Aalst & Schoevers, 2008). The prevalence rate of non-improvement varies considerably across different studies from 14-56%, which likely reflects the different outcome measures, service contexts and psychological interventions on which these studies are based; for instance, studies in inpatient settings and those using the more stringent criteria of clinical recovery report tend to report higher non-response rates (Gvani et al., 2013; Hansen et al., 2002; Reuter et al., 2015; Stiles et al., 2015; Van et al., 2008). As Steinert, Kruse & Leichsenring (2016) note, many studies measure only the post-therapy outcome and that even where a sufficient follow-up period is included, clients who do not improve tend to be lost to follow up, meaning that it is largely unknown how these clients fare after therapy.

A large outcome study of over 26,000 clients across primary and secondary care psychological therapies services in the NHS found that 18.8% of clients experienced no reliable change on the CORE-OM, which is a battery measure of common symptoms of psychological distress, risk and functioning (Stiles et al., 2015). However, an earlier study of NHS psychological therapies services that also used the CORE-OM found a significantly higher rate of no reliable or clinically significant change of 36% (Evans et al., 2002). Both of these studies were based on mixed primary and secondary care samples; however, some studies have looked at these populations separately. For example, a recent study of 925 secondary care clients in the NHS reported 45% no reliable change, of which 14% were a non-reliable deterioration and 31% non-reliable improvement (Evans, Beck & Burdett, 2017). In addition, a study of IAPT services found that 29% of clients did not meet the criteria for reliable change on the PHQ-9 or GAD-7, which are measures of depression and anxiety routinely used in IAPT services (Gyani et al., 2013). This potentially suggests that non-improvement rates are higher in secondary care than primary care, at least according to standardised outcome measures. However, further studies, particularly ones that are able to contextualise the outcome measure scores, are needed to confirm this.

Interestingly, much larger rates of non-response were reported by two large studies in the US than any of the NHS-based studies discussed above; a study by Carr and colleagues (2017) in psychology training clinics found that the proportion of clients who did not achieve reliable change on the Outcome Questionnaire (48.9%), was greater than the percentage of clients who experienced either reliable improvement or clinically significant change (41.2%). Similarly, a study of 6 psychology services, including community mental health and university counselling services, that employed the same outcome measure as the study by Carr and colleagues (2017), reported that 56.8% of clients did not meet the criteria for reliable change and only 35% achieved either reliable improvement or clinically significant change (Hansen et al., 2002). One interpretation of these findings is that the outcome measure used in these studies may lack the sensitivity and specificity to detect change within the lower tiers of mental health services.

Predictors of improvement and lack of change

At present, much more is known about the factors associated with change in psychotherapy than the factors associated with lack of improvement (Lambert & Ogles,

2014; Lorentzen et al., 2011). Research has consistently shown that client ratings of the therapeutic alliance are a strong predictor of final outcome (Horvath, Del Re, Fluckiger & Symonds, 2011; Wampold, 2001). In addition, a number of therapist variables, such as empathy and genuineness, have been associated with positive outcomes, whereas hostility, rejecting behaviour, attachment anxiety and therapist lack of attentiveness to the alliance have been associated with poorer outcomes (Iwakabe, Rogan & Stalikas, 2000; Fuertes, Moore & Ganley, 2018; Kolden, Klein & Wang, 2011; Najavits & Strupp, 1994; Norcross, 2011; von der Lippe, Monsen, Rønnestad & Eilertsen, 2008; Wampold, 2015). Similarly, there is evidence to suggest that certain client characteristics such as chronicity of symptoms, expectations for therapy, treatment preferences, motivation, resistance, engagement, interpersonal difficulties and cognitive difficulties also have a considerable impact on outcomes (Black, Hardy, Turpin & Parry, 2005; Lindheim, Bennett, Trentacosta & McLear, 2014; Norcross, 2011).

To give some examples, a recent study of client-therapist dyads by Fuertes, Moore & Ganley (2018), demonstrates the impact of both client and therapist factors in therapy outcomes. They explored associations between a range of self-report measures completed by each member of the dyad, including ratings of the therapeutic alliance, treatment progress and attachment security. The study found that therapists' ratings of attachment anxiety and avoidance were significantly negatively associated with their ratings on the Real Relationship Inventory ($p=0.001$) and Counselling Outcome Measure ($p=0.003$). Similarly, clients' ratings of the alliance were positively associated with client self-reported treatment progress ($p=0.02$). In addition, a study that compared the impact of client and trainee therapist pre-therapy expectations with the actual outcomes found that whilst neither positive nor negative expectations for therapy had an impact on the duration of therapy, expectations did account for 11% of variance in outcome, with poorer expectations leading to poorer outcomes (Swift, Derthick & Tompkins, 2018).

Given that little research has directly investigated non-improvement, it is difficult to ascertain whether the factors associated with it are related to those associated with change in psychotherapy. However, the few studies available, which employ various means of measuring non-improvement, suggest that the following variables may be predictors: previous lack of change in psychotherapy, lack of early response (usually within the first 8 weeks), client interpersonal difficulties and poor quality therapeutic alliance (Borkovec,

Newman, Pincus & Lylte, 2002; Carter et al., 2018; Crits-Christoph, Gibbons, Narducci, Schamberger & Gallop, 2005; Davis-Osterkamp, Strauss & Schmitz,1996; Horowitz, Rosenberg & Bartholomew, 1993; Keeley, Storch, Merlo & Geffken, 2008; Mohr, 1995; Reuter et al., 2016).

In addition, a recent study of outcomes in NHS primary care psychology and counselling services investigated client and therapist predictors of a no reliable change outcome on the CORE-OM (Harvey, 2014). This study found that the risk of no reliable change reduced as CORE-OM scores (excluding risk items) at the start of therapy increased, with the exception of those at the high end of the severe range, who were more likely to experience no change. Being unemployed or a recipient of benefits and duration of symptoms were also significant predictors of no reliable change. Although client score on the risk items of the CORE-OM did not relate to outcome, therapists with greater proportion of high risk clients on their caseload were more likely to have clients who did not achieve reliable change. Whilst this study provides a useful starting point for further research into the predictors of non-improvement, it is important to note that the clients included in the study were a highly select group of primary care clients that are likely to be significant different from the clients typically seen in secondary care psychological therapies services.

The relationship between non-improvement and harm

A cross-sectional survey of 14,587 clients from NHS psychological therapies services found that 5% experienced 'lasting bad effects' (Crawford, Thana, Farquharson, Palmer, Hancock, Bassett et al., 2016). Although the study did not collect data on the nature, duration or perceived cause of the harm, it identified that those from ethnic and sexual minorities were more likely than other clients to report them. Whilst non-improvement, in the sense of remaining largely unchanged by therapy, is often conceptualized as a distinctly different phenomenon from harmful therapy, recent research suggests a more complex relationship between the two. For example, some of the participants in studies of client experiences of non-improvement expressed feeling in some way worse off as a result of their therapy (Radcliffe, Masterson & Martin, 2018; Werbart et al., 2015). This begs the question of whether, somewhat paradoxically, non-improvement can itself be a damaging experience. It has been put forward that experiences of harm exist on a spectrum, ranging from minor

hinderances and temporary hurts to the profoundly damaging and abusive (Bowie, McLeod & McLeod, 2016; Henkelman & Paulson, 2006; Paulson, Everall, & Stuart, 2001).

Bowie, McLeod & McLeod (2016) explored the experiences of 10 qualified therapists who self-identified as having had a negative experience as a therapy client. The overarching theme of this IPA study was that of having received the opposite of what was needed. A key factor in the unhelpfulness of the therapy, much like the clients in the studies by Werbart et al. (2015) and Radcliffe et al. (2018), was around difficulties in the therapeutic relationship; for example, lack of genuine care, not being listened to, lack of collaboration and feeling unsafe with the therapist. Unlike the other studies, all of the participants ultimately dropped out of therapy, but they were left with similar feelings at the end, as they described a sense of being let down, exposed and cheated. However, the duration of time since the therapy ended ranged from 1-12 years, which has potential implications for the reliability of the results, as it may have been more difficult for participants who had the therapy many years ago to recall the experience in detail. In addition, the participants were a highly select group, as they were qualified therapists themselves. Therapists were the focus of the study to mitigate potential ethical concerns around interviewing mental health service clients about a harmful experience; however, one limitation of this is that the findings may not be generalisable to more vulnerable populations, such as clients who have experienced severe trauma and those who experience thoughts of suicide. It may be that harmful therapy has more profound and lasting negative consequences in clinical contexts than those reported by the therapists in Bowie et al.'s study.

A recent mixed method study explored in more detail experiences of unhelpful and harmful therapy in 205 self-identified clients and 324 therapists who felt their client had a negative experience, using interviews (40) and questionnaires (489) (Hardy, Bishop-Edwards, Chambers, Connell, Dent-Brown, Kothari et al., 2017). The thematic analysis suggested that a poor fit between the needs of the client, the skills of the therapist and the structure of the service were facilitating factors in these experiences. This gave rise to a therapy that was experienced as a struggle in the face of inadequate containment and the therapists' exertions of power and control. For example, clients discussed the therapists' absence of core interpersonal skills and failure to establish the client coping skills required to deal with the emotions stirred up in sessions, in addition to therapist silencing, dismissing and blaming behaviours. This led to decreased client engagement and ultimately, both client

and therapist participants reported being left with loss of hope, loss of confidence, diminished sense of coping and feelings of failure at the end of therapy. These findings find a useful starting point for understanding harm in therapy and suggest that the underlying processes are comparable to those at play in non-improvement. However, alternative designs are required to explore the ways in which incidences of harm unfold within specific cases, how well harm is captured by standardised outcome measures and develop a clearer picture of the relationship to non-improvement.

Client experiences of non-improvement

Research into the factors that are associated with, or predict, good outcomes and non-response in psychotherapy provide a useful starting point; however, these studies cannot tell us how these variables might influence the outcome of psychotherapy, how clients make sense of this experience, or what the implications are for those who do not experience meaningful change. A small number of studies have therefore used a qualitative methodology in order to develop a more in-depth understanding of what it means to experience lack of change and explore client perceptions of unsuccessful therapy. To date, these initial studies have begun to investigate the experiences of two types of non-improvement: clients who self-identify as not having improved and clients whose outcome measure scores meet the criteria for no reliable change according to the RCI (Radcliffe, Masterson & Martin, 2018; MacLeod, 2017; McElvaney & Timulak, 2013; Werbart et al., 2015; Werbart et al., 2019).

For example, Werbart and colleagues (2015) used grounded theory to explore the perspectives of clients recruited from a clinical trial who, according to the RCI, had not responded to either individual or group psychoanalytic psychotherapy in a service for people aged 18-25. The core theme of the analysis was 'spinning one's wheels'; as the authors note, the experiences of these clients seemed to be marked by contradiction in the sense that therapy was perceived as meaningful enough for them to persevere, due to benefits such as increased insight into their difficulties, but not meaningful enough to bring about genuine change regarding the key problems they were seeking help for. Some common themes emerged in terms of the participants' beliefs about the factors that had limited their progress, such as experiences of the therapist as distant or passive and the perception that the intense focus on past experiences did not help them to improve their lives in the present.

Whilst this study provides a valuable initial insight into client experiences of non-response, it is important to note the limitations. Although the fact that all of the clients received the same model of psychotherapy strengthens the homogeneity of the sample, it is difficult to get a sense of how generalizable these findings might be to other therapies. Furthermore, it is difficult to assess the extent to which the researchers' use of the Problem Theories Interview (Witzel, 2000) to collect the data may have limited or influenced participants' responses from the information provided. In addition, the type of therapy offered and the clients treated in this study differ from the NHS context in several ways. Firstly, psychoanalytic therapy is less commonly offered in the NHS than other models. In addition, participants in this study were in treatment for 22 months and almost half of them had two sessions per week, whereas NHS clients generally receive less intensive and shorter-term interventions. Finally, most of the clients in the study had self-referred to the service from which they were recruited, whereas NHS secondary care services have a high threshold for access, with only those with the severest difficulties and highest levels of risk being offered a service.

Participants in an IPA study in NHS Adult Psychological Therapies services who self-identified as non-improved also perceived a sense of passivity or judgment on the part of the therapist and they described struggling to see how the material addressed in therapy could help them in their daily lives (Radcliffe, Masterson & Martin, 2018). Radcliffe's study also highlighted the same sense of contradiction described by participants in the study by Werbart and colleagues'; some small benefits were reported, such as the relief of having someone to talk to, but participants felt their therapy ultimately failed to get to the heart of the problem. However, in contrast to the study by Werbart and colleagues, who highlight that clients rarely discussed their own role in the outcome of the therapy, the avoidance of core issues was discussed by all 8 participants. The themes from Radcliffe, Masterson & Martin's study were developed into a model, which proposes that past traumas had resulted in a compromised sense of self-worth that simultaneously fueled the desire to engage in therapy and also made it more difficult to connect with therapist or discuss distressing material. They hypothesised that for the clients in their study, this seemed to lead to a cyclical process in which the nature of the client's difficulties played a role in the outcome and the experience non-response itself exacerbated their difficulties. However, further research is needed to test the generalisability of this model. In addition, the fact that no data was

available regarding the quantitative outcome has implications for the homogeneity of the sample, particularly as some participants reported feeling that their difficulties had actually worsened in therapy.

These findings regarding the potential role of non-disclosure in non-improvement resonate with the wider literature that suggests difficulty being open in therapy may be a common experience, and one that is often motivated by shame or fear of upsetting the therapist (Blanchard & Faber, 2016; Hill, Thompson, Cogar & Denman, 1993; Pope & Tabachnick, 1994; Rennie, 1994). For example, in a mixed-method online survey, 72% of the 547 clients surveyed reported having lied about or concealed information relevant to their therapy (Blanchard & Faber, 2016). Amongst the most common omissions were: failing to disclose the full extent of their distress in general (54%), concealing negative feelings about themselves (31%), hiding their true feelings about their therapist's interpretations or suggestions (29%) and claiming that therapy was helping more than it actually was (29%). In addition, a significant proportion chose not disclose experiences of abuse (10%). Few studies have directly evaluated the impact of non-disclosure on clinical outcome; however, one study found a significant relationship between the numbers of reported non-disclosures and final outcome, with those with fewer non-disclosures having lower symptoms (Kelly, 1998).

Interestingly, an IPA study with a very similar design to that of Werbart et al. (2015) found strikingly different results in an NHS primary care service. MacLeod (2017) interviewed 5 clients, who had ended therapy with their scores on the CORE-OM in the no reliable change range after 6-12 sessions with a psychologist, about their experience of the therapy and understanding of the outcome. All 4 core themes demonstrated various forms of benefit that the clients had taken from their therapy: helpful for me, talking is good, something has shifted in me and I'm coping. Only 1 of the 5 participants felt somewhat ambivalent about the outcome and none of the participants reported difficulties in the therapeutic relationship. Unlike the participants in the study by Werbart et al., the participants in MacLeod's study generally felt that their therapy had been successful, despite it not having been a complete cure and there being more work for them to do on their own after therapy. However, as the recruitment procedure is not described, it is unclear whether participants who did not agree with the measures that little had changed were explicitly sought or if the study was open to all experiences.

These findings recall those of an earlier study that compared the perspectives of clients' in NHS primary care services who reliably improved on the outcome measure with those who did not, using a 'descriptive and interpretive' approach; they found that both groups reported similar experiences and benefits (McElvaney & Timulak, 2013). However, a subtle difference was that participants who had improved on the measures tended to describe experiences of vulnerability in therapy, whereas the other group did not, which may suggest different levels of openness and disclosure.

Therapist experiences of non-improvement

In addition to studies of client experiences of non-improvement, two recent studies explored the therapist perspective (Hopper, 2015; Werbart et al., 2018). Hopper (2015) interviewed 7 NHS therapists about a recent experience of non-improvement, as defined by the therapist; she found that the experience tended to be described as a process in which the therapist's belief in the possibility of change and level of engagement with the client were increasingly eroded. Several participants also suggested that at times the therapeutic process was impeded by the sense of hostility and hopelessness they both perceived from the client and felt towards the client; these findings resonate with those from the studies of client experiences of non-improvement, in which some participants described experiencing their therapist as withdrawn or irritated (Radcliffe, Masterson & Martin, 2018; Werbart et al., 2015).

Similar findings were reported in a study of 8 therapists of clients who did not achieve reliable change on self-report measures of psychological symptoms (Werbart et al., 2018). The therapists were interviewed after the first session of therapy, as well as at the end of therapy, to allow their experience over time to be explored. The core theme of 'only having half of the patient in therapy' signified a difficult process in which the client consistently attended therapy and engaged on some level, but ultimately remained distant from the therapist and aversive to their attempts to facilitate connection. The therapists reported struggling to reconcile and balance the client's need for distance with the therapeutic imperative of closeness, leading the therapist to feel helpless. This partial absence of the client was sensed from the early stages of therapy and became increasingly apparent over time; key aspects of the client's difficulties either remained ambiguous or it did not feel possible to bring them into the room in a meaningful and therapeutic way.

However, despite the therapists' agreement with the outcome measures that the clients' core difficulties remained unchanged, they also sensed the client had experienced some subtle benefits; for example, increased insight into their difficulties.

The findings of this study on therapist experiences complement those of the earlier study by Werbart et al (2015) on client experiences regarding the role of negative interpersonal process in non-improvement, but with some important differences. Although both studies identified distance in the therapeutic relationship as a key factor, the therapists attributed this to the client's attachment style and defenses, while the clients generally attributed it to the therapist's passivity or their frustration at the therapist's unwillingness to focus on the present. The clients did not describe the aversive reaction to closeness perceived by the therapists. The researchers suggest that the distance in the therapeutic relationship meant that the therapists struggled to bring difficult, 'split off' material that was central to the core problem into the room. Furthermore, the authors interpret the therapists' perception of increased insight and subtle gains, in spite of the clients' apparent aversion to closeness and ambivalence, as a defense against feelings of failure and suggest this a contributing factor to the lack of change on the clients' outcome measures. However, the participants in the two studies were not matched pairs of clients and therapists; this could be a key factor in the considerable differences in their experiences. In addition, 3 of the therapists' clients had reliably deteriorated, whereas the clients in the earlier study fell within the no reliable change range, which further limits the comparability of the two studies.

The emphasis placed on negative interpersonal process in qualitative studies of non-improvement is echoed in the wider literature on psychological therapy outcomes. A number of studies have demonstrated a link between client and therapist in-session hostility, which often consisted of subtle expressions of rejection, frustration and disinterest, on clinical outcomes (Chui, Hill, Kline, Kuo & Mohr, 2016; Najavits & Strupp, 1994; von der Lippe et al., 2008). However, as the above studies focus solely on therapist or client perspectives, it is difficult to get a sense of how these processes might be at play within an individual case; for example, whether the client perceived the frustration described by the therapist, or if the therapist was aware that the client was holding back, and how these processes might have affected the course of the therapy.

Client-therapist dyad experiences of non-improvement

Building on from research that has explored client and therapist perspectives separately, a recent study recruited the clients of 6 therapists to compare experiences of therapy where there was no reliable improvement with therapies where there was reliable change for each therapist (Werbart et al., 2019). In reliable change cases, the dyads' understandings of the problem and goals were more closely aligned. The therapeutic relationship was experienced as both supportive and challenging, whereas in no change cases there were unresolved difficulties in the alliance. In addition, the therapist tended to adjust their approach to client in reliable change cases, for example to meet the client's expectations about the role of the therapist and structure of therapy, whereas in poorer outcome cases there was less negotiation. The clients of reliable change therapies reflected more on their anxieties about therapy, barriers to engagement and experiences of ruptures in the relationship being repaired. In contrast, therapists in no change cases tended not to reflect on their role in the difficulties; they identified the nature of the client's problems and issues with collaboration as key barriers, but they did not tend to discuss how they tried to overcome these challenges. The authors suggest that strong countertransference, usually negative but occasionally positive, led to therapists' either struggled to work with or minimised important aspects of the clients' difficulties. This study provides a useful insight into the types of issues that might influence improvement and lack of improvement in client-therapist dyads. However, a limitation is that the authors provide only brief descriptive summaries of each participant's perspective, rather than themes and there are few direct quotes to ground the findings, which makes it difficult to get clear and detailed sense of how the dyad experienced the therapy. In addition, there is little consideration of the extent to which the standardised measures captured the client's perspective; it is assumed that measures provide an accurate picture of the outcome.

Summary

Non-improvement in therapy is an important area of research, but it is fraught with difficulties, due to the complexities of defining and measuring change. A small body of qualitative literature has begun to investigate client and therapist experiences of non-improvement in order to better understand the processes that affect therapy outcomes and to give context to standardised outcome measures. Of the few existing studies, most explore

client and therapist perspectives in isolation, which makes it difficult to develop a sense of how important interpersonal processes play out. In addition, most of these studies were conducted in service contexts that are very different to NHS mental health services. The few studies undertaken in the NHS focus either on primary care or self-identified clients and therapists from secondary care. To date, there has been no qualitative study of client-therapist dyads in NHS secondary care services where the outcome measures suggest no reliable improvement has taken place.

Aims

The present study will investigate the following questions:

1. How do client-therapist dyads experience and make sense of therapy in which the standardised outcome measures suggest no significant change has taken place?

2. What themes emerge from the accounts of client-therapist dyads regarding the interpersonal process in these therapies?

CHAPTER TWO: METHOD

Methodological approach

Selected method

The existing research on non-improvement in psychotherapy has typically employed a quantitative methodology; for example, to examine the predictive ability of variables such as the severity or chronicity of psychological symptoms, clinical diagnosis and ratings of the therapeutic alliance (Harvey, 2014; Saxon & Barkham, 2012; Taylor, Abramowitz & McKay, 2012). Although this research provides a useful overview of the characteristics of the clients most at risk of a poor outcome, the reliance on predetermined criteria does not allow for the discovery of other key factors that might be at play and without the inclusion of client perspectives, it is not possible to know whether the clients themselves would themselves identify as not having befitted from therapy. In addition, the small number of qualitative studies on client or therapist experiences of non-improvement suggest that certain interpersonal processes, such as client non-disclosure and therapist hopelessness, may be implicated in lack of change; however, as these studies did not have access to the perspective of the corresponding therapist or client, it is difficult to gauge how such processes may have affected the therapy and final outcome (Hopper 2015; Radcliffe, Masterson & Martin, 2018; Werbart et al., 2015). A qualitative methodology was therefore selected for the present study of how client-therapist dyads experience and make sense of therapy in which the outcome measures do not demonstrate reliable improvement; this approach allows for the open-ended and detailed exploration of subjective experience and understanding, in accordance with the aim of the study (Willig, 2008). Interpretative Phenomenological Analysis (IPA) was identified as the most appropriate qualitative method as it provides a framework for analysing lived experience and meaning-making processes.

Alternative methods considered

In addition to IPA, the following qualitative methods were also considered: Discourse Analysis and Grounded Theory.

Discourse Analysis is a method for exploring how the phenomenon of interest is constructed through the language that is employed and how individuals use language in

different ways in different contexts in order to achieve particular personal, social and political aims (Willig, 2008). As the focus of this study is to explore client and therapist understandings and experiences of the non-response, rather than how particular discourses construct and influence participants' experiences of non-improvement, Discourse Analysis was not felt to be appropriate.

In Grounded Theory, the central aim is to identify and integrate different categories of meaning in participants' accounts in order to develop an explanatory theory of the processes underlying the phenomenon being investigated (Glaser & Strauss, 1967). The analytic process involves coding the available data until no new categories emerge and theoretical saturation can be assumed (Willig, 2008). Given that the aim is to develop an explanatory model, Grounded Theory generally requires a larger sample size than other qualitative methods, which may be beyond the scope of this exploratory study. Furthermore, a Grounded Theory approach may overlook idiosyncrasies in the participants' experience and given that qualitative research on non-improvement is still in its infancy, it is important for these potential differences to be acknowledged.

Interpretative Phenomenological Analysis (IPA)

IPA allows the researcher to explore how participants experience and make sense of the phenomenon under investigation through the systematic analysis of qualitative data (Smith, Flower & Larkin, 2009). The primary aim of IPA is to develop themes that capture both the shared and unique elements of the participants' experiences and the researcher plays an active role in the analysis, which aims to balance the input of the 'phenomenological insider' and 'interpretative outsider' (Reid, Flowers & Larkin, 2005). A key advantage of this method is that it allows for the open-ended and in-depth exploration of the complexities of participants' lived experiences. IPA research typically utilises individual semi-structured interviews as the primary data collection method, as this allows for an open-ended and in-depth exploration of lived experience, whilst also giving the researcher some scope to focus the discussion of the phenomenon of interest. Although IPA bears some similarity to the Grounded Theory approach, one of the key differences between the two methods is that IPA focuses on the nature of the experience itself, whereas Grounded Theory prioritises the development of a theoretical model to explain the phenomenon.

However, it is important to note that IPA is not without criticism; it has been highlighted that IPA relies on the representational validity of language as an adequate medium for participants to accurately convey their experiences through. In addition, it has been noted that the utility of IPA research is limited in its ability to offer only a descriptive account of the phenomenon, rather than an explanatory one (Willig, 2008). However, more recent IPA research has included the development of a model where this seemed appropriate, so the choice of IPA would not necessarily rule out the development of a tentative theoretical model or use of the data to validate existing models (Hopper, 2015; Radcliffe, Masterson & Martin, 2018).

Dyadic IPA

Although the focus of IPA is typically the interpretative analysis of accounts of individual experience, it has also been adapted for in-depth exploration of the experiences of a dyad (Antoine, Flinois, Doba, Nandrino, Dodin & Hendrick, 2016; Banerjee & Basu, 2016; Burton, Shaw & Gibson, 2015; Eisikovits & Koren, 2010; Ummel, 2016; Wawrziczny, Antoine, Ducharme, Kergoat & Pasquierer, 2014). It has been argued that this approach can allow for a more comprehensive and nuanced account of the phenomenon under investigation, as it facilitates consideration of how key processes mutually affect each member of the dyad (Ummel & Achille, 2016).

Within the dyadic IPA design, the data can be collected either through individual or joint interviews. In the existing literature, individual interviews have typically been preferred and it has been argued that this is a better fit for IPA, as it allows for the consideration of the experiences of the dyad without neglecting the individual experience (Antoine et al., 2016; Banerjee & Basu, 2016; Eisikovits & Koren, 2010; Ummel, 2016). However, a small number of dyadic IPA studies have opted for joint interviews in order to explore the co-construction of the topic of interest (Burton, Shaw & Gibson, 2015; Wawrziczny et al., 2014).

As the aim of this study is to explore how both the client and the therapist experienced and made sense of the work they did together, the possibility of a joint interview was considered. However, given the personal and sensitive nature of the topic, it was thought that this approach might limit the ability of the participants to speak freely about their experiences. Furthermore, in line with the existing literature, it was thought that joint interviews would render the task of elaborating the experiences of each individual, as well

as that of the dyad, more difficult (Antoine et al., 2016). In addition, given the importance often placed on endings in psychotherapy, it was also considered that joint interviews might be more emotionally demanding for the participants. Individual semi-structured interviews were therefore the chosen data collection method.

To date, much of the existing dyadic IPA research has explored couples' and familial dyads' experiences of physical health or mental health problems; for example, a recent study interviewed people with a diagnosis of anorexia and their partners about the impact of this difficulty on their relationship (Antoine et al., 2016). However, some have used this method to explore client-therapist dyads; for example, Banerjee & Basu (2016) interviewed clients and their therapists about their experience of the therapeutic relationship. In addition, Rabu, Binder & Haavind (2013) analysed post-therapy interviews with clients and therapists who both agreed that a good outcome had been achieved to explore the experience and process of ending long-term therapy. To the best of the researcher's knowledge, no previous study has used dyadic IPA to explore experiences of non-improvement in psychotherapy.

Analytic procedure

In dyadic IPA, the analytic procedure followed is largely the same as the process outlined by Smith, Flowers & Larkin (2009) for IPA with individuals. However, one of the challenges of IPA research with dyads is that there some issues and considerations that are unique to the dyadic design and these are not covered in general IPA guidelines. In order to address this issue, Ummel & Achilles (2016b), who have considerable experience of using IPA with dyads, make some suggestions regarding issues such as the order of analysis, generation of themes and presentation of findings. The analytic procedure, which was developed using both of these guidelines, was as follows:

1. Analysis of each transcript in the dyad at the individual level

This includes multiple readings of the transcript, in-depth analysis (assigning a theme to capture the meaning of each section of text) and the identification of emerging themes across the transcript as a whole. The transcripts should be analysed in the same order as interviewing (Smith, Flowers & Larkin, 2009).

2. Analysis at the dyadic level

Repeat the analysis of each transcript in the dyad, cross-referencing the emerging themes from the first transcript in the dyad with the themes from the second transcript, until no new themes emerge. This process of repeated analysis includes noting areas of convergence and divergence, commonality and idiosyncrasy between the transcripts in the dyad. Develop a summary table for the dyad (master themes, subthemes and quotations) (Ummel &Achilles, 2016b).

3. **Analysis at the group level**.

Once all of the transcripts have been analysed as dyads, contrast and compare the themes across the dyads and develop a summary table of master themes (with supporting quotations) that capture the data set as a whole, using where possible the participants' language (Ummel & Achilles, 2016b).

4. Discussion and development of findings in supervision

Presentation of the data in supervision to show the development of the themes from the initial transcription to the final themes and allow for quality checks. Use feedback from supervisors to further refine themes.

5. **Development of an interpretative account or narrative**

Each theme, and the relationships between themes, is explored in detail and illustrated with evidence from the transcripts (Smith, Flowers & Larkin, 2009).

6. Reflective discussion of the researcher's own process and the potential impact on the final interpretation

Inclusion of pen portraits to acknowledge the researcher's experience of the interviews and reflexive statements outlining researcher's relationship to the topic at the start and end of the process.

Quality Assurance

The quality of quantitative research is determined by evaluation of its reliability and validity; however, the epistemological differences between quantitative and qualitative research have led to the development of alternative criteria for measuring rigour and quality

that are more applicable to qualitative approaches (Tobin & Begley, 2004). Trustworthiness and credibility have been put forward as more useful concepts for evaluating qualitative research (Rolfe, 2006). In IPA research, the researcher actively participates in the generation of the interview data and the creation of themes in the analysis will inevitably be influenced by their own beliefs, assumptions and experiences, known as the double hermeneutic. Researcher reflexivity and transparency about their position in relation to the topic are therefore essential to account for the influence of their lens in the development of the findings and increasing their trustworthiness (Elliott, Fischer & Rennie, 1999). It allows the reader to understand the role of the researcher in developing the results, such as how the themes may have been shaped by the researcher's beliefs and life experiences (Stiles, 1993).

As Bourne (2014) notes, the use of dyads complicates these issues, due to the 'research triangle' in which multiple relationships are at a play; interviewer-therapist, interviewer-client and client-therapist. Although consideration was given to the importance of maintaining a neutral stance during the interviews (e.g. regarding both accounts are equally true, not looking for objective truth), it is possible that the order of interviewing influenced the researcher's impression of the second interviewee of the dyad. In an attempt to manage these issues, the researcher kept a reflective diary regarding the process and content of the interviews, such as the use of probes or re-direction and emotional responses to the interview material. Furthermore, quality checks would be incorporated during the analysis of transcripts and construction of themes; for example, the inclusion of a reflexive statement and audit trail, and use of supervision to increase the credibility of the analysis. The researcher also took part in a reflexive interview with a colleague prior to data collection in order to explore her relationship to the topic. The data from this interview was used to inform the reflexive statement provided at the end of this chapter and referred to during the analysis to consider the role of personal assumptions and biases on the generation of themes.

Research design

Sampling and recruitment

Participants were client-therapist dyads from NHS Adult Psychological Therapies services; this included Community Mental Health Teams (CMHT), IAPT services and a Clinical & Health Psychology service were approached. Recruitment took place in 5 local NHS Trusts: Leeds & York Partnership NHS Trust, Leeds Teaching Hospitals NHS Trust,

South West Yorkshire Partnership NHS Trust, Tess, Esk & Wear Valleys NHS Trust and Rotherham, Doncaster and South Humber NHS Trust. The inclusion and exclusion criteria are summarised in Table 1. Recruitment began in August 2017 and ended in December 2019.

Table 1. Inclusion and exclusion criteria for the recruitment of participants

Inclusion criteria	Exclusion criteria
▪ Client-therapist dyads from primary or secondary care. ▪ Aged 18 or over. ▪ Completed at least 6 sessions and finished within last 3 months. ▪ 'No reliable change' on the standardised outcome measure as defined by the Reliability Change Index (RCI) (Jacboson & Truax, 1991); either on a global outcome measure (e.g. CORE-OM) or on two trait-specific measures (e.g. PHQ-9 and GAD-7).	▪ Dyads from inpatient or specialist mental health services. ▪ Therapies of less than 6 sessions or with unplanned endings. ▪ Those who would require an interpreter due to centrality of verbal expression and language in IPA. ▪ 'Reliable change' or 'reliable deterioration' on the standardised outcome measure; 'no reliable change' on a therapy specific measure (e.g. Acceptance and Action Questionnaire (AAQ). ▪ Clients whose therapists consider them not have capacity to consent (e.g. due to cognitive impairment or learning disability).

Therapist participants were recruited first via email invitations and presentations at service meetings (Appendix I). It was considered that this approach to recruitment would likely mean that fewer clients would be given the opportunity to participate. However, approaching potential client participants first would have necessitated researcher access to the outcome databases of participating services, which was not possible due to confidentiality and data protection.

Therapists who signed up for the study were then asked to identify eligible clients from their recently discharged cases (up to 3 months after the final therapy session) or cases discharged during the recruitment period, using the pre and post therapy scores on a global outcome measure. Although a specific global outcome measure was not required, all participating services routinely administered the CORE-OM or CORE-10, so these were the measures used to identify all of the participants. On the former, no reliable change range is an improvement or deterioration of less than 5 points and on the latter, it is change of less than 6 points in either direction. Eligible clients were then invited to the study via an opt-in letter from the service that provided their treatment (Appendix I).

Potential client participants were informed on the opt-in that they had 3 weeks in which to decide whether or not to participate, in order to avoid a situation in which multiple clients of the same therapist signed up for the study. This was considered undesirable for several reasons; firstly, the preferred focus was to explore the therapies of different therapists. Secondly, it may have put pressure on the same therapist to participate twice which or have meant one of the interested clients was not allowed to participate and that there would need to be a process of selection. Interested clients then contacted the researcher directly either via email or post to register their interest and provide contact details. The researcher then contacted them directly to discuss the study and arrange an interview. Once a client participant opted-in, the researcher contacted the therapist to arrange a separate interview.

Data collection

Participants took part in one audio-recorded semi-structured interview and were given the option of being interviewed either at the University of Leeds or at the NHS service to which they were affiliated (Appendix II). The order of interviewing was determined by participant availability. The interview schedule was initially developed by the researcher and refined after feedback from academic supervisors. The schedule had been piloted with two volunteers who the researcher had personal relationships with prior to the interviews; one volunteer had personal experience of having psychological therapy and the other had experience of delivering therapy.

At the end of the interviews, participants completed a brief demographic questionnaire (Appendix III). Each participant was offered a £15 voucher in recognition of

their contribution and could choose from either Amazon or W H Smiths. Participants had the opportunity to give feedback on the interview; all of the feedback was positive. Immediately after the interviews, the researcher made a note of their experience of the interview, including the interpersonal process, initial thoughts in relation to potential themes and personal reactions to the content of the interview, in a reflexive diary. This information was used to inform the pen portraits and analysis. The audio-recordings were then transcribed either by the researcher or by an experienced transcriber who had signed a confidentiality agreement.

Ethics

The study was approved by the North West Greater Manchester NHS Research Ethics Committee and the Research and Development (R&D) departments of the participating NHS Trusts (Appendix IV & V). The key ethical issues considered in these proposals are as follows:

Service-user involvement

Prior to applying for ethical approval, the research protocol was presented as the University of Leeds Service User and Carer Panel 'Everybody's Voice'. The project received positive feedback and the comments informed the final proposal submitted for ethical approval.

Data protection

As client participants were identified by therapists in the participating services, no information regarding potential participants was made available to the researcher until the client participant contacted the researcher. Data from the outcome measures was not shared with the researcher until the client participant consented to this during the initial contact with the researcher.

Researcher safety

The interviews took place during the working hours of the University or NHS service, so that the researcher would not be alone in the building. The researcher had access to research supervision to discuss any aspects of the interviews that were distressing.

Informed consent

Participants were informed at the point of invitation that their client or therapist would also be interviewed. They were also provided with an information sheet covering key issues such as voluntary participation, potential risks, right to withdraw, data protection, dissemination of the research findings and contact details for making a complaint (Appendix VI). Participants were given 3 weeks in which to decide whether or not they wanted to take part. Prior to taking written consent at the interview (Appendix VII), the key points of the information sheet and consent form were summarised, and participants were given the opportunity to ask any questions, although no one did.

Potential for participant distress and risk management

Given that participants were asked to discuss an experience of psychological therapy in which there appeared to have been no significant change, the potential for distress was considered. It was emphasised to participants prior to interview, and during the interview as appropriate, that they were free to withdraw at any time, take breaks if needed and decline to answer any of the questions. As I am a Psychologist in Clinical Training, appropriate emotional support was offered as necessary. In addition, client participants were provided with contacts details for sources of further support they could access if left feeling distressed (Appendix VIII); however, none of them reporting needing immediate support around this. All therapist participants had access to their routine clinical supervision.

Confidentiality

Participants were informed that the content of the interview would be kept confidential unless there was reason to believe that the participant or someone else might be at risk of significant harm, which would necessitate sharing this information more widely. In addition, as the study included clients and therapists who have worked together, and the analysis presents the findings for each dyad, it was considered that participants may be able to recognise the contributions of their therapist or client. Participants were therefore given the opportunity to completely withdraw any content they felt uncomfortable with or request that specific extracts not be included in the report at the end of the interview. Participants were informed that should they have any concerns regarding this after the interview, they could contact the researcher to discuss this during the next 7 days, after which time transcribing would commence.

Reflexive Statement

Through this statement, I acknowledge the pre-existing beliefs, assumptions and biases that I bring to this topic, which have been shaped by personal and professional experiences relating to psychological therapy and mental health.

I am a 29-year-old White British female from a working-class background. I developed some understanding of mental health problems at a very young age due to the difficulties experienced by my parents. As a result, I spent a considerable portion of my childhood living away from my biological family. This is likely to have been a factor in my decision to train as a clinical psychologist, influenced my strongly held beliefs about the role of attachment in psychological distress and shaped my view of what the work of therapy often involves.

As an undergraduate, I accessed a University Counselling Service; I did not experience any positive changes as result of this therapy and was left wondering if it had been harmful. It was a short-term intervention of approximately 8 sessions and I felt that some very difficult things had been opened up, but not dealt with in a meaningful way. In addition, there were some difficulties in the relationship, as it did not always feel warm and authentic between us, and on a couple of occasions I found the therapist's responses invalidating. However, I went on to have therapy privately shortly afterwards; this was a much more positive experience in which I felt I benefitted greatly from the therapist's genuine compassion, validation and positive regard.

During the process of choosing a thesis topic, it came to my attention that my supervisors were interested in non-improvement in therapy, including how client and therapist perspectives relate to outcomes measures. I thought this would be an interesting and worthwhile area in which to develop a project; this was partly due to my own experience of unhelpful therapy, but also my professional experiences of delivering therapy in which there was little change. Prior to clinical training, I worked as an Assistant Psychologist in an IAPT service. My experience there was that a considerable proportion of clients were left feeling unsatisfied with their therapy due to the brevity of the intervention and focus on the present, with little scope for working through childhood trauma.

At the same time, I have worked with several clients, both within IAPT and secondary care services, whose outcome measures at the end of therapy showed no

significant change, but this did not fit with our shared understanding of the outcome. I'm also aware that whilst I didn't complete outcome measures during my therapy, symptom-based measures would not have adequately captured the most important changes that I experienced. This has led me to develop a curiosity about how well standardised outcome measures, which are so frequently relied upon in research and NHS service evaluations, reflect clients' experiences.

In light of these experiences, my expectation at the outset of the project was that although ostensibly exploring non-response, I would likely encounter a spectrum of experiences with regards to the degree of improvement and level of satisfaction experienced by clients. However, I anticipated that the findings would be positively skewed, as I assumed that therapists would be more likely to invite clients who they believed had benefitted. I expected that where clients didn't feel they had improved, potential themes associated with experience might include issues in the therapeutic relationship, unresolved childhood trauma and the impact of wider systemic issues (e.g. poverty and discrimination).

CHAPTER THREE: OVERVIEW OF RESULTS

Presentation of the main findings

The results are presented in the style of a case series, with a separate chapter for an in-depth account of each dyad. Although IPA studies typically focus on the group level analysis, the case series approach was considered more appropriate for the present study, in order to capture the richness of each pair's experiences and the nuances of how the outcome unfolded over the course of therapy. A group level analysis is then presented in the final results chapter to briefly summarise shared and divergent aspects of the dyads' experiences of therapy in which the outcome measures do not demonstrate a significant improvement. Each chapter begins with a pen portrait of the dyad, in order to provide some context to the therapies and interviews, followed by a detailed consideration of the themes. The individual themes of each participant's transcript are not covered in the main body of the report as there was considerable repetition between the individual, dyad and group themes. The individual themes are therefore presented in the appendices (Appendix IX).

Participants

Three client-therapist dyads took part in the study, giving a total of 6 participants. Demographic information for each participant, including the characteristics of the therapy completed by each dyad, is reported in Tables 2 & 3. All therapist participants were clinical psychologists. The client participants were all from secondary care Adult Psychological Therapies services in the Leeds & York Partnership and Bradford District Care NHS Trusts. They were referred for a range of presenting problems and received interventions of various orientations, including integrative approaches, which reflects the reality of clinical practice in the NHS. Interviews were conducted either at the University or at an NHS clinic base, depending on participant preference. The duration of the interviews ranged from 40 minutes to 135 minutes.

Table 2.Client participant demographics and the characteristics of the therapy they received

Participant	Gender	Ethnicity	Age range	Level of education	Pre-post therapy scores	Type of therapy received	Number of sessions	Presenting Problem (as defined by client)	Previous therapy (Yes or No)
Emily	Female	White British	35-45	University	6-6	Integrative (Cognitive-Behavioural, Eye Movement Desensitisation and Reprocessing, Compassion-Focused)	10	Postnatal depression, anxiety, childhood trauma	N
Angela	Female	White British	70+	University	12-10	Integrative (Cognitive-Behavioural, Acceptance & Commitment Therapy, psychodynamic)	14	Depression, anxiety, childhood trauma	Y
Mark	Male	White British	35-45	University	17-21	Cognitive Analytic Therapy	16	Depression, anger, childhood trauma, interpersonal difficulties	Y

Table 3.Therapist participant demographics and the characteristics of the therapy they offer

Participant	Gender	Ethnicity	Age range	Number of years qualified	Therapeutic orientation	Service context	Limit on number of sessions
Sophie	Female	White Other	35-45	5-10	Integrative (Cognitive-behavioural, Acceptance & Commitment, Compassion-Focused, Eye Movement Desensitisation & Reprocessing, attachment-focused)	Secondary care	16-20 with limited possibility of extending to 25
Jane	Female	White British	45-55	20-25	Integrative (Acceptance & Commitment, Compassion-Focused, Cognitive-Behavioural and psychodynamic)	Secondary care	16 sessions with limited possibility of extending to 20
Catherine	Female	White Other	35-45	10-15	Integrative overall orientation, but adherent to one model within an individual intervention (e.g. Cognitive-Analytic, Compassion-Focused, Dialectical-Behavioural and Cognitive-Behavioural)	Secondary care	16 sessions with limited possibility of extending to 20

CHAPTER FOUR: DYAD 1 – EMILY & SOPHIE

Pen portrait

Emily is married with two young children and runs her own business. She described having had postnatal depression with her first child, which reoccurred a few years later with her second child. Emily had not had any contact with mental health services prior to the postnatal depression and during the first episode, she received care co-ordination and medication, but no psychological therapy. Emily seemed reluctant to talk about her experience of depression. Her description was that she "went bonkers" and it was "pretty bad".

Sophie had been a qualified clinical psychologist in Community Mental Health for a number of years. She described her orientation as "very integrative", but often "EMDR-based" due to the prevalence of childhood trauma in the population that she works with and the influence of EMDR training on her way of conceptualising difficulties. When describing Emily's initial presentation, Sophie added that there were "some kind of psychotic elements just after having given birth, when it was all a bit too much for her". Sophie described herself as "pro-research" was interested in the study due to a belief that "we need more studies on outcome measures, especially where outcomes do not pick up all the significant changes the client and therapist might feel have been made".

Although it was unclear exactly how Emily came to be with the CMHT, it was her care co-ordinator who referred her for therapy. Emily discussed being "really keen" to avoid medication the second time around and feeling motivated to try an alternative approach. Emily explained that she went into therapy thinking that it may enable her to manage stress more effectively and improve her sleep. She also hoped to learn how to "cope with [her] mother a bit better", as she saw their relationship as playing a key role in her low mood, low self-esteem and anxiety. Although on the one hand, Emily was "keen to make some headway", she was also fearful that talking about her difficulties would "bring it all back" and "tip [her] over the edge". Whilst she had never had therapy before, she had met a therapist in her personal life through a friend, which made her wonder if therapy might be too "hippy dippy" and involve "overanalysing everything".

Sophie discussed how her understanding of what can be generally achieved in therapy had changed with experience. She no longer expected to "make people ok", as she felt the degree of trauma typically experienced by her clients often only left scope for change "in a limited sense". She gave the example of the client who is completely unable to go outside at the start of therapy being able to sit in their garden by the end of it, to demonstrate the parameters she tends to work in. However, Sophie felt that seemingly small changes could still be personally meaningful. In terms of her work with Emily, she viewed the core problem as "too much stress following the birth" and an "attachment trauma" that was deepened by the experience of having her own children. She felt from the initial consultation that Emily had "achievable" goals, but she also shared Emily's "valid concerns" about the potential for therapy to be "destabilising" and so left it up to Emily to decide whether it felt worth taking this risk.

I found Emily engaging and funny; I liked her straight away and admired her accomplishments. Although Emily spoke enthusiastically about how the therapy "was really good", at times it felt that the interview was being rushed and it seemed to me that she wanted to get it over with. Emily's was the shortest interview at 40 mins, followed by Sophie's 45 minutes. Although, on the surface, Emily was happy to talk about her experience, it seemed that she found connecting with some aspects of it very difficult. She became tearful at a couple of points during the interview. Each time, she reiterated that this was purely due to having slept poorly and I noticed that she seemed very uncomfortable with being openly emotional. Towards the end of the interview, she jokingly asked me if other participants had cried. This suggested to me that she did not feel it was acceptable and wanted to seek reassurance about this, but without showing too much vulnerability.

It was notable that whilst the focus of Emily's therapy was around facilitating connection with and compassionate acceptance of her emotional experience, she felt the need to justify and explain away her emotional responses during the interview. I felt it was beyond the scope of a research interview to reflect this back to Emily, but I was curious to know what she would make of the apparent discrepancy between the progress she felt she had made on this issue in therapy and her discomfort during the interview. This was particularly resonant given that both Emily and Sophie expressed reservations about to extent to which intervention was warranted and justifiable. It seemed that Emily's primary motivation for taking part in the study was to express her gratitude to Sophie for the support she had

received. Emily was conscious that the lack of change on the outcome measures meant that, on paper, the therapy "doesn't necessarily look amazing" and she "wanted people to see that it's not necessarily about that questionnaire". As the interview progressed, I began to wonder if part of her felt that she needed to take part and provide positive feedback, in order to justify having received the care she was not entirely sure she deserved.

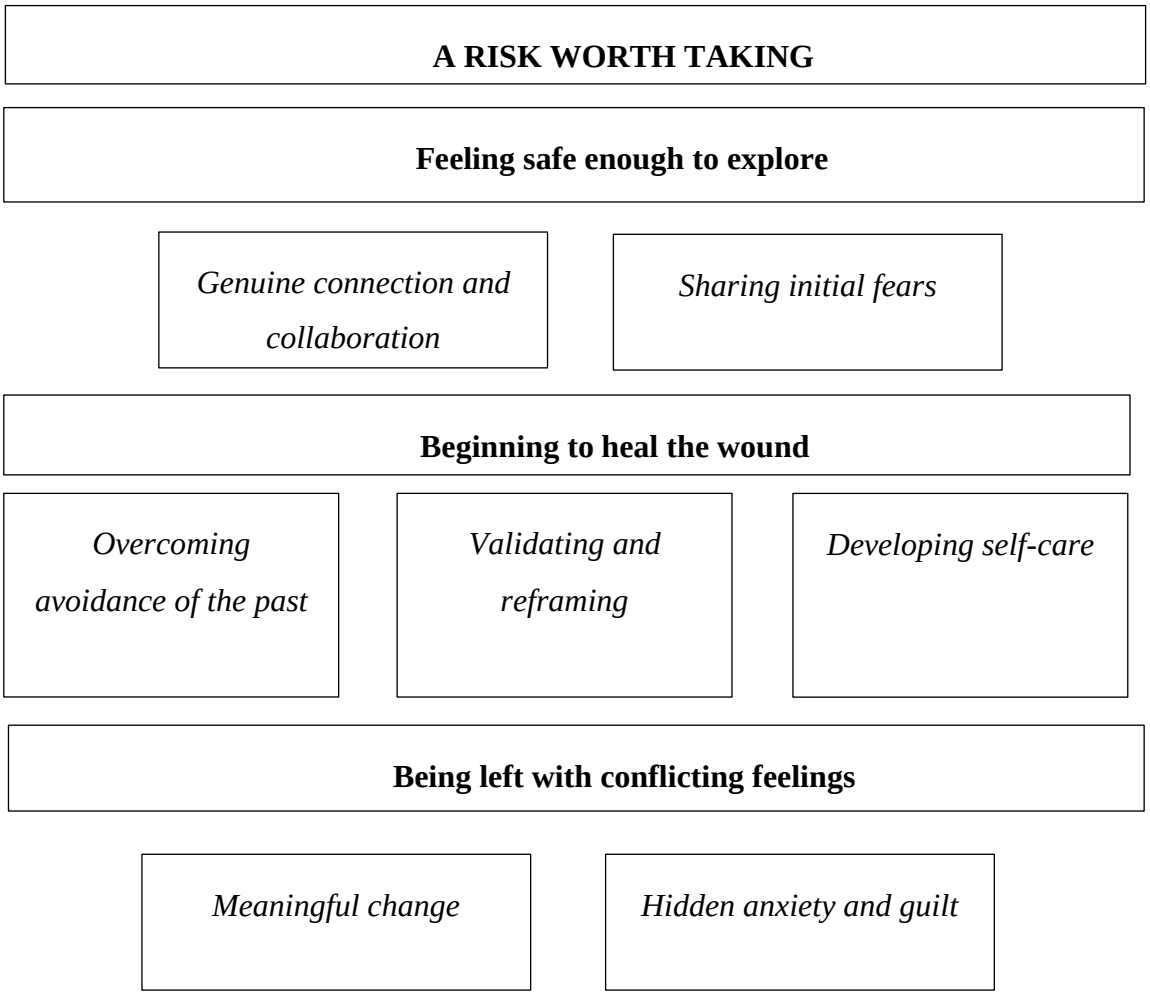
My experience of Sophie was of a compassionate, containing and dedicated psychologist. Like the previous interview, I sensed a reluctance to attend to certain aspects of her experience. I noticed that Sophie tended to focus on her formulation of Emily and perception of Emily's experience during the therapy. It felt much more difficult to facilitate connection with and exploration of her own internal experience. For example, when I asked Sophie how it felt having difficult conversations with Emily about her mum's inability to meet her emotional needs; "[pause] that's interesting actually, how was that? Yes, I guess it's so much the bread and butter of most therapy, isn't it, having people realise that they didn't get it? And what Emily was able to do, which not everyone is able to do, is to move on…but you mean how was that for me? Yes [pauses], see it's very interesting that question actually, because I so much see that as my job, but how was it for me?" I wondered if this apparent disconnect served a protective function after many years working with what she described as "really longstanding, severe and risky kinds of clients".

After having done both interviews, I was left with mixed feelings; for the most part, I was pleased that Emily felt she had benefitted from therapy and moved by the genuine bond they seemed to have. However, I also wondered with some unease about her guilt about taking up resources, her discomfort at becoming tearful and the family culture she had grown up in where emotions were seen as weaknesses. It seemed to me that this may have led Emily to minimise her needs in therapy and that Sophie may have taken this at face value as genuine readiness to end.

Analysis

The overarching theme that emerged from the analysis of Emily and Sophie's experiences was 'a risk worth taking' (see Figure 1). This theme was comprised of three subthemes: feeling safe enough to explore, beginning to heal the wound and being left with conflicting feelings.

Figure 1 Summary of the themes of Emily and Sophie's experiences



Feeling safe enough to explore

Emily and Sophie described establishing a trusting and collaborative therapeutic relationship from the outset of therapy. This allowed anxieties about the possibility that therapy might be too threatening and overwhelming to be held and contained. Although it was not possible to completely alleviate these plausible fears, the relationship was experienced as safe enough and led to mutual agreement to take the risk of opening up past traumas.

Genuine connection and collaboration

Both Emily and Sophie described feeling that they connected right from the first session and that developing a therapeutic alliance felt easy. They each described positive qualities that they valued in the other:

"I thought it would be weirder than it actually was… I liked her straight away, so that was quite easy. I didn't feel like she was judging me, which is great… she's got a really soothing way about her Sophie and I think I felt immediately comfortable with her and like I could trust her with stuff." (Emily)

"I also think that we connected really well just on a human level, you know, like you do with some people … it was just a match, a personality match kind of thing. She's quite outgoing, she's quite hip, she's into stuff that interests me, she's built up her own business, which I have a lot of admiration, genuine admiration for, you know, she saw herself as a dropout as a teacher, but I saw her as someone who's built a great business. You know, I think we personally had a lot more in common than I do with a lot of other clients, so there was some kind of – a sense of a kind of – yeah, she could almost be a friend, you know? Which is actually to be honest, in a lot of the years I have not thought that about hardly anyone." (Sophie)

They both gave examples of how key decisions about the therapy were made together:

"I didn't feel that pressure to start when I wasn't – she said I needed a bit of emotional energy do therapy properly, so we delayed it quite a few times before we started and that was quite good for me because I don't think I could've coped." (Emily)

"At the initial session Emily was very ambivalent about change and I liked her straight away because she's very honest.… I said, you know, these are all very valid concerns and I said 'why don't you think about it?' I think she perhaps expected me to be more kind of, 'you should do this' and I was like, 'no that's absolutely fine, you don't have to do this.'" (Sophie)

"It felt very much like I had to decide whether I was gonna go for it or not. Rather than like, 'this is what we recommend you do', it was more like, 'this is your choice whether you do decide to do it.'" (Emily)

The collaboration established at the initial session continued throughout the therapy. Emily described feeling that the therapeutic approach was tailored to her needs and evolved organically:

"I don't think she'd ever told me that there was a thing we were doing specifically… I think there was elements of all different kind of stuff… yeah I think she kind of reacted to what I said and then we did stuff off the back of that." (Emily)

"I said yes we could work on that - so I could offer her a perspective on what she really wanted, for her to be less bothered about her mum being critical….so we looked in the formulation at her kind of tendency to be critical of herself and her negativity around having dropped out of school, that seemed to be very related to how her mum saw her and sees her and she internalised that, so it made sense to me to say, 'yes, that seems to be the issue'". (Sophie)

Emily seemed to value this flexibility and freedom to choose the issue she wanted to work on, rather than having the focus of therapy dictated by the reason for referral:

"Talking about my childhood was kind of a surprise. I don't know, I think I thought it would be more about when I was ill with [my daughter], but I think it was more about how I am and why perhaps I am how I am and not just about me going bonkers, kinda thing." (Emily)

Similarly, decisions about the ending were made together:

"She was quite good 'cause toward the – like 'cause I thought - one week I was like is she just gonna say, 'oh shall we just stop', but we kinda talked about it and she said, you know, like what do you think? And I said, you know, a couple more would probably be – you know, it felt like a joint decision to stop rather than her just saying you've run out of your quota, or whatever." (Emily)

"I thought, 'you're doing really well', so I did bring that to her and said, you know, 'how much longer do you think is useful?', so that it didn't feel abrupt." (Sophie)

Sharing initial fears

Emily was very anxious about the prospect of commencing therapy and openly discussed these fears with Sophie during the early sessions of therapy:

"I was worried that it was going to like make – because I was still a little bit wobbly I guess and I was worried that I would potentially get ill again and I talked to Sophie about what would happen if it brought it all back again…I think I thought 'oh, once

I start -', especially talking about when I was ill, I thought that's gonna really like upset me and potentially – I think that was my main concern at the beginning and we talked about that quite a bit in the first session or two." (Emily).

Sophie empathised with Emily's fears and the dilemma about whether it was the right time to open up past traumas in therapy:

"Her ambivalences about opening them up I shared with her, 'cause I wasn't sure whether she'd be terribly destabilised… especially if you have young kids and need to get on with life, you know, I have all the time for that" (Sophie)

They both felt that Sophie was open about the potential risks and her inability to guarantee that therapy would be helpful:

"I was very honest with her, I said, 'therapy is not always the best thing'." (Sophie)

"She said, you know, like, 'I can't promise that, you know – people have different reactions to it. Yeah, I think the fact that she was like quite honest from the beginning that she couldn't promise me anything." (Emily)

In addition to exploring and validating Emily's fears, Sophie also expressed feeling hopeful about the possibility of change, which she felt encouraged Emily to engage in an emotionally challenging process:

"She said she would like to be less emotionally stirred up by interaction with her mum and I said, 'well that is certainly something that we could work towards, you know, that is achievable'. And I think was something that perhaps made her feel a bit of pain, or getting destabilised, is worth it." (Sophie)

Emily highlighted that being open about her fears outside of therapy and utilising other supportive relationships was also an important factor in deciding to take the risk:

I think I talked to [my husband] quite a bit after that first session and said, you know, like, 'what if I do get ill again?' and he said, 'well you can always stop, if you think it's like, having the opposite reaction to what we want it to do'. (Emily)

Beginning to heal the wound

Emily and Sophie developed a shared formulation that becoming a mother opened a "wound" regarding the neglect she experienced as a child and the lack of emotional support in her relationship with her mother as an adult. The focus of the therapy was on healing this wound using various therapeutic techniques: working through unresolved childhood memories, validating her distress and allowing her to grieve for what she felt she missed out on, reframing her distressing interpretation of why she did not get it and developing ways that she could give herself the nurturing she missed out on as a child in the present.

Overcoming avoidance of the past

Sophie felt that a key factor underlying Emily's postnatal depression was that having her own children had made her painfully aware of the care she had lacked as a child. She thought that Emily's main coping strategy was to suppress the distressing memories and feelings being triggered by her own experience of being a mother:

> *"Her own children really opened up this wound for her, having her own children…my perception of Emily when she came was that she managed relatively well on a symptom level because she kept everything in her boxes…in her case, for example, there was a memory of being locked away with her brother and sister in a playing pen…them being left to their own devices, neglect really, and her not having the emotional kind of nurturing that she needed. So, in that way it's trauma, it's an attachment trauma and you can work with it in that way". (Sophie)*

Emily also indicated that she had learned to avoid emotional experience and expression, as this was the norm in her family, and she feared being seen as "weak":

> *"I've not grown up in a place where you talk about your emotions, like my mum doesn't talk about feelings… I thought that I was always treated like I was a bit of an emotional wreck because the rest of my family are very, like, closed.... like we lost my dad when I was at uni and I talked to Sophie about that, that we never deal with that as a family because none of the rest of my family ever talk about stuff really." (Emily)*

Sophie viewed Emily's use of avoidance as helpful only on a superficial level and considered it to be preventing healing. Sophie therefore suggested that it might be useful for Emily to

connect emotionally with her childhood experience, to process the trauma and move forward:

> *"We used something called the loving eyes technique, the idea is that you start to see what's happened to you and some of your childhood experiences and you start to be, so to speak, your own mother, so it's psycho-dynamically informed." (Sophie)*

Emily described sharing experiences in therapy that she had never talked about before or had always minimised:

> *"A lot of the stuff about my mum and stuff I'd never really said to even [my husband] and we've been together nearly 20 years. He knew that she used to like, beat us and things, but I think I'd always kind of made it a bit of joke, so talking to someone who took it seriously – not that he didn't take it seriously, it was more that I didn't take it seriously…" (Emily)*

They both described that Emily became more able to connect emotionally with how difficult some of her childhood experiences were:

> *"She made me hold these, like, electrodes, while I was talking about a childhood memory that was upsetting and she made me think about what I would've done if it was my – if it was [my son or daughter] and that really actually made me think – it actually made me think, 'oh well actually, it wasn't ok how we were treated as kids.'" (Emily)*

> *"At the beginning she was so worried she'd disintegrate and get worse by becoming more aware of what's been wrong, and that definitely happened… it definitely made her more aware that her mum really wasn't a great mum and that she emotionally was very much on her own." (Sophie)*

Whilst connecting with these painful memories and emotions that Emily had previously been quite cut-off from was a challenging process, they both believed it to be in therapeutic in itself:

> *"I think that first – well I think I pretty much cried in all of them – I think the first couple I found really upsetting, um, but I don't necessarily think that was a bad thing, I think it was quite good to talk about it straight away." (Emily)*

"She did open up a can of worms, which she was worried about, she let the worms out and then it was perhaps ok to leave the lid off…(Sophie)

However, Sophie was left wondering if there were some emotions that Emily still struggled to access and whether a certain level of avoidance might be functional for her:

"I think that to really get angry with her mum would really complicate her relationship with her, having young children and wanting some contact with her. And I think everyone's ability to emotionally engage is limited by the on-going relationships they have to maintain, the people around them. You know, so I'm not sure she was in a position – I'm also not sure she needed to." (Sophie)

Validating and reframing

Emily described how discussing painful childhood memories in therapy was a very validating experience and that having this acknowledgement lessened the distress she felt, as this challenged the self-critical beliefs about just being a "weak" person that she seemed to have internalised:

"I don't know whether it was the electrodes, I think it was just talking about the memory more than anything. I don't know, but yeah it just made me feel a bit like stronger about it all I guess, and like vindicated – not vindicated, I don't know what the word is, but like that it's ok to feel this way about how I was brought up because, yeah, Sophie said words like neglect and stuff and actually, that seemed really shocking to me at the time, but like if it was another – if it was somebody else's parent now, like a friend of mine doing it, I would think, 'oh my god' at how awful it was, so hearing it from someone else was like, 'oh, actually'." (Emily)

Similarly, Sophie described the genuine empathy she felt for the difficulties Emily had experienced and the importance she placed on challenging the idea that the distress she felt about her childhood was a flaw on Emily's part:

"I had a lot of empathy, a lot of – I really liked Emily I think, as a person, I had a hell of a lot of empathy and I really wanted her to be kinder to herself and not see – not take these messages of being the emotional one in the family and 'pull yourself together', you know, not see it that she's wrong." (Sophie)

Emily also felt that Sophie appreciated the difficulties that her current circumstances presented:

> *"Yeah, she kind of made me feel ok about how I was thinking about stuff. You know, saying things like, 'well, it's really hard sometimes being a stay at home mum'. It's nice to hear that kind of stuff that – you know, it's nice that someone's said that, 'cause people think it's silly sometimes." (Emily)*

In addition to the validation of distressing experiences, both Emily and Sophie expressed that moving on to then reframe them played an important role in the healing process:

> *"…and also, kind of re-writing the memory really helped and it sort of made me kind of – and one of the best things she said to me, Sophie, was, 'think of your mum as emotionally disabled [laughs], which sounds – but it's that she can't do it, it's not that she's choosing not to, it's like it's a disability, the fact that, like, she doesn't - she doesn't want to see her kids, it's her – like thinking about the fact that she can't do it, it's not a choice, has actually made me think about things differently and made it less hurtful I guess." (Emily)*

> *"I think what really helped her was I once I said to her something like, 'when people have a physical disability, it's interesting because we don't ask them to get up and walk, but if then actually – because her mum really seems to have a lack empathy, you know and if people are not able to do that, we expect that they choose not to do that. I didn't want to let her mum off the hook, but it felt a little bit she was hoping her mum to be someone that she isn't… it's not because she's choosing to be evil, her mum, but that is not how she is, you know? And that it's ok for Emily to be different, to be emotional and empathic and all of that." (Sophie)*

Developing self-care

They both described how developing techniques that Emily could use to soothe herself when distressed and triggered by the difficult relationship with her mother, was an important aspect of the therapy:

> *"…like thinking about the circle of people that have supported me, like when I'm talking to her, or having a bubble, a protective bubble around me kind of helps. And, like, trying to say positive things to myself, about myself before I speak to her….*

finding your safe place, taking yourself to a safe place and trying to imagine you're like – mine's on the moor and that really helped to like calm myself down, so just some basic things like that." (Emily)

"We did an exercise where she imagined all these people who nourish her in a supportive circle with her in the middle and she can look at each one at a time and kind of feel that love and support. I thought that allowed her to really see what she's been able to create for herself now, she now has that support, so she's been able to change fundamentally the relationships she can have with people and feel nourished by that." (Sophie)

Interestingly, whilst Emily's experience of having children seemed to be the key trigger that opened the wound regarding her own childhood, they also drew on this as a source of healing in the therapy, as it allowed to access her capacity for compassion and nurturing:

"She has the capacity to be self-nurturing, which is always really important with that and I could draw a lot on her love and care for her own children, you know, where she's very different to her own mother, almost over-compensating that she her mother wasn't there for her, so being really there for her own children. Um, yeah, so she could really do that, it was easy I would say, relatively easy, because I work with a lot of people who don't have the self-compassion and then you are struggling, whereas with her that was easier. And when it was difficult, like at the beginning, for her to relate it to herself, I used her children as a 'what would you say to so-and-so, to your children? And can you say that to yourself?' And that was sometimes very emotional for her, but also very healing". (Sophie)

"She made me think about what I would've done if it was my – if it was [my son or daughter] and that really actually made me think… I think that I need to be a bit kinder to myself generally. Yeah, it's been good to try and think about – like prioritising my mental health again." (Emily).

One of the barriers to Emily being able to take better care of herself was that she had learned to criticise herself when distressed:

"That was part of one of the issues, she said she didn't want to - she said, 'my emotions are just under the surface all the time and I'm going to break out into tears',

and she definitely saw that as a weakness…she could go there in a second, which she saw as a problem, I think, whereas we might see it as an openness to be vulnerable, she saw it as, 'why am I so quickly vulnerable?' (Sophie)

The way that Sophie approached this in therapy was to model compassion and soothing for Emily. They both suggested that over time Emily began to internalise this and became more able to give herself what she had lacked from her own mother:

' Um, and there was deeper stuff, so not having the backbone of her mum, of being held enough to know that's ok, that she can [be tearful]. Um, so yeah it was normalising I think, some of that, there was some re-parenting happening in the relationship between us, you know, and in herself of course… I guess it's so much the bread and butter of most therapy, isn't it, having people realise that they didn't get it? And what Emily was able to do, which not everyone is able to do, is to move on and say 'ok I'm not able to get that, but can I give myself that and achieve some healing that way.'" (Sophie)

"I think I am a bit cynical about it a little bit, but I think I kinda made a joke with Sophie about you know, 'ughh' [pulls face], but actually even some of the stuff that I thought was hippy dippy nonsense has actually kind of – I think the more time I've had to think about it, I'm like actually a lot of it makes good sense. Erm, yeah, I think with [my husband] as well, I'll make a joke about 'ooh, well this is what Sophie would say', but actually I don't mean it in a bad way, I just mean like – acknowledging that actually it all makes a lot of sense, even if my cynical brain is like 'ughh'." (Emily)

It seemed that Emily felt less confident than Sophie about her ability to be kinder to herself and draw on self-soothing strategies, as she described a disconnect in which she knew the compassionate approach modelled by Sophie "makes good sense", but it still did not always resonate emotionally.

Being left with conflicting feelings

An interesting contradiction was that whilst Emily and Sophie clearly expressed that the work had been beneficial, particularly through Emily's increased capacity for self-care, there was also a striking ambivalence in their accounts of the therapy. Sophie described

feeling “anxious” about how well Emily was doing and “unsure” about how justifiable it was within the service criteria to offer her therapy. This was echoed in Emily feeling “guilty” about the care she received and pressured to make it “worthwhile”. These issues were not discussed in the therapy, which suggested that an opportunity to explore Emily’s beliefs about her needs being less important and feelings of unworthiness was missed.

Meaningful change

Emily and Sophie shared the sense that meaningful change was achieved in the therapy. More specifically, they felt Emily achieved her main goal of wanting to cope more effectively with the difficulties in the relationship with her mother and developing a more open and compassionate attitude towards her emotions:

> *“I just wanted to cope with my mother a bit better, that’s one of the things I found has helped no end is that I feel a bit less – she’s still rubbish, but I feel a bit less hurt by it, I guess I can cope with it a bit better…. Yeah and knowing actually, it’s ok to feel how you feel, and it doesn’t make you necessarily weak that you’re feeling like that.” (Emily)*

> *“I think that we made some quite significant, but very subtle progress on emotionally quite complex issues, of how enmeshed she was and her expectations. And her healing herself, so being a bit more compassionate with herself in the end, you know, and perhaps not seeing every time she gets upset as so much of a weakness, that that’s ok.” (Sophie)*

Emily described that the progress made in therapy had also allowed her to be more open outside of therapy:

> *“Hopefully I won’t ever get it again because I’m like more aware of how I feel and more sort of willing to talk about it, because it’s definitely made me talk more about things with my husband and my in laws.” (Emily)*

They both felt that the outcome measures did not capture the important changes that had taken place:

> *“Even though – ‘cause obviously she said to me that my scores didn’t look massively different from the beginning to the end, but that kinda wasn’t a surprise to either of us, so I kinda wanted to – ‘cause I felt like she helped me and just because on paper*

it doesn't necessarily look amazing, I kinda wanted people to see that it's not necessarily about that questionnaire." (Emily)

"The scores didn't change, I think it's exactly the same score at the beginning and the end, but it's actually showed her that you can open these things up and that she was strong enough to look at it. And otherwise, would she not have lived for a long time thinking, 'there's something I need to look at, but I'm not strong enough or I don't wanna rock the boat?' So in that way, a lot has been achieved internally, you know? A security, hopefully, that shows her – that benefits her in a deeper way, even though from a system level she wasn't someone who scored 'severe' at all, you know?" (Sophie)

It seemed significant that Emily spoke more tentatively than Sophie about the change she experienced, and that she suggested that therapy was just the starting point, with there being more work to do on her own:

"I do obviously still worry because that's my nature, but I think I'm slightly dealing with it better. I think that will be an ongoing thing for the rest of my life, I'll always have to think 'is that a helpful thought?'.... I think I've come away with strategies for how to deal with how my mum is, that's been a great help, and strategies, that I definitely still need to work on but they're coming, for dealing with when I get stressed and anxious." (Emily)

Hidden anxiety and guilt

Despite feeling that the therapy was beneficial, both Emily and Sophie seemed somewhat conflicted about it. Sophie discussed her ambivalence about the extent to which intervention was necessary:

"I think it's one of those things where the system really reacts, but I don't know if she really needed it. I think she benefitted from therapy, but I don't know if she really needed it, because we know there's a lot of people that don't get care co-ordination, but if you have that combination of young children and depression, then services go 'ooh, let's do something!" (Sophie)

The meaningful change that Emily was making in therapy seemed to leave Sophie feeling increasingly anxious about continuing to work with her:

"I think there a little bit in me where I thought, 'this client is doing much too well for our service' [laughs], you know like I never really have any gain – I mean this is the symptom-level, but I never have anyone do so well normally. You know, we have people who are doing really poorly and they do a bit of change, but she probably is more of a primary care client or as a private therapist someone I would see privately." (Sophie)

Similarly, Emily described feeling guilty about having therapy. She held a sense of her needs being less important than others' and questioned whether she deserved to have it:

"It is something I felt slightly guilty about. Like, there were people that were obviously really suffering, and I'd been – I'm generally ok, you know, should I be in the queue for therapy? There's probably people who should be further up the queue.'" (Emily)

She seemed to be left feeling somewhat burdened by a pressure to justify it:

"I think we stopped at the right time and now it's like whether I'm going to make it worth all the effort from her and from the NHS and everything, it's whether I carry it on in my life, I guess." (Emily)

Emily indicated that, unlike her initial fears about commencing therapy, she did not discuss her anxieties about whether she deserved the therapy with Sophie, which was particularly striking given that they were working on self-compassion:

"I don't suppose I talked about that with Sophie so much, but it's definitely something that I thought about and when I came the first time, I definitely thought, 'well this is a bit frivolous in a way'. I think as well because it was some of the first times I had without [my son], it felt like a bit of a luxury, even thought it was kind of tough, it felt a bit like, 'oh I'm just wandering off to [town]'. So yeah, I don't know, I suppose I didn't really talk to Sophie about that." (Emily)

In this sense, the guilt and anxiety Emily experienced around having was resonant of the difficulties she was coming with.

"In the processing it's what was there for her, so there was a lot of guilt and shame and regret, a lot of feelings of being naughty." (Sophie)

One interpretation of this is that Emily's guilt was part of a wider pattern that was repeating in therapy. When Emily spoke about the ending, she indicated that she felt able to do the rest of the work on her own. And yet, there was also a suggestion that Emily felt she could have benefitted more, but that it would have required a lot more sessions, and perhaps too many in her view:

> *"I think we were both – I was ready to – yeah I don't think that without doing loads and loads and loads more, I don't think we'd have – I felt like we'd done quite a lot of stuff that I can do, it's more about me applying it now. I think, yeah, it's more like work I've got to do." (Emily)*

In Sophie's account, there was a sense of feeling pressure to end and not feeling needed. Interestingly, her final reflection was that in hindsight, she probably would not have offered Emily any therapy at all:

> *"I mean for a while, towards the end, I thought she's done so well, I wonder how much longer I have to – or maybe I can see her, because I enjoyed seeing Emily…at some points I thought, is she – is she coming because she feels she has to come, kind of thing... I couldn't have justified seeing her for much longer, she was not even in the clinical scores anymore, you know?... if I was a manager, which I'm not, but if I was, then I would say 'actually, Sophie, this is not your kind of client, you know, she isn't severe enough to qualify for this kind of service.'" (Sophie)*

In addition to the guilt Emily felt about the care she received, she also alluded to being left with guilt because she didn't feel she expressed her gratitude to Sophie enough:

> *"I kinda wish – I thought at the end, I was like, oh I should've taken her some flowers- I just kinda wanted to say to her – but without me getting really like – but it was really useful, but I didn't know how to articulate that she'd been really helpful – [tearful] even thinking about it now makes me want to– sorry, I'm really tired. Erm, but yeah I wanted to sort of tell her – [begins to cry] sorry – but yeah, she was brill." (Emily)*

It seemed that, in keeping with the difficulties for which she was seeking help, fear of becoming tearful was a barrier to Emily having a more open conversation about the ending. Interestingly, whilst Emily indicated that something important was avoided at the final

session, Sophie did not appear to be aware that the ending was emotive for Emily. She explained that she did not have "a close sense" of how Emily found it, but that she thought she "felt alright" about it. This again seemed suggestive of an iterative process of masking and minimising.

A risk worth taking

Despite the suggestion that Emily could have gotten more out of her therapy, both she and Sophie reflected on how Emily benefited from confronting her difficult early experience, being allowed to grieve for this and learning strategies to regulate her emotions when triggered, notwithstanding their concerns about the potential for this to be destabilising.

CHAPTER FIVE: DYAD 2 – ANGELA & JANE

Pen Portrait

Angela was married with three adult children and semi-retired. She had struggled with depression and anxiety on and off throughout her life. Prior to the most recent episode, she had NOT been in contact with mental health services since early adulthood. Angela had sought private counselling on a couple of occasions in her later life and although she did find it "helpful" to talk, she didn't find that it had any lasting impact on her distress or ability to cope with her difficulties.

Jane was a highly experienced psychologist. She described her therapeutic orientation as being influenced by cognitive-behavioural, systemic and psychodynamic perspectives. She reported being "very keen on doing outcome measures" and interested in looking at different "patterns" in client's scores. She decided to take part in the study due to being "curious" about the factors influencing different scores and outcomes.

Following concerns from a family member, Angela saw her GP and was then referred to the Community Mental Health Team (CMHT) for an assessment. A psychiatrist prescribed an anti-depressant and then referred her on to Psychology. Angela described feeling "very pleased" with the referral and "readily" attending the appointment.

Angela described being bothered by feelings of "dread" and thoughts about being "evil", which she found it "extremely difficult" to understand. She hoped that therapy with a psychologist would lead to more tangible changes than the counselling had in terms of "insight" and "easing" of her distress. Jane also felt the core problem was around being overwhelmed by "intense feelings", but she also linked this to a "big insecurity" she felt Angela experienced in her relationships.

Jane viewed the key task of therapy with all of her clients as being about "how to help someone make the best of the situation they're in". She felt that recovery is closely linked to "adjustment" and saw her role as being to try and "help that person reach their potential that they can do in the context of where they're at in their life now". However, Jane sensed that she may not be able to fulfil Angela's expectations for therapy, as she felt she

was seeking a "cure". This was echoed in Angela's reflection that "it would have been good if she could have waved a magic wand".

My impression of Angela was of a warm and thoughtful person who was keen to help me with my research and to give positive feedback about Jane. Angela began the interview by emphasising how warmly she felt towards her and how she had benefitted from therapy, despite this not being reflected in the outcome measure. At the same time, the interview did not always feel entirely comfortable. It was difficult to elicit a detailed account of how she experienced the therapy and I sometimes felt I was being held at arm's length. I found myself needing to ask a lot of questions to keep the interview going. I was aware that our conversation often went off-topic, for example, to people in her family and recent events in her life. This led me to wonder if something was being avoided and whether she had found the therapy as helpful as she initially said she did. Despite speaking positively about the therapy, it seemed it was very painful for her to reflect on issues that she didn't feel were not adequately addressed. I also noticed that Angela seemed to anticipate judgement from me, as she made comments about not wanting to seem "self-indulgent" or "selfish". The disconnect I perceived between what was said and how it felt in the room resonated with Jane's comment about how it sometimes felt "strange" between them.

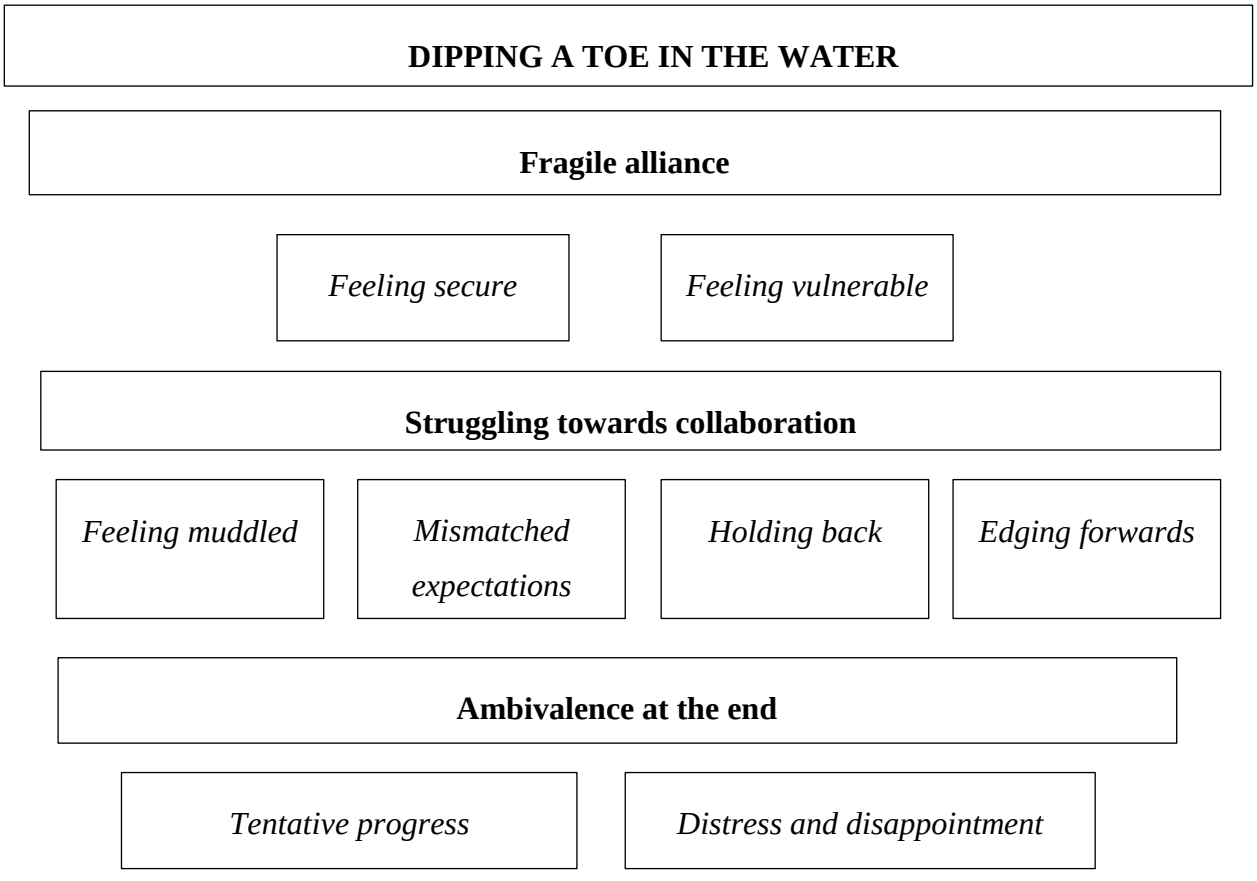
Angela was reluctant to accept the voucher I offered her for participating, as she was concerned that I had bought it with my own money and said I should save it for someone else. I was struck by the sense of underserving this suggested. We had a brief discussion about this; I explained that the vouchers were purchased from my research budget and that whilst she need not feel pressured to accept it, it was being freely offered as genuine token of appreciation for her valuable contribution. I gently enquired as to whether she thought the difficulties around self-worth that she had discussed in the interview felt relevant to this decision. In this moment, I felt very aware of the potential for the boundaries between my roles as a researcher and as a therapist to become blurred. However, I also considered it an ethical imperative that if Angela's difficulties were a factor in her reluctance, that this ought to be tentatively brought into her awareness before she decided about whether or not to accept the reward that the other participants had received. Angela appeared to be moved by this exchange and she decided to keep the voucher. It feels important to acknowledge this interaction here, as it stayed with me when analysing her transcript and is likely to have influenced the subsequent development of themes.

Throughout the interview with Jane, I experienced her as warm, reflective and curious about the experience she'd had. It seemed that the interview was a positive experience for her; "I could have done with some of these questions in supervision actually [laughs], thank you, it's really helping me think". I admired and appreciated that Jane shared with me some of the difficult feelings that came up for her during the therapy, such as frustration with Angela's negative thoughts and relief about ending. I was struck by the parallels in our experience of Angela; for example, we were both left wondering if Angela had a "filter" that was preventing her from expressing, or perhaps recognising, her true feelings and getting her needs met. I also noticed that Jane sometimes smiled or slightly laughed when discussing challenging aspects of the therapy and I wondered if there was more difficult feelings that Jane felt unable to share.

Analysis

Angela and Jane's experience fit within the overarching theme of 'dipping a toe in the water', which was comprised of three master themes: 'fragile alliance, 'struggling towards collaboration' and 'ambivalence at the end' (see Figure 2).

Figure 2. Summary of the themes of Angela and Jane's experience



Fragile alliance

Angela and Jane described having quite complex and somewhat contradictory feelings towards each other; they portrayed the therapeutic relationship as simultaneously an effective working alliance and a source of insecurity.

Feeling secure

Angela and Jane described a positive working relationship characterised by warmth and empathy:

> *"What made it hopeful? Well, her very nature… I think that her warmth combined with detachment and great professionalism, I just felt that intuitively. I would rate her very highly." (Angela)*

> *"I did like her, I do feel for her a lot…I hope she would have felt that I had respected her and valued her…I did find her life interesting and what she's done". (Jane)*

Angela highlighted that Jane was understanding, reassuring and validating, whilst Jane described feeling attuned to and moved by Angela's distress:

> *"It was very good to be able to tell her some of my fears – you know, about being – you know, about how I could harm people...but I think the way Jane was, in respect to hearing some of the bits about me, that was helpful and professional, and it almost made it normal." (Angela)*

> *"It was hard sometimes to sort of see how lonely she must have felt at times, and how as well there was this sense where she was kind of like, 'did I make the right choice there?' and 'should I have done the opposite of this thing with my life?', and actually still really struggling with those sort of crossroads decisions." (Jane)*

They expressed similar understandings of the issue that Angela wanted to work on in therapy:

> *"I think it's tied up with feeling that I am in some ways evil…very often I wake up feeling awful and dark…I think dread comes into it as well." (Angela)*

> *"She was experiencing, y'know, quite intense feelings and feeling very overwhelmed by them, very frustrated by them…despairing about the feelings she would get". (Jane)*

Despite the difficulties in the relationship, Jane discussed valuing being challenging and appreciating Angela's positive qualities:

> *"It's also very refreshing at the same time…it does keep you on your toes, clients like Angela, because they do really make you think and they have the courage to reveal a little bit more of their needy side". (Jane)*

Feeling vulnerable

Angela described feeling anxious about whether she deserved to have the therapy, she seemed to worry that Jane would feel the same and dismiss her:

> *"I think one of the things I felt overall was if I was ill enough to take her time and I felt that quite strongly because I can – you know, I don't remember ever going off work because of it, because I've always been able to keep going with it and it comes and goes." (Angela)*

This was echoed in Jane's observation that Angela seemed to anticipate invalidation and rejection:

> *"She was very worried about what I would make of her and that I would judge her in some way, that she might be written off as not being valid, that she shouldn't be here, that she was wasting my time." (Jane)*

This was also a suggestion that Angela felt insecure and unimportant in her relationships outside therapy:

> *"I'm much more likely to think about killing myself because I think, 'how can I struggle with it any longer? … and then of course my husband gets hurt because how would it be for him? Well I find myself thinking he'd find somebody else and get over it". (Angela)*

Jane described the recurrent nature of Angela's relational insecurities, which seemed to make her feel implicitly criticised and anxious in return:

> *"I'd think that had gone away and then she'd say something that would make me realise it's either back or it's never really gone away at all, you know, she worried about was I going to tell her that that was it, we've finished. And it always surprises*

you when you get from a client 'cause you kinda think, 'I never said we would do it like that and I would never do that to somebody." (Jane)

"I think she was certainly someone that in my head I'd find myself thinking 'oh gosh, would you be doing better if you were seeing somebody else?... it would make me nervous about where I stood with her because she'd be so anxious about where she stood with me [laughs]. It would increase my anxiety a bit at times; 'well am I letting you down here, is that what you're really trying to tell me?'" (Jane)

Jane discussed the impact that she felt this had on the therapeutic relationship. She described at times feeling reluctant to engage and finding it distressing:

"There were things in the therapy sometimes that were just sort of like almost torturous really, in terms of – which I think is what Angela would say she feels with her emotions sometimes, that they are torture to her…part of me would sort of think, 'I don't really want to see her today [slight laugh], it's not always going to be very comfortable." (Jane)

In this sense, Angela's anxieties about rejection, and the discomfort this elicited in Jane, seemed to create a dynamic in which Jane did sometimes feel a pull towards rejection, which was at odds with what she was trying to model for Angela:

"I'm trying to kind give out the messages, 'well, you are okay', you know in your sort of therapy way, but you're trying to say, 'I accept you' and 'you are okay' and 'you are an acceptable person and that's warts and all'. And it's actually really hard when someone feels like there's something about themselves that's not right." (Jane)

Struggling towards collaboration

Although Angela and Jane discussed working well together in some ways, it seemed that establishing a collaborative relationship, where they worked in partnership on shared understanding of the problem and towards mutually agreed goals, was a challenging process.

Feeling muddled

Angela explained that she was seeking therapy because of disturbing and perplexing feelings that she was struggling to make sense of:

"It's very hard to describe actually, extremely hard… I sometimes get extremely dark feelings when I think I'm going mad, it's partly an awful feeling of dread…but when I have this feeling the day loses some of its normal feel." (Angela)

These confusing feelings left Jane feeling puzzled and at a loss about how to help:

"There was a sense that - as if she felt like, 'I've done something really awful, but I can't remember what it is', and yet there was no evidence that she had done anything, but like, 'there might be something really wrong with me and if people really – but how do you actually get to the bottom of that for somebody if they can't remember?... it's like, 'I don't know what you do because I can't see it either [laughs], you know like I can't extract that out of your brain or memory 'cause it - and it might not even be real anyway.'" (Jane)

Overall, Angela felt that she was unable to articulate these feelings to Jane and that the therapy did not aid her understanding of them:

"I've been unable to give a shape to my worst feelings." (Angela)

Jane suggested that she found this process of struggling to make sense of an ambiguous problem frustrating and that it felt counterproductive to continue with this. Her response to this was to move away from discussing the feelings and look for a tangible focus for therapy, for instance, by looking at exercises Angela could use to cope with the feelings:

"I felt it was hard really and the best I could I do was, 'well let's just work on what we know and what we've got because you're spending all your time worrying about something that you don't even really know if it happened or not…it's almost like, 'let's just stop talking about it and just get on with doing it, there was a sense that the more we talked about it, the less we were actually getting on with it. I remember that kind of feeling of like, 'actually if we carry on having this conversation, we're not doing the work, we're talking about the work; we're talking about the lake we're going to swim in rather than actually getting on with swimming in it'. (Jane).

Mismatched expectations

They both discussed the challenge of mismatched expectations, particularly with regards to the potential outcome they were working towards. Angela described that she was seeking an expert who would be able give her answers and relief from her distress:

""I think it was not a cure for the worst feelings…I suppose it would be good if she could have waved a magic wand and that feeling had gone, you know?" (Angela)

Jane described feeling that Angela's expectation that she might get rid of the problem were unrealistic:

"I think she was hoping that I would somehow unlock a key and she'd never have to feel those feelings again." (Jane)

It seemed that this tension was difficult for both of them. This process of managing expectations and trying to negotiate an achievable goal left Jane feeling frustrated and stuck:

"But then yeah, sort of like take that to supervision really, that feeling of like [sigh] 'What- y'know, why is this feeling like this?'… I think for me it was where I could take some of that sort of like – I feel frustrated and irritated, and um the neediness that I'd feel I was getting from Angela." (Jane)

When Angela was asked what it was like to realise that her expectations of a cure could not be fulfilled, she explained that this was upsetting:

"Oh, it's not nice. It's not nice at all." (Angela)

Jane was aware of the potential for these conversations to be painful and discouraging for Angela, which meant she found herself giving reassurance about the possibility of change and feeling anxious about letting her down:

"I think there was a sense where I felt like I had to say, 'it doesn't mean to say those feelings won't change. If you have a different relationship with them, they will alter'. I found myself saying to her, 'I'm not saying that you'd carry on feeling the experience of them in the way you do, but it's not necessarily about those feelings going away…. then I would find myself thinking, 'well, she's going to judge me because I don't have the answer [laughs], y'know like, I'm not going to unlock this.'" (Jane)

Closely related to this, Angela and Jane also had incongruent expectations about their respective roles in the therapy. Angela suggested that she anticipated taking a more passive role and Jane spoke about feeling pushed into an expert role that did not fit:

"I think I hoped there would be insights into me…I probably wanted somebody who could observe things about my nature that might lead to difficulties, as well you know?" (Angela)

"There was a feature of a bit of Angela wanting - thinking that perhaps there was going to be a set answer in some way, or if only she would do this then that would unlock everything for herself and that was a hard struggle because it's sort of being thrown into that thing of, yes you are an expert, but not in that way." (Jane)

Jane felt her attempts to work more collaboratively were met with anxiety. For example, during the contracting phase where they just agreed to a small number of sessions:

"It was interesting, but this is where that sort of dance started to play out …I don't want somebody coming if they're not finding me helpful and what we're doing, but I think it made her nervous that we were just sort of, 'is this going to be helpful to you?'. She wasn't seeing that the ball was in her court, she was thinking it was all in mine." (Jane)

Holding back

Angela described having particular topics she wished to explore more in therapy that she felt Jane did not follow up and it seemed that Angela felt unable to foreground them herself:

"I think there was also some areas that I felt – but then I don't know why I felt as if there were some areas that I felt that I perhaps needed to explore a bit more than I did – but she didn't and I don't know quite why…there was the sexual difficulties in the relationship with my husband…I think too I had rather a strange relationship, not sexual particularly, with a lady who I felt figured enormously on my horizon for a time… I feel that I have a – that strong women, because she was particularly strong, have a pull for me really." (Angela)

Angela also disclosed a distressing experience from childhood that she had not told Jane about. She described being left unable to make sense of the significance of this event:

"I used to be frightened at night that I was going to die and ask for my mother regularly…and then when I called out at night, it must have been very difficult for my father because I remember he came in and walloped me. And whether – because

there was much more hitting when I was a child, I think, it was more acceptable probably – but whether it did anything to my self-respect, self-image, I don't know." (Angela)

The implication is this experience early in life had left Angela anticipating attack should she express her fears and it seemed that this would be have been valuable for Jane to know, but she was unaware. In addition, when Angela felt that therapy was feeling less beneficial over time, she didn't feel it was her place to address this and she seemed to question herself about whether this was a valid way to feel:

" I didn't feel as if Jane gave many insights of that sort of measure, as the time went on. And [pauses] – but then perhaps I'm looking for someone to say, 'now, you behave like this, you behave like this and that's why you get these feelings' [laughs], you know? And of course that's not the case." (Angela)

"No I didn't. Maybe I should've done. I didn't think about saying it because it's not up to me to - [struggles for words] she was the person who would know where to steer the course." (Angela)

Her comment about expecting someone to be able to tell her why she feels and behaves the way she does echoes Jane's perception that Angela was seeking answers and certainty that she was not able to provide. Jane sensed that Angela struggled to be completely open with her:

"I think Angela would have found it hard to let me know what I hadn't managed to do with her because she wouldn't want to disappoint me. There was a sense where she wanted to please me by doing well in therapy, so it was hard to know whether she was able to be as honest as she needed to be at times. I just wonder if there was a filter then that even she, she might not always have been aware of or she couldn't cast quite to one side." (Jane)

She interpreted this as part of a wider pattern that was established through Angela's childhood experience of growing up in an environment that did not seem to be emotionally nurturing. It was not clear whether this is something they explicitly discussed in therapy and given Angela's account of her childhood, it seemed that Jane did not have an accurate picture of how damaging her early experience was:

"When we talked about her upbringing, there was a sense where there was a right thing to do about things, but also the emotional struggles about things were not really well heard, so they would you know - people didn't want to know your kind of messy feelings". (Jane)

However, like Jane, Angela suggested that fear of invalidation was a barrier; for example, she described how these anxieties prevented her from fully discussing her worries about not deserving to have the therapy with Jane:

"I might have done, but I don't remember it being a particular issue for Jane…I don't know why I didn't, unless it was her saying, 'well, perhaps you're right, perhaps you should only make it very few sessions.'" (Angela)

Jane described trying to tailor the intervention to address Angela's difficulties around expressing herself and getting her needs met in her relationships outside therapy, but it seemed they struggled to achieve this within the therapeutic relationship:

"It's quite a good tool for helping people learn how they communicate their needs in a different way, that communicating your needs is important even if you don't then get it met and you might get it met, you might get it met better because of how you've communicated it". (Jane)

Edging forwards

They both described that, over time, they came to a shared understanding of a helpful way to approach Angela's distress:

"I think probably part way through I began to realise that possibly these feelings would never go completely and what I was then looking to with Jane was strategies to cope with the feelings when they came, I think. And also, I realised the value, if I could do it, of living in the present moment. And she said – well, together I think, we thought about the possibility of doing some mindfulness… not getting preoccupied with guilt about things you've done or felt or been." (Angela)

"I think we did sort of talk about, you know, 'you'd like these things to go away, but…', to try and help Angela see that we're all kind of living with those feelings and it's about how we live with then…I think it was better when we were talking about it" (Jane)

Jane explained that to move things forward, she encouraged Angela to bring specific examples of situations that triggered her distress to their sessions:

> *"Some of the work, when we were getting on with it, was looking at those sort of scenarios…examining the detail of what she had thought and how she'd responded to things…it's that sense of like helping people see, 'was that a relevant thought? Were you bringing in things that were nothing to do with that moment?', and it's facilitating how they control they own conduct in those conversations". (Jane)*

Angela described that this focus had sometimes been useful in enabling her to manage her emotional reactions to difficult situations in a more helpful way:

> *"One of the things Jane encouraged me to do was to focus on particular incidents – what I might have said, what I might have hoped for and how I might do it differently…yes, I'm perhaps responding differently to my husband when I'm likely to get really cross or really worked up." (Angela).*

However, Angela also expressed a sense of not getting anywhere with some of the techniques, such as mindfulness-based acceptance. She appeared to implicitly question the extent to which this practice was useful. She seemed to suggest that there is a fine line between acceptance of difficult feelings and cutting off from them, or dismissing one's needs:

> *"I just can't seem to do it very well…I had a situation with this friend yesterday and I found that I was very, very cross with her, but I didn't say it and I wonder where it's gone that feeling." (Angela)*

Here, Angela casts doubt on the extent to which she did feel that her difficulties were adequately formulated and how much the approach made sense to her.

Ambivalence at the end

Angela and Jane both described feeling that some meaningful progress was achieved in the therapy, particularly regarding Angela's relationship to her distress. At the same time, they also suggested that the final outcome felt in some sense incomplete or dissatisfactory. Whilst Jane was keen to model that an imperfect ending can be 'good enough', Angela seemed to be left feeling that, despite having made some gains in therapy, a key source of pain had not been attended to.

Tentative progress

Angela described feeling that the therapy was helpful:

> *"I valued my time with Jane…I suppose I hoped for an easing of the darker - the dread sort of feelings, and I think in a way it has been beneficial from that point of view." (Angela).*

Jane also felt that Angela had benefitted, although she seemed more cautious and uncertain about this:

> *"I hope I helped her feel a bit more secure in those relationships…but I don't know, I don't know for sure whether that – how that's lasted for her, I felt like there was probably some more work and thinking for her to do beyond the therapy too." (Jane).*

Like Jane, Angela described noticing an improvement in her relationships, but it seemed that was inconsistent:

> *"I think maybe that in some situations - maybe the realisation that I was a bit competitive – because my husband is quite competitive too in a way, I think that's part of, sometimes, any difficulty between us – so if you can say, 'ah, well, I know I'm a bit like that', or 'I know I'm likely to -', you can perhaps sometimes behave a bit differently." (Angela)*

> *"I can easily sink into sloppy, quick reaction, say to my husband, rather than use some of the ideas that I learned with Jane." (Angela)*

Angela also highlighted that she had experienced a shift in how she thought about her distress and her relationship to it:

> *"I don't know how to put it – the thing that comes into my mind at the moment is a cake. If you've got a cake in the tin and you can – it's cooked – and you can just begin to ease it out, you put your knife around it or do something like that. Sometimes I can feel that yes, it's there, but it hasn't perhaps got the hold that it had, and although that's small, it's a step…one little thought that she gave me that has remained easily helpful is, 'you're more than you think', because my tendency is very much I am what I think." (Angela)*

Interestingly, they both described feeling uncertain about the extent the other genuinely felt optimistic about the outcome, which seemed to suggest that they each picked up on the other's ambivalence about the therapy:

> *"I think she certainly articulated to me taking that stance of not bringing in everything in a relationship in one interaction, being able to slow it down a little bit for herself there and being more mindful of what was influencing how she saw what was happening and how she could then see if there was a different way to negotiate something and get different outcomes for herself… but I don't know for sure if she really meant that or if she found out later she hadn't."" (Jane).*

> *"I was interested in Jane's expression, and how far she meant it I don't know, she said, 'the healing will go on'. She may have been – I recognise that there were possibly things that she said, um, to soften the end and that might have been one, but she said the healing might well go on." (Angela)*

Distress and disappointment

In both of their accounts, there was a sense that the final outcome was in some way disappointing and incomplete. When Angela disclosed in the interview that her father had hit her as a child, she was asked if she had hoped to deal with this issue in therapy:

> *"Angela: Well, I don't know, I don't know.*
>
> *Interviewer: Okay, I was just wondering why it came up just now –*
>
> *Angela: Um, perhaps, yes, perhaps [long pause], perhaps it didn't come out enough. I feel quite tearful [begins to cry]."*

Angela discussed feeling that her early life experience in general was not explored in the therapy. She indicated that having previously felt dismissed when sharing this distressing experience made it difficult for her to do in therapy:

> *"My eldest daughter was present once when I said, 'oh, my father used to hit me'. She said something like, 'oh, it happens to lots of people, you should be over that by now, it's happened to loads of people', or something like that." (Angela)*

Although she was not able to address it in therapy, she felt the negative impact of the experience "probably went quite deep really". This seemed to resonate with something Jane

had said about her struggle to make sense of Angela's difficult feelings and the puzzling sense of badness she seemed to carry:

> *"It's actually really hard when someone feels like there's something about themselves that's not right, but they don't even really kind of know what it is, but they just know that it makes them feel like that they've got something really to be ashamed of that they're trying to - you know, that that's what they're somehow trying to make up for all the time". (Jane)*

Jane felt that Angela was unsatisfied with the outcome of the therapy, but she understood this in relation to unrealistic expectations and a wider pattern of feeling let down by others:

> *"Whether I helped her kind of adjust, 'look, it's ok that you are where you're at' - because it felt like there was a lot of trying to help her, you know, 'look, it's ok that you have those feelings, they don't have to be chased away and actually you can live with them and move with them, they don't have to disable you' - I think she didn't really want to, that wasn't the outcome she really would have wanted...a bit of Angela would always feel like she'd not got quite enough of things." (Jane)*

Angela discussed feeling some regret about the things she had not said in therapy and yet, she also appeared ambivalent about whether she could do this differently given the chance:

> *"I would have told her about the difficulties – I'd make more of the 'I'm not ill enough', perhaps, you know I might've done that…. I might have asked her why she didn't focus more on, uh, some of the things. Maybe the sex thing or my father – I might, but I don't know whether I would, you know." (Angela)*

Jane emphasised that her approach was based on acceptance and focusing on the present. Given the grief Angela seemed to still experience regarding her childhood, there was a sense that unknowingly this approach may have been incongruent with the needs Angela struggled to articulate:

> *"You've got to live the life that you've chosen, there might be a place for reviewing that and then taking a different course, but when you're at a certain point in your life, you're not being able to go back and do something else, you kind of have to carry on living with the choices you have made and what they mean… And it's sad,*

you know, it is sad and that's why we do our work, we want to help those people feel better with what they've got." (Jane)

Angela described feeling unfinished and wanting more from therapy:

"I suppose inevitably it would have been good if I could have had it for longer…I sometimes felt it was getting to something important when it was time to finish…. you always hope, I suppose, that more of the same might have done a bit more". (Angela)

Jane was aware that Angela was not ready to end at the point that they did, which was before the maximum number of available sessions, but she felt there was a therapeutic rationale to leaving it somewhat incomplete:

"I think there was a bit of her that might have been a bit cross with me that I didn't offer her all 20, but I also didn't feel that we needed to keep going any further and it was ok at that kind of mid-road…, something about having to live with something. I guess in a way I was asking her to live with things and I'd sort of live with what I might have wanted to wrap up and make a bit more shiny" (Jane).

However, Jane also suggested that she refrained from offering a follow up, as it would have been difficult to see Angela again if she was not doing well:

"But actually, to kinda get pulled into that and, like, bring her in a for a review in 6 months and, 'well, how you've got on?'- and also kinda thinking actually, 'what if she hasn't done very well, what are we going to do then?" (Jane)

Dipping a toe in the water

Both Angela and Jane described feeling that they never got to the crux of the problem and the real work of the therapy, despite having made some progress. Insecurities in the therapeutic relationship, struggling to make sense of the ambiguous dread and guilt that Angela experienced, and difficulty establishing a collaborative approach in which she felt able to take up an active role, seemed to be key in preventing them from getting to the core of the problem.

CHAPTER SIX: DYAD 3 – MARK & CATHERINE

Pen portrait

Mark had struggled with his mental health in some form for most of his life and referred to himself as "mentally disturbed". He felt that a difficult upbringing, characterised by physical and emotional abuse, was a key factor in his difficulties. Mark had sought therapy on multiple occasions since being an undergraduate student, but he didn't feel that he had benefited from any of these interventions. In the months preceding the current episode of therapy, things had become so difficult for Mark that he had been signed off sick from work due to a "breakdown". He had become increasingly isolated, as he found it distressing to be around other people. His motivation for taking part in the study was that he felt "very frustrated" not to have benefitted from the therapy and he hoped the research might provide an indication of how psychological therapies might be improved.

Catherine described herself as "quite an experienced psychologist, but not an experienced therapist", as she had been qualified for many years, but her previous roles involved less direct clinical work than her present one. She described her therapeutic orientation as "eclectic", but generally adherent to one specific model within each individual intervention. It was Catherine's commitment to research as part of her "scientist practitioner" identity and interest in research "based on real clinical practice" that led her to take part in the study. She also reported finding it useful to be able to offer Mark a further opportunity to reflect on the therapy, as she was aware that he didn't feel it had been helpful.

Mark was initially referred to a primary care mental health service by his GP, where he commenced Cognitive Behavioural Therapy (CBT). Mark described this as an unsatisfactory experience in which he felt the therapist had given up on him and unfairly blamed him for the premature ending of the therapy; "he discharged me after 3 weeks… he'd said something along the lines that I hadn't done the homework properly, but I didn't know what to write, I didn't know what to do". Shortly afterwards, Mark presented to A&E when feeling suicidal and he was then referred to the Community Mental Health Team (CMHT). He was initially offered a 5-session consultation model of Cognitive Analytic Therapy (CAT) with a different therapist, who stepped Mark up for 16 sessions of CAT at the end of their work.

Mark struggled to explain the exact nature of his difficulties. However, the overall impression he gave was that any reminder of the trauma he experienced in childhood would trigger overwhelming distress. He discussed how at times, his distress had felt so unmanageable that he worried about harming himself or others. He described himself as someone who has "been made angry and they can't do anything with it and they've got to store it up". Catherine outlined a similar understanding of his difficulties; she felt he desired closeness with others, but that difficulty being able to "tolerate" and "communicate" the distressing feelings that came with this, led him to keep himself "separate" from others.

A key difference in their perspectives, however, was that Mark frequently employed medicalised narratives of psychological distress and recovery; he expressed the desire for a diagnosis, described himself as "broken" and discussed his expectation that Catherine should have been able to "fix" the problem. Catherine, on the other hand, emphasised the importance of collaboratively developed ways of managing distress in effective therapy. Although she viewed recovery as "very individually determined", she generally hoped that her clients would end therapy with increased "insight" into their difficulties. In Mark's case, she felt he needed to find ways of relating to others differently in order to break the interpersonal "patterns" that she viewed as perpetuating his distress. Mark also identified a difficulty being with other people; for instance, through reports of verbal aggression and "dark thoughts" towards others. He discussed feeling completely "powerless" in the face of his difficulties and desperately wanted mental health services to help him to "feel better".

From the outset of the interview, Mark came across as deeply angry and cynical, both towards mental health services and society more generally. It was the longest of all the interviews at 135 minutes and the hostility that I sensed throughout the interview, although not directly towards me personally, made it a very intense experience. I felt somewhat intimidated by Mark and noticed myself holding back; at times, I felt afraid to ask follow-up questions and re-direct the interview when it was going off-topic. My anxiety was heightened by his frequent swearing and use of violent imagery; for example, "I will fucking slay the next person who says that to me" and "I often have very dark thoughts about killing people". Given that Mark "didn't say anything at all" to Catherine about the difficulties in the therapeutic alliance, my impression was that the interview became an opportunity for him to express the resentment and frustration that was left unspoken in therapy. I was aware that I found it more difficult to empathise with Mark; however, it did feel more connected

between us at times when the conversation went beyond his anger to his sadness, shame and fear. In this sense, my experience mirrored Catherine's, as she described feeling "attacked" by Mark, struggling to stay "engaged" and unable to establish reciprocity in the relationship.

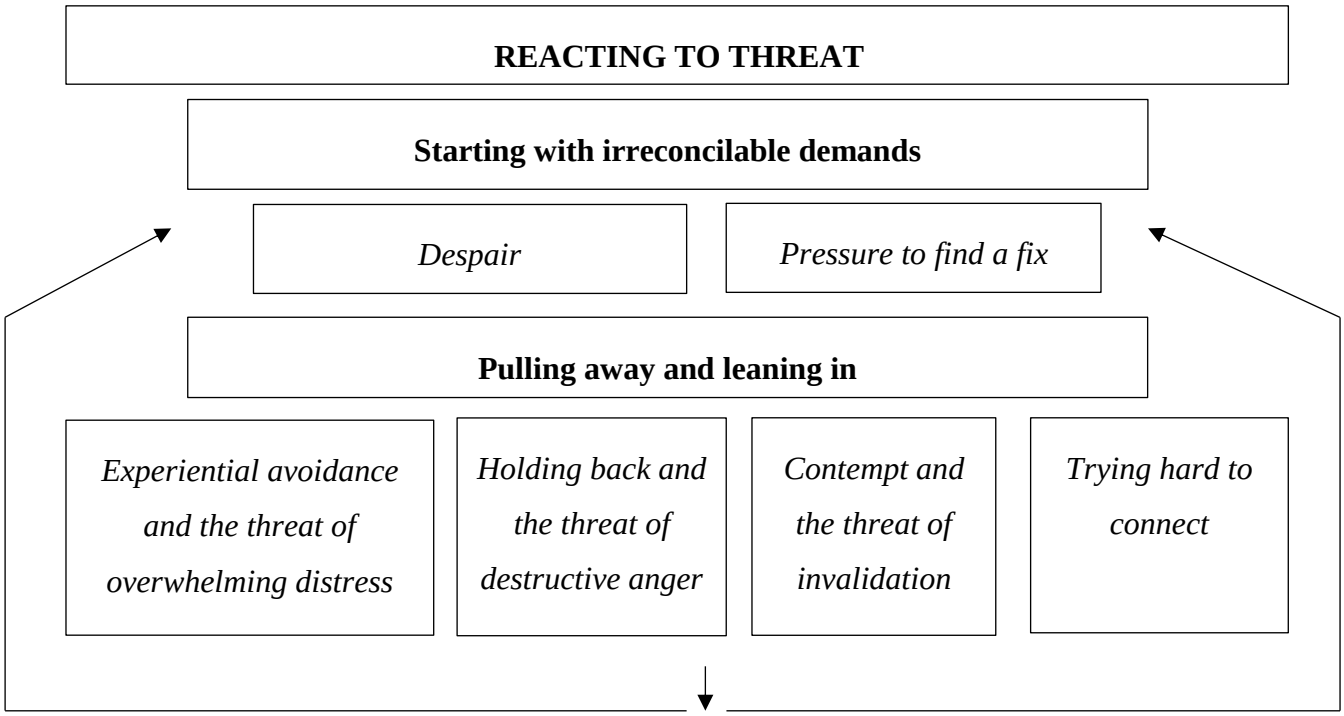
It seemed that the interview was also taxing for Mark, who reported feeling "exhausted" at the end. He didn't explicitly state that he found the interview a helpful experience; however, when discussing what went wrong and how therapy could have been more useful, he said several times that he had "never really put two and two together until literally right now", suggesting that it had been a useful reflective space.

I admired Catherine's honesty in speaking about the difficulties in her relationship with Mark and willingness to share her part in the interpersonal process. In contrast to this willingness, I also noticed that it felt more difficult to get the interview going and elicit a detailed discussion of specific events in the therapy. I wondered if the hopelessness and resignation she described experiencing in the therapy was present in the interview. Overall, the process of the two interviews felt very different. Catherine's interview was very focused, I felt much more actively involved and she was more able than Mark to speak experientially about the therapy. In contrast, Mark seemed to struggle to articulate his experience, instead often describing what happened and making evaluative statements, which left me to make inferences about his experience from the dynamic of the interview.

Analysis

Mark and Catherine's experience as a dyad fit within the overarching theme of 'reacting to threat', which was comprised of two master themes: 'starting with irreconcilable demands' and 'pulling away and leaning in' (see Figure 3).

Figure 3. Summary of the themes of Mark and Catherine's experience



Starting with irreconcilable demands

Mark and Catherine discussed experiencing powerful and contradictory emotions from the outset of therapy. They described becoming mired in despair, resignation and pressure to fulfil a desperate need for relief. This sense of feeling simultaneously incapable of, and urgently required to, make progress seemed to be distressing and disabling for both of them.

Despair

A defining aspect of the distress that brought Mark to therapy was intense feelings of despair:

> *"Have you, like, ever woken up and thought, you know, in a calm, considered way, 'it's not worth being alive anymore'? Because I have." (Mark)*

> *"I never feel better about anything, like, nothing kind of – you know? Well that's – I'm exaggerating, but the things that stick, like from years and years ago, or even like 5 minutes ago, who cares, you know, it's all the same. Like, wanting to talk*

about them and why didn't they do this? Why has that person done that? Because I don't understand. It doesn't make sense and I can't feel better about it." (Mark)

Mark's despair over the possibility of change and healing was reflected in the hopelessness and resignation that Catherine experienced from the outset of therapy:

"He had already been given the expectation that he would have the therapy, but that wasn't really an assessment that I had been part of. So, there was a sense of having to…I guess if I'm honest, I was resigned from early doors that this was what we were doing and would give it a good blast for the 16 that we'd got, we'd give it our best shot, but not necessarily holding out a great deal of hope that it was gonna make anything really different." (Catherine)

Both Mark and Catherine indicated that the pessimism they felt at the start prevailed throughout therapy and they reflected on the perceived inadequacy of the therapeutic tools they were using:

"We'd done loads of maps, we had a book full about this big [gestures] of maps and I was just like, 'yeah, actually, it's – we've exhausted it, there's nothing more I can do. But knowing that from quite early on and just having to do that week after week in terms of, 'I've got nothing else for you here'." (Catherine)

"I think a lot of those things are just this very tiny, light touch. Like, 'how are you feeling today? Are you a bit down today? Are you feeling a bit sad? Feeling a bit angry? Yeah, meditation will help you.' Brilliant. But like, 'are you mentally disturbed?' You know, 'do you have deep-rooted problems? Because this isn't going to fucking help' [laughs]." (Mark)

The fact that Catherine never truly felt able to hold any hope for a positive outcome was marked. It seemed that she felt powerless in the face of his extreme distress and that experiencing this as an inevitable failure led her to some extent to disengage emotionally.

Mark described how the approaching the ending gave new depths to the crushing sense of hopelessness he experienced. Ultimately, the therapy seemed to reinforce the difficulties that he was referred for, with this perceived failure deepening his despair and the sense of brokenness he held:

"When you get towards the end and you realise you only have two weeks left, it really comes home and – no different. You just, like, fall over, you know? It's like I've tried, I tried, what do I have to do? And you also have to think, am I– am I really broken? Am I? You know, am I one of those people you might read about on the news and never again?" (Mark)

It was these very characteristics that appeared to have a contaminating effect on the therapy from the initial session and tragically, it seemed to come full circle with the therapy potentially exacerbating the risk of suicide:

"Well if this is the best there is, what's the point? You know what I mean? There is no point in carrying on if that is all you've got to look forward to…Why would you carry on, why would you?" (Mark)

And yet, in the midst of his despair, Mark retained a glimmer of hope and was engaging with another therapist:

"So this whole therapy thing - it's like I'm one of those people who is beyond help. That's how I feel and I will always be secretly hoping that's not true because, you know, I don't know how things are going to work out with this [new] therapist." (Mark)

Pressure to find a fix

Despite the resignation and despair, Mark and Catherine still felt a sense of pressure and expectation to somehow make the therapy successful. Mark described feeling desperate for it to help, as the highest of all stakes was on the line:

It's like that thing, 'failure is not an option', you know, in therapy… it's like, 'this has got to work. This has got to work because I don't want it to go back to how it is because – because I might throw myself off a bridge.' (Mark)

Mark seemed to hold quite a medicalised view of mental health difficulties, he put Catherine in an expert role and felt that ought to be able to fix his distress for him:

"I never felt like a light bulb went on in the other person…if you say it right then you can unlock – and you've got like, 'ah, now you say it like that, now we can get

somewhere because I get it now, I know what's going on and I know how to fix it.' And I never, ever got to that stage." (Mark)

This had a considerable impact on Catherine, who felt the weight of his expectations from the initial meeting and felt set up to fail by the implication that she ought to be able to bring about change on her own:

"I suppose I felt a real pressure to do something different then, to do something even though I also felt a bit like, 'I'm not sure I'm going to be able to do anything different here', because I wasn't sure there was much sense of collaboration. There was a real – he had all this need that he expected someone else to meet and I was like, 'I'm fairly certain that I'm going to fall short of those high expectations." (Catherine)

"I don't think there was any amount of saying, 'oh, it must awful' that helped him feel like I could get it. He kept presenting it as 'so, do something now' and I'm like, 'well I can't do anything, it's awful.' And there were times I would say, 'it's ok to feel that it's awful and still do things about it when you feel awful." (Catherine)

This dynamic Catherine describes was also alluded to by Mark:

"I didn't feel like – you know there's that whole 'Good Will Hunting' thing, but I never felt like there was anything beyond, like, a normal relationship really…nothing extra, I never felt like there was this extraordinary connection." (Mark)

In the film Mark references, the therapist is working with a client who has been abused as a child and he knows exactly what to say to get behind the client's defences. He repeatedly says, "it wasn't your fault", until the client allows himself to connect emotionally with his words and from then on, the client makes a good recovery. Mark implies that he was disappointed not to have received the same connection and corrective experience with Catherine. In this sense, it seemed that his expectation of "extraordinary" may have made it more difficult for an ordinary, but 'good enough', relationship to feel sufficient.

They discussed the issue of pressure and expectations in the therapy. Mark felt attacked by Catherine's suggestion that he was seeking rescue from his distress and found the perceived insinuation that he was responsible for their lack of progress intolerable:

"'Oh, you're just looking for a quick fix, aren't you? You just want a quick fix.' I will fucking slay the next person that says that to me. It's, like, such a horrible thing to

say. I even think she said something like that, she said I wanted to be 'rescued'. You know, like, I'm not – as if maybe I wasn't willing to put the work in?" (Mark)

Whilst Mark dismissed this idea, he seemed to also hold a sense of inadequacy and helplessness at being unable to give Catherine what she needed to be able to fix him:

"*Again, about this barrier, translation barrier, that's like, 'I haven't said it properly and I don't know what to say, I don't know what to say to get through, I can't get through… I couldn't – well, I clearly didn't. You know, it's staring me in the face, if I'd said the right thing – but I couldn't." (Mark)*

Despite the fact that Catherine clearly felt Mark's expectations were unrealistic, part of her also felt responsible for the failure of the therapy. When discussing her decision to invite Mark to the study, she said:

"This research was nice to be able to offer something. So, 'you could go and talk to someone else about how unsatisfactory this has all been'. So that was – it felt like there was something I could offer at the end…it was a bit of a balm to my guilt of not being able to offer anything useful." (Catherine)

This is particularly interestingly given that she seemed to have been anticipating that Mark would hold her responsible and trying to protect herself from this from the very first session:

"In the first session I said to him, 'what would it be like if therapy was the same situation as well, where people weren't able to give you what it was that you needed?'" (Catherine)

Pulling away and leaning in

In response to the sense of irreconcilable demands, Mark and Catherine described vacillating between getting pulled in to negative interpersonal processes, due to feeling under threat, and working really hard find ways of meaningfully connecting with each other.

Holding back and the threat of destructive anger

Mark discussed not having been to express the full extent of the anger that brought him to therapy and not having felt able to disclose it when he felt angry about things that happened in the therapy:

"I feel like I'm crippled half the time, you know? Crippled with anger and frustration, you know, for me it's crippling, 'cos I'm not an outward person with it, it goes inwards..." (Mark)

"I didn't say anything at all. It didn't occur to me until just now. It doesn't occur to me until I leave the office....then afterwards you can't say things to people. I can't. I think it's like – I don't know, being afraid of conflict or challenge." (Mark)

This meant that a number of ruptures in the therapeutic alliance went unresolved. Mark described an incident that happened shortly before he commenced therapy, which was then discussed at the first session because it had been recorded on the electronic record system:

"Getting angry is bad. Getting angry is dangerous as a client…from the outset she knew what had happened, he'd fucking written to people to tell them from his point of view and what she knew about me was what he'd said. So, straight away, I'm on the backfoot, I'm on the defensive, 'you fucking people', you know, all this stuff, and the therapist said, 'I'm aware you've frightened a female doctor." (Mark)

Mark's perception was that he had expressed justifiable anger and distress, but that this had been misconstrued as him being an aggressive and threatening person. He felt this disadvantaged him because "she'd been prejudiced from the word go; her starting point was that [he's] dangerous". In addition to this difficult start, Mark described how bottling up his anger had served an adaptive function earlier in life and that his experience was that anger could have devastating consequences:

"It just doesn't occur to me to say things. Just that whole experience of, like, trying to argue back, at home I did that, like, arguments with my parents. My dad tried to kill me twice…so you learn very quickly to just keep it in or you might die." (Mark)

In this sense, Mark had both been on the receiving end of the destruction that anger can cause and experienced the shame of being accused of being the aggressor, at least as Mark perceived it, which made it difficult for him to open up in therapy and address difficulties in the alliance.

Catherine sensed that anger played a key role in Mark's difficulties, but that he had struggled to bring this to therapy, and she suggested that she was unable to find a way of helping him express his anger without acting it out:

"For him to have the feeling, it meant acting the feeling and he felt really quite trapped that he couldn't…it was almost like I couldn't understand his anger until I saw the consequences of the fury, that he'd have to smash stuff up and he couldn't do that, he felt very restrained in that. So, there was probably a lot he couldn't say about how cross he was." (Catherine)

In addition to the distress that brought him to therapy, Catherine felt that Mark was angry with her for the lack of change they experienced in the therapy, despite the fact it was not overtly expressed:

'Yeah there was lots that he didn't say really… he never really got cross with me, and I was anticipating that a bit really, that he would get angry that I couldn't fix him, but that wasn't there. I think he was angry, but that he just didn't bring it." (Catherine)

It was unclear whether or not Catherine invited discussion of the anger at not being able to be fixed that she perceived, and that Mark also articulated:

"This is why the scores plummeted at the end, like, 'it's really helping – oh, oh, we've only got two weeks left, it's really going to end, oh', you know? They're not going to go, 'yeah we arranged – but we're going to keep going, we're going to keep going Mark'. No, 'we're just going to do 16'…and it's like, 'yeah there's nothing that can't be solved with 16 hours of therapy'. Well actually, it's not therapy at all." (Mark)

In contradiction of what he said elsewhere about having gotten "nowhere" and the therapy being "useless", as Mark expressed his frustration at having to end, he implied that he wanted to continue because it was "really helping".

Experiential avoidance and the threat of overwhelming distress

Both Mark and Catherine saw difficulties with emotional regulation as a key aspect of the presenting problem. In particular, Mark's distress was triggered by reminders of his childhood experience, such as issues around drugs and alcohol:

"It could be anywhere, at any time, with anyone, doing anything and somebody could just start blurting on about their fucking 'misspent youth' or whatever they call it and that's me – I have to like – I can't stay at home, I'll end up in hospital.

So I have to – you know, I have to run. That's all I've done for the last two years is just run away from everything." (Mark)

"I think it was about his inability to tolerate really difficult feelings…and the expectation was that someone should do something to stop this happening." (Catherine)

Given that Mark typically coped through avoidance, he found it very difficult to access and connect with the buried painful feelings that brought him to therapy:

"It was so draining, it was like I couldn't answer the questions properly, it was so hard trying to dig, trying to really dig in and I was frightened, I was frightened and I was sort of ashamed because it was so hard. I couldn't answer these things that were like, 'if this is hard then it must be important', but I couldn't do it… and I came out of therapy thinking, well, I'm not in touch with any of my feelings, not the ones that matter, because I can't talk about them…how I feel when people talk about the things that upset me, you know, and like the intensity of them." (Mark)

This experiential avoidance was acted out, both in the therapy and the interview, with Mark closing his eyes and throwing arms around, as if batting things away, when he felt overwhelmed:

"When she'd ask me things and I'd do this [closes eyes and gestures with arms], 'cos that's what I do when I'm struggling." (Mark)

Mark's tendency towards avoidance was mirrored in Catherine "clock-watching" and her difficulty remembering the content of their sessions:

"There were times when I was thinking, 'did you tell me that before? I think you told me before'. Or feeling quite caught on the hop that he was like, 'I told you that last time', and I was like, 'what did you tell me last time? I've got no idea what you told me last time'. I couldn't hold it in mind, it was really hard to think about or retain what he told me from one session to the next…I did notice that was part of the material he was bringing, that people didn't remember him and I wasn't remembering him either" (Catherine)

Catherine suggests that she was less engaged with him than other clients and that this seemed to be part of a wider pattern in Mark's relationships. One interpretation of this is that

Catherine to some extent disengaged emotionally in response to the conflict discussed in the earlier subthemes of despair and pressure to find a fix.

This dilemma about how much to engage was demonstrated most strikingly through the therapeutic letter, that Catherine composed to read to Mark at the final session, but never did. Mark hadn't brought a goodbye letter to the session as requested, which she experienced as an "attack" on her because the therapy had been "so useless". When asked how it felt to read the letter, she said:

> *"It was tricky, although I think because I'd had that supervision session about session 12 or 13 that took some of the pressure off myself to deliver the goods and we'd talked [in therapy] about what it would be like to end when things had not changed a great deal. So maybe it wasn't as hard as it would have been if we'd saved it all up for the last session. There wasn't anything in the goodbye letter that I hadn't already talked about. I think I remember now that it was kinda hard because he was avoidant [pauses] and actually I can't – I should've thought of that beforehand - I'm not even sure if I read it to him, because there was so much discussion that it was like, 'how will this even matter?' And then we just never did them, there wasn't enough space." (Catherine)*

Catherine makes an interesting juxtaposition between the avoidance she anticipated from Mark given the emotive content the letter and her abandoning of it. Ending letters are a crucial feature of the CAT model, as this tool is conceptualised as one of the mediums through which the client internalises the therapist and more adaptive reciprocal role procedures (Ryle & Kerr, 2003). The fact that Catherine felt delivering the letter was futile, as well as perhaps feeling anxious about exposing her feelings, recalls the despair they both articulated from the very beginning. Catherine was aware of the pull to be resigned from the start, but by the end of therapy, it seems that she found it more difficult to resist this. In addition, her reference to feeling that Mark did not write her a letter to reject her, and the therapy, suggests that avoiding reading was also about protecting herself from feeling exposed and invalidated. Interestingly, Mark did not reference the letters at all, possibly suggesting that he didn't view them as significant. Following a question about what had meant there "wasn't space" for the letter, she replied:

> *"I can't remember [pauses]. There was a lot about Christmas, what's going to happen at Christmas, how am I going to get through Christmas? 'What if I attend the crisis team and they just send me away and I go to A&E and they just send me away because people don't understand? And, um [pauses] we talked about suicide being a choice that he could make…which is hard, really hard to deal with, really hard to listen to." (Catherine)*

Catherine's difficulty in recalling the details again feels significant, given the extremely emotive content of the session. The therapy seemed to come full circle; at the final session, they were both feeling the weight of the risk of suicide, Mark's desperation for relief and the expectation of a solution, just as they were at the first session. Catherine emphasises that this distress was not only "really hard" for him to experience, but also for her to witness. This again suggests that, at times, she disengaged with the session as a threat response to overwhelming suffering that she felt helpless to alleviate.

Contempt and the threat of invalidation

Mark described numerous instances of feeling invalidated in the therapy. Notably, it seemed that Catherine's attempts to facilitate change or encourage Mark to try a different way of coping were often experienced as dismissing the severity of his difficulties. This led Mark to be very critical of Catherine and regard her as incapable of understanding the magnitude of his distress:

> *"My scores plummeted right at the end, because I knew we, like, had two more sessions to go and we'd got nowhere. So, you know, I became very depressed, you know, suicidally depressed. Um, and she seemed to react in a way that was like, 'oh, you know, you're just going to have to throw yourself in there'. She actually said that, she actually said that, and I was like well – it's like jumping in, rowing into the Atlantic and then going 'now!' and jumping in. You'd be dead in seconds and again, that seemed to reflect to me a lack of – a complete lack of understanding. To me, had she understood it, there's no way she would have said that." (Mark)*

Although Mark felt that the idea of "jumping in" and exposing himself to feared situations was dangerous and undermining, he also felt invalidated by her suggestion of playing it safe. Whilst he felt powerless to reconnect with the world around him, the thought of continuing to live in avoidance also felt unbearable. Seemingly unaware of the dilemma this posed for

Catherine, Mark again felt contemptuous towards her, although he suggested this went unspoken in the therapy:

> *"That's another thing she said [mocking tone of voice], 'you should just stick to your board games and your music recording.' She said that about half way through, I think, and I just thought what?! You know? Like, 'play it safe'. I don't know if she just decided to try and – you know, 'maybe he just needs a kick in the right direction somewhere'...I just thought, 'really? You mean I should just like accept this new sort of life, this safer life? Um, which just completely, completely disregarded all this stuff, you know? Like, what?! We're back to this - were you even paying attention or are you just like frustrated that you can't – that we're not getting anywhere? But, you know, what about all bad stuff? What about the breakdown?" (Mark)*

Similarly, her attempts to shift his thinking away from the medicalised notion of having a mental disorder felt invalidating. This again provoked feelings of contempt:

> *"There's often been this, [mocking tone of voice] 'does it matter what it is? Does it matter? And I'm like, 'you reading that off a script? That's – you know, of course it fucking matters, what a stupid question! And it's like, 'well yes, I'm here to ask you questions, and I've got nothing Mark, so I'm going to ask you these questions." (Mark)*

Catherine sensed that Mark felt contemptuous towards her and she was aware that he tended to find her contributions invalidating. She in turn felt criticised and undermined by his insistence that she didn't understand:

> *"I think he was very contemptuous of suggestions that I made." (Catherine)*

> *"He was kind of, if I wasn't for him I was against him, you know? There was no opportunity to have a different view, or it felt very difficult to have a different view. And I think I said, 'well might there be a different way of looking at this?' But even like that possibility there was another perspective was like, 'no, you don't get it, you don't get it, how could anything else be possible? It's just this, it's just this, and if you understood, you would know it's just this." (Catherine)*

When feeling dismissed and frustrated that they were unable to establish a shared formulation of and approach to the presenting problem, Catherine sometimes found herself

responding with contempt, much in the same way that Mark felt critical of her perceived inability to understand him:

> *"At times, I wondered if I was almost doing it a bit punitively because I was like, 'oh for God's sake! It's here, look, we're doing this bit!' You know whether – because it was so blatant to me at times, but not in a way that it was for him, so it felt like I was a bit experimenting and a bit like, 'you are doing this'. You know, it felt a little bit, yeah it felt quite critical I think maybe at times. Maybe I was being quite – yeah I hope it didn't, I hope it didn't feel too much, but I worry that I was being drawn into that contemptuous role, to reciprocate the contemptuousness, you know? So, I was up here looking down on him and going, 'oh for God's sake, can't you see the process." (Catherine)*

Catherine implied that, like with Mark, this contemptuous response arose as a defence against her feeling invalidated and ineffectual in the therapy:

> *"I had written him a goodbye letter and he hadn't written a goodbye letter… you can see that as a bit of an attack that, you know…it was more an attack I was expecting, so it felt like there was something that was just a bit contemptuous, a bit, 'oh yeah, of course you haven't done yours. You were never going to do yours, were you? We knew that from the start." (Catherine)*

Mark expressed feeling that his suggestions and participation in the therapy was met with contempt, not only from Catherine, but also from the other therapists he had seen. Although he didn't identify specific instances of this, his description recalls what Catherine said about feeling "contemptuous" of him because he couldn't connect with the formulation or reflect on the therapy process occurring between them:

> *"You know, I went to every session, I did my best with everything she said. You know, you do all that stuff and they go, 'by the way, your effort in this therapeutic relationship, Mark, has been sub-par." (Mark)*

> *"There's been that element of, like, a client comes in and says, 'I think it's this', then it seems to be automatically in the therapist's mind, 'well, it certainly isn't fucking that', no matter what you say. You know, it's just like – you see, I've seen it quite a*

lot, like 'oh here's a patient who thinks he knows what he's talking about', you know, 'I've spent years studying this stuff.' (Mark)

The way in which Mark seemed to blend together different episodes of therapy in describing his experience with Catherine suggested that he felt the same pattern of feeling invalidated, contemptible and contemptuous was repeating in the current therapy, although Mark did not name this explicitly.

Trying hard to connect

Despite the difficulties Mark and Catherine experienced in establishing a positive working alliance, and the ways in which their engagement in the therapy was derailed by the sense of threat, they both felt they tried really hard to make it work. Catherine described the effort she made to stay connected and empathic. She talked about using the formulation and the counter-transference therapeutically, to avoid getting pulled in to unhelpful relational patterns:

"I felt a lot of it as a heart sink and I also remember really having to think about that, really trying to retain a sense of empathy. You know, I had to work quite hard to get myself into a place where I was thinking about, 'well what might be the function of that heart sink? What might that say about where he is and personally how I might be experienced by him…I think the function of it was to keep me at arm's length." (Catherine)

Catherine conceptualised some of the interpersonal issues they were having as being an enactment of a conflict that Mark experienced generally in his life in terms of being desperate for closeness and terrified of rejection:

"I think the formulation helped with that, that was like, 'this is the work, this is what it's like for him, day in day out, you know, he has this dilemma about how much to engage and how do you retain that, and wanting to pull away?' Yeah that's kind of the core of his dilemma, so in a way, it was like 'okay, if you understand it like that, well of course I'm going to feel like that'. You know what I mean? You can't feel like that until you start doing it and I had to do it for him, so this is the bit where I can work hard, just work hard doing this and knowing this and saying this and still trying to do something different, to be engaged.'" (Catherine)

Similarly, Mark described the extreme effort it took for him to engage in the sessions:

> *"I would just talk and I would try to get to the stuff and try my best to answer the questions, but sometimes, it was so hard, you know? And like, stuff that I've never thought of before. There was one day that was particularly tough, and I could barely stand and I felt – ah, I don't know, I felt a bit humiliated really, because it was so tough... like, 'I can't do it, I'm trying, but I don't know what to do, I don't know what to say, I don't know the answer, I have to really think about this." (Mark)*

Although they both felt overall that they "didn't get anywhere", Catherine also described feeling that over time he allowed her glimpses of a more vulnerable side. This side drew her in, as opposed to the "combative" side that kept her "at arm's length":

> *"Other times I suppose he seemed really tiny, he seemed like very small? Like, really that bit was much easier to connect with, the bits that were easier to connect with was that more vulnerable side, which I didn't see an awful lot of." (Catherine)*

Interestingly, it seemed that Mark experienced contradictory feelings about the outcome and that perhaps some subtle changes did take place for him:

> *"It was weird, I got a bit – I got a bit tetchier in the last few sessions and we both, I think, thought that things were a bit more 'real', you know?" (Mark)*

Mark suggested that towards the end of therapy he began to express himself more authentically and articulate some of his anger, although Catherine did not comment on this. This recalls his earlier comment, disclosed in the midst of his frustration at having to end, about therapy "really helping". Reflecting on what it means to have a therapeutic relationship, he said:

> *"Does it mean that you can just say what you think, you know, when you get to the point where you can just say, 'oh, I don't like that', you know?'...'I don't like that, that makes me angry; I don't like that, why have you written that? Um, maybe that's what they mean? I don't know, I guess it is, maybe, 'cos when I started getting a little bit like that she felt – I think we both felt that we were getting somewhere. But, you know, I never really put two and two together until literally right now." (Mark)*

In this sense, the full impact of therapy didn't become apparent for Mark until after the therapy finished, but these changes seem to benefit him with the therapist he had gone on to see privately after the work with Catherine:

> *"You know, that's actually funny that 'cos with this therapist work have got me on, I've been a bit like – because I came into it on the defensive expecting more of the same – so maybe I was just like – I've been a bit snappier with her, but that seems to have worked because, like, I've said things to her that I've struggled to say beforehand… you know when people say things in anger and what they say in anger is actually the truth?" (Mark)*

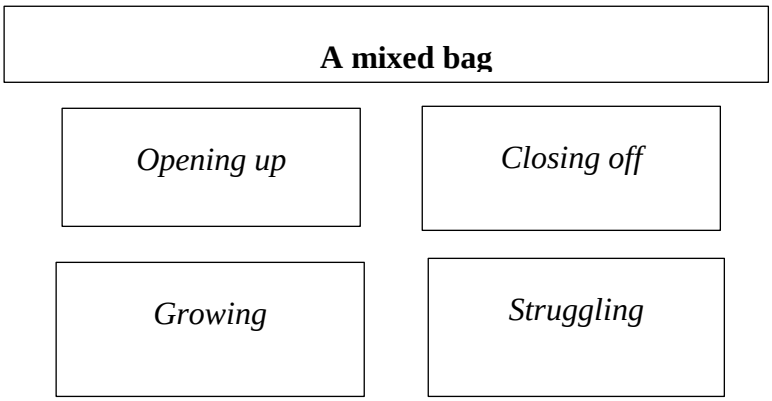
Reacting to threat

From the very first session, therapy seemed to be an overwhelmingly difficult experience for both Mark and Catherine. The long-standing depression and considerable history of ineffective interventions that brought Mark to therapy was reflected in Catherine feeling hopeless about the possibility of change right from the initial meeting. Somewhat paradoxically, this mutual despair was accompanied by an intense pressure for the therapy to be helpful, which seemed to leave them both feeling anxious and inadequate. The sense of threat created by these seemingly impossible demands in which they must make progress in a hopeless situation, appeared to contribute to a dynamic in which both client and therapist anticipated attack, rejection and failure. This gave rise to a conflict in which their attempts to work collaboratively and therapeutically together were punctuated by threat responses such as non-disclosure, emotional avoidance and contempt. These countertherapeutic behaviours meant that Mark continued to be highly distressed and there was little change; in this sense, the despair and desperation for relief that fuelled the sense of threat were inadvertently perpetuated by the therapy.

CHAPTER SEVEN: GROUP ANALYSIS

The primary focus of the study was to explore the experiences of each client-therapist dyad in detail. A brief group analysis was also conducted to bring these unique stories together by pulling out key similarities and differences (see Figure 4). The master theme 'a mixed bag' was developed to represent the group's experiences of the therapy process (opening up; closing off) and outcome (growing; struggling).

Figure 4. Summary of the themes of the group analysis



Opening up

All the client participants described sharing distressing life experiences and expressing difficult feelings in therapy:

> *"I was surprised at how easy it was to open up to her straight away…I was keen to do it, partly because my relationship with my mum is quite difficult – we talked about that a lot, me and her…" (Emily)*

> *"It was very good to be able to tell her some of my fears – you know, about being – you know, about how I could harm people." (Angela)*

> *"I would come and I would just talk, and I would try to get to the stuff… I always felt that I was as honest as I possibly could be, you know? Like I say, I pushed myself to the point where I could barely stand." (Mark)*

For Emily and Angela, this led to a sense of validation:

"No one's ever said to me that my childhood wasn't ok, so for Sophie to acknowledge that there was something quite traumatic about some of my childhood memories, I felt affirmed that actually I'm not just making a mountain out of a molehill or just an emotional wreck… maybe just opening the box in the first place made me go like, 'oh actually, maybe I will talk about this more." (Emily).

"I think the way Jane was, in respect to hearing some of the bits about me, that was helpful and professional, and it almost made it normal." (Angela)

Both of their therapists described opening up as an important part of the process:

"She was doing well quite consciously, by not looking at her problems …she did open up a can of worms, which she was worried about, she let the worms out and then it was perhaps ok to leave the lid off, but also to find a mechanism of controlling how she – you know, to be more conscious of how to protect herself." (Sophie)

"It would feel more real when we were looking at 'well what did you say? And what did they say? And how did you respond? What was going on for you inside when that was happening?'.... she was good, you know, at bringing [an example] back and then we'd look at it." (Jane)

Whilst Mark was able to share some of his life story, he seemed to struggle to allow emotional vulnerability in the sessions and didn't feel it safe to express his most difficult feelings:

"People talk about the therapy space as if it's safe, but it's not… if you're angry about people having done bad things to you, what can you do? There is nowhere to go, there is nothing you can do. You have to shut up, you have to stomach it and swallow it all the way down." (Mark)

"He had a real difficulty with how to be with others, he said he wanted to be with others because he wanted to join in, but also he held himself quite separate, I think. And that was a thing throughout the therapy as well." (Catherine)

However, despite Mark and Catherine seeming to have a much more difficult experience of trying to connect than the other pairs, Mark still felt he had become more open over time, although this seemed to come too late in the therapy to make a difference to the core problem:

"It was weird, I got a bit – I got a bit tetchier in the last few sessions and we both, I think, thought that things were a bit more 'real', you know…just more about saying what I thought" (Mark)

Closing off

In each pair, progress in therapy was limited, to varying extents, by closing off in therapy; for example, through experiential avoidance and withdrawing from the therapeutic relationship. All of the client participants alluded to experiences of invalidation, rejection and physical punishment during childhood. In this sense, it seemed that fear and shame may have been common factors driving this in. For Mark and Catherine, avoidance of emotional experience and of addressing ruptures in the relationship seemed to have a highly detrimental impact. Outside therapy, Mark described having to "run away from everything" because of the "intensity" of the distress he felt when memories his childhood were easily triggered. In therapy, he described "not being in touch" with important feelings:

"It was so draining, it was like I couldn't answer the questions properly, it was so hard trying to dig, trying to really dig in and I was frightened." (Mark)

Catherine felt this had a paralysing effect on the therapy. She also described being closed off in the therapy; she found it "really hard to think about or retain" what they discussed and because of difficulties they experienced, she gave up on the therapeutic letter she had written for the final session. In addition, they were unable to openly discuss ruptures in the therapeutic relationship, which seemed to reflect Mark's experience of dealing with conflict in relationships:

"I think he was angry, but that he just didn't bring it." (Catherine)

"I never said anything…I've been like that my whole life. If I actually respond to something, it's a fucking miracle…getting angry is dangerous." (Mark)

The role of avoidance was also very striking in Angela's story, as she found herself unable to disclose her difficult early experience, or to let Jane know that she felt certain avenues of discussion had been overlooked, due to fear of invalidation and feeling it was not her place "to steer the course" of therapy. Jane sensed that Angela had a "filter", although she was unsure what might have been held back. Like Catherine had with Mark, Jane wondered if there was unexpressed anger at the end for Angela, particularly with regards to

not being offered the maximum number of sessions available, but also frustration at what had not been achieved:

> *"I think Angela would have found it hard to let me know what I hadn't managed to do with her because she wouldn't want to disappoint me." (Jane)*

There was also a suggestion that Jane did not extend to the maximum number of sessions available, or offer a follow up, partly because of her own anxieties about how she would manage it if Angela had not "done very well" in the time since therapy.

It was notable that avoidance and disengagement was discussed the least in Emily's account, as she spoke to most positively about her experience and the degree to which she felt she had benefitted. However, avoidance still featured; like Mark and Angela, there were feelings that Emily didn't disclose to her therapist. She didn't share that she was feeling "guilty" about having the therapy and she wasn't able to address her feelings about the ending, despite wishing to express her gratitude, for fear of getting overwhelmed. Furthermore, Emily's embarrassment and dismissal of her tearfulness during the interview, suggested an ongoing struggle with self-compassion and acknowledging her own emotional needs. Whilst Sophie felt there was some avoidance, she saw this as pragmatic and functional:

> *"I think that to really get angry with her mum would really complicate her relationship with her, having young children and wanting some contact with her. And I think everyone's ability to emotionally engage is limited by the on-going relationships they have to maintain, the people around them. You know, so I'm not sure she was in a position." (Sophie)*

However, it seemed that Sophie was not aware of how ongoing issues might have been avoided through Emily's holding back of certain feelings.

Growing

Mark, Angela and Emily all expressed feeling that they'd grown in some way as a result of their therapy. For Emily, it was combination of using the strategies she had learnt to improve her mood and coming to new perspective:

> *"I suppose it has changed how I think about stuff… I'm a bit of a tense person sometimes, but I think I feel like more equipped to cope with stuff and a bit calmer*

maybe about things… I feel like I'm a bit more proactive about stuff rather than just like getting into a cycle of worry…Yeah, and the thing about my mum being emotionally disabled helped more than I ever thought it would." (Emily)

For Angela, it was embarking on a different relationship to her distress, such as through mindful acceptance of emotions and defusion from upsetting thoughts, which helped her to feel more contained and be less "reactive" in relationships:

"It was a relatively powerful period for me I think, seeing her, the therapy… it's hard to say, but perhaps it made me feel able to be more expansive." (Angela)

For Mark, it was a subtler change. It seemed that his experience with Catherine, although difficult, led to learning about the importance of authentic self-expression in meaningful relationships. Although his instinct was to "swallow" his distress, which meant feeling "crippled" by it, after therapy finished, he began to realise the value of letting his guard down. Reflecting on what it means to have a therapeutic relationship, Mark said:

"Does it mean that you can just say what you think, you know, when you get to the point where you can just say, 'oh, I don't like that', you know?'…'I don't like that, that makes me angry; I don't like that, why have you written that? Um, maybe that's what they mean? I don't know, I guess it is…. it's about saying what you really mean." (Mark)

He considered that this learning seemed to be helping him in his next therapy, as he had told his new therapist things that he'd "struggled to say beforehand".

With the exception of Catherine, the therapist participants described witnessing change in their clients. Sophie expressed this most strongly, as she felt Emily had achieved her primary goal for therapy, echoing Emily's comments about viewing her relationship with her mum from a new vantage point:

"She was just sort of doing so well and her business was picking up and she was also in terms of her mum, so her explicit aim, able to say she's hurt, but also then focus on something else. So, there were behavioural changes with her mum that made me feel like, 'yeah ok, this has had an impact on how she is with her mum and how much she can kind of look after herself in that relationship." (Sophie)

Jane was less certain about how Angela had benefitted, but she felt she was being "more mindful of what was influencing how she saw what was happening" in situations that triggered her distress and using this skill to "negotiate different outcomes for herself", recalling Angela's comment about becoming "more expansive".

Struggling

Each participant was left with struggling with some degree of distress or unease after the therapy, such as disappointment, guilt or doubt. Mark described a crushing sense of disappointment that left him feeling anxious and distraught about the possibility of recovery:

> *"When you get to the end and you realise you only have two weeks left, it really comes home and - no different. You just, like, fall over, you know…so, this whole therapy thing, it's like I'm one of those people who is beyond help…I'm no better now that I was at the start." (Mark)*

This disappointment did not seem to be shared by Catherine, for whom the lack of progress was "expected from the start" and it had been discussed in her supervision that there might be therapeutic value in allowing Mark to feel disappointed at the end. However, she felt his disappointment keenly and was left with "guilt":

> "*The third supervision I remember quite clearly because what got him talking was about my expectations and how I was working very hard to try and get a good outcome in this therapy and maybe I needed to do a bit less work, it needed to be less me and just allow him sit with: 'what if this therapy ends and you don't get enough out of it?'…this research was nice to be able to offer something, you know; 'you could go and talk to someone else about how unsatisfactory this has all been.'" (Catherine)*

For Angela, the disappointment was the focus of therapy. She felt that difficult experiences from her childhood "didn't come out enough"; Angela described that while the impact of these experiences "probably went quite deep", she had been told by her daughter that she "should be over that by now" and also reflected on physical punishment being "more acceptable" at the time, suggesting that she was left feeling confused about the validity of her distress, as well as disappointed.

Jane sensed Angela's disappointment, which she linked to her desire for a cure and to other experiences of feeling unsatisfied outside of therapy:

> *I do feel that Angela would have liked to have achieved something a bit different from what she got…and she'd do that, she'd have much more of, 'that might have been better', or you know, 'this has been a disappointment.' (Jane)*

Despite her awareness of Angela's unspoken disappointment, Jane did not describe feeling disappointed with the outcome herself, and unlike Catherine she did not experience guilt. However, she was left with uncertainty about the impact of the therapy:

> *"I do think as well she was genuine in that she did feel she had got something from it, but it's like, I suppose to what degree really?" (Jane).*

Emily was the only client participant not to articulate feeling disappointed. However, she did describe being left with doubt about whether she really deserved to have the therapy and guilt over the resources that had been invested in her recovery:

> *"…they were both complicated births, and then I went bonkers after [daughter], and then I had therapy after that, and you know, it's like, 'oh, that's a lot of money that the NHS has spent on my mental health'… that questionnaire also made me think 'is this a bit frivolous?' because I was never on the like, 'I want to kill myself' end, because I wasn't currently – you know, like I thought, 'oh no, are people coming and they're like at the extreme and I'm currently not, I'm something in the middle?" (Emily)*

Whilst not explicitly stated, Emily implied that this discomfort motivated her to end therapy sooner than she might otherwise have done, as she felt "without doing loads and loads more", she had come as far as possible after 10 sessions. Unlike Catherine and Jane, Sophie did not report sensing that Emily was left with any difficult feelings. However, she was left with some doubt about whether the therapy was really needed and if she should have provided it, echoing Emily's guilt:

> *"I think it's one of those things where the system really reacts, but I don't know if she really needed it, I think she benefitted from therapy, but I don't know if she really needed it…in the back of my mind I was thinking, you know, I'm probably – if*

someone came around I probably couldn't justify seeing her in a secondary care service, you know? (Sophie)

Despite describing very different experiences, there was a striking parallel between Sophie's and Catherine's accounts. Sophie's experience of a rewarding therapy with a client she felt made good progress and Catherine's difficult experience with a client she felt made no change, left them both feeling they were working outside of their remit and interestingly, they both reflected on whether the therapy would have been offered:

"I think I would be a bit more careful about saying, 'does this person really need therapy?', I think Emily could have done without therapy, but I think she's learnt stuff that she wouldn't have learnt without the therapy." (Sophie)

"I think I'd be a bit braver at the start and just say: 'what have you got from those five [pre-therapy consultation] sessions? Have you been able to use it? Because really if there's not much there for you, I'm not sure there's much here we can do either.'" (Catherine)

A mixed bag

Within each dyad, experiences of the therapy and understandings of the outcome were multi-faceted and contained elements of contradiction. Across the dyads, there was also a sense of diversity, with considerable variation in degree to which the different characteristics seemed to feature in their experience and in the overarching narratives that they held about the ultimate impact of therapy.

CHAPTER EIGHT: DISCUSSION

The purpose of this research project was to explore the following questions:

1. How do client-therapist dyads experience and make sense of therapy in which the standardised outcome measures suggest no significant change has taken place?

2. What themes emerge from the accounts of client-therapist dyads regarding the interpersonal process in these therapies?

In the individual analysis of the three dyads, the overarching themes were ‘a risk worth taking’, ‘dipping a toe in the water’ and ‘reacting to threat’. The group analysis of the dyads’ accounts, led to the development of the master theme of ‘a mixed bag’, which had the subthemes of ‘opening up’, ‘closing off’, ‘growing’ and ‘struggling’.

In this chapter, I aim to answer the study’s research questions by drawing on the results above. The findings will initially be discussed in the context of the literature reviewed in the opening chapter and additional literature relevant to the results. I will then discuss the clinical implications of the results, the limitations of the study and possible avenues for further research.

How do client-therapist dyads experience therapy in which the standardised outcome measures suggest no significant change has taken place?

‘A mixed bag’: ‘growing’ and ‘struggling’

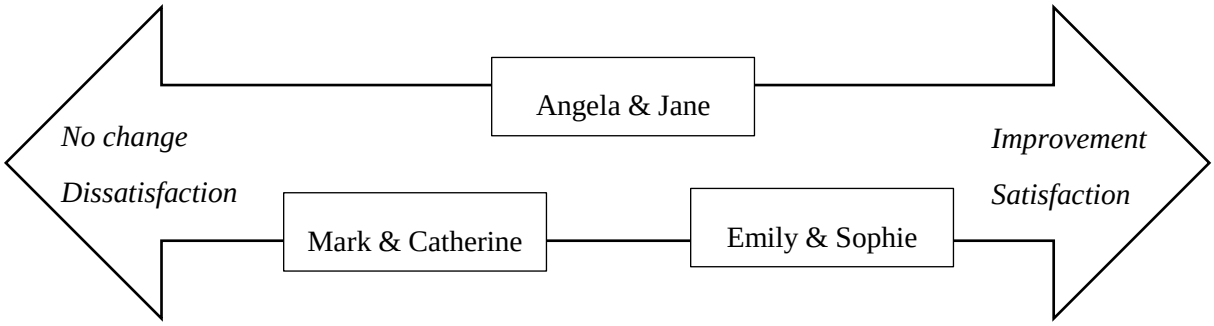
The master theme of the group analysis, ‘a mixed bag’, represents the diversity and complexity of the lived experiences of client-therapist dyads who shared the same statistical outcome of ‘no reliable change’ on the standardised outcome measure. Each dyad varied considerably in terms of the degree of change they felt they experienced and how satisfied they were with the outcome. Whether or not the outcome was viewed favourably, the clients’ and therapists’ views of the overall outcome were generally well aligned within each pair. Whilst the dyads’ experiences differed in many ways, there was some evidence of benefit and of unmet needs across all the pairs, which was captured in the subthemes ‘growing’ and ‘struggling’. Given the context of lack of change in outcome measures, it was interesting that only one of the pairs described feeling that there had been no therapeutic change; even

then, it seemed that Mark's experience of the therapy was still being revised at the time of the interview, with some small benefits being brought to light by his experience of engaging in a new therapy.

A continuum of change and non-improvement

In this sense, the findings fell on a continuum of change and non-improvement (see Figure 5). All of the accounts were somewhat contradictory, with the interplay of disappointment and gain in each of the three case studies, but each dyad held a different overriding narrative about the impact and helpfulness of the therapy.

Figure 5. Client-therapist experiences of therapy: a continuum of change and non-improvement



Although the dyads' overall assessments of the therapy determined where they were placed on the continuum, these are intended as dynamic rather than fixed positions. Experiences and understandings shifted depending on the specific aspect of the therapy being discussed, as well the point in time; for example, whether the client's primary goals or other unexpected changes was being focused on and if the participant was reflecting on their perspective at the end of therapy or a few months after the ending. In line with earlier research, the two clients who had multiple experiences of therapy, Mark and Angela, reported less change than Emily, who had never had therapy before (Radcliffe, Masterson & Martin, 2018; Reuter et al., 2015).

That the participants in the present study had such varying experiences provides a stark contrast with those of 'no reliable change' clients in NHS primary care services. For example, MacLeod's (2017) study, where 4 out 5 of participants felt they benefitted greatly from the therapy. Only 1 out of 5 participants described mixed feelings about the outcome and none of the participants reported experiencing difficulties in the therapeutic relationship.

The key themes of MacLeod's study were overwhelming positive, as participants described that therapy was 'not a cure, but still successful', experiencing important internal changes and feeling able to the rest of the work on their own. There was no suggestion of participants' struggling to engage or being left with any difficult. Similarly, McElvaney & Timulak (2013), found that no reliable change clients felt they'd benefited considerably from therapy, describing similar experiences to reliable improvement clients. Whilst Emily and Sophie's experiences were similar to the participants in these studies, as the therapy was viewed as a success, the experiences of the group were more diverse. The different service contexts may be a contributing factor in these different results, as the increased complexity of secondary care clients in the present study may have meant more barriers to engagement, making such dramatic change less likely. In addition, the interviews in McElvaney and Timulak's study were only 20-30 minutes long and the schedule was more structured, focusing on helpful and unhelpful aspects of therapy. In the present study, the interviews ranged for 40-135 minutes and the participant was invited to tell their story of the experience from the beginning, which may have allowed for the generation of richer accounts.

The experiences of the participants in the present study bear some resemblance to those in Werbart and colleagues' (2015) study of 'no reliable change' clients from a clinical trial of psychoanalytic therapy for young adults in Sweden. In their study, the participants reported a contradictory experience in which small benefits of therapy maintained their engagement, but they were ultimately left disappointed and frustrated, as the therapy did not seem to create a shift in the difficulty they were referred for. This is similar in to Mark and Angela's experiences, as they also described that their core difficulties remaining largely untouched by therapy, but that feeling better for having someone to talk to kept them going until the end. This also recalls the experiences of a sample of secondary care NHS clients who self-identified as not having experienced significant change in therapy where 5 out of 7 participants felt there was "no lasting positive impact" on the core problem. (Radcliffe, Masterson & Martin, 2018). However, the two existing studies found their participants to be a relatively homogenous group, unlike the continuum suggested by the present study.

Despite the similarities, there were some interesting differences with the findings of Werbart et al. (2015). Evidently, Emily and Sophie's experience of 'a risk worth taking' suggests a far more positive encounter. In addition, the overarching theme of Mark and Catherine's accounts, 'reacting to threat', indicates a more distressing experience that

'spinning one's wheels'. Whilst Mark did briefly allude to therapy "really helping" when he discussed his distress at having to end, for the most part he reported experiencing "no benefit at all". Mark felt that desperation was the driving factor in continuing to engage in a therapy that both he and his therapist described as overwhelming difficult. As such, Angela and Jane's experience of 'dipping a toe in the water' seems more comparable to 'spinning one's wheels'. And yet, despite the fact that Mark appeared much angrier than Angela in response to the lack of change, there was also a suggestion that Mark gained some insight as to why the therapy with Catherine failed. He described that this seemed to be helping him to begin making progress with the core problem in the next episode of therapy. However, Angela did not report feeling better equipped to approach the core problem in the future; in fact, she described feeling that she probably would not have been to disclose the important aspects of her experience that she withheld, even with the benefit of hindsight.

That the present study found a wider range of experiences of the outcome applies to the therapists' experiences as well the clients' experiences (McElvaney & Timulak, 2013; MacLeod, 2017; Werbart et al., 2015; Werbart et al., 2018). Sophie felt the therapy was very successful, Catherine felt nothing had changed and Jane was left feeling unsure whether anything meaningful had been achieved. There are two existing studies of therapists' experiences of 'no reliable change' cases; both of these derived from the Swedish psychoanalytic therapy clinical trial discussed earlier and one of them included client-therapist dyads. Unlike participants in the present study, these studies found the participants' overall perception was that the therapy been unsuccessful, due to lack of shift in the core problem and in the dyad study, there was a high level of agreement within the dyads regarding the lack of change (Werbart et al., 2018; Werbart et al., 2019). However, an interesting difference was that in the therapist only study, when small benefits where reported despite the core problem being largely unaffected, the researchers interpreted this a self-serving bias. In contrast, in two of three dyads in the present study, both client and therapist reported that the outcome was somewhat mixed and in the remaining dyad, Mark and Catherine, it was the client that reported a small benefit that the therapist was not aware of.

Clients' difficult experiences of case tracking

Regarding the experience of using standardised outcome measures and case tracking in therapy, some research suggest that clients generally view the use of these measures more

positively than therapists (Thew et al., 2015; Unsworth et al., 2012). However, in the present study, all three therapists reported generally finding these measures helpful in their work, in spite of their limitations; although Catherine added that in the therapy with Mark, she felt the measures became a "distraction" that made it difficult to focus on the same issue from week to week. Although the inclusion criteria for the study was only to have a pre and a post therapy score, all of the dyads used the measures sessionally. Interestingly, none of the three clients reported finding the outcome measure useful in opening up discussions with their therapists or making sense of their progress. They felt the CORE was too "one size fits all" and that it did not adequately capture many of the areas they were hoping to experience change in. This provides interesting contrast with the suggestion of an earlier study of non-improvement that using case-tracking may have helped to get therapy back on track.

In addition to lack of benefit, they also reported some negative effects of using the outcome measure. Both Emily and Angela linked having a low score and largely unchanging score each session to the guilt they felt about whether they deserved to have therapy; they also expressed that part of their motivation for taking part in the study was to highlight that the scores were not an accurate reflection of their understanding of the outcome. This stands in contrast with a previous study of client perspectives that found case tracking to be a therapeutic experience (Thew et al., 2015; Unsworth et al., 2012). Furthermore, Mark and Catherine's use of the measure seemed to lead to a crucial misunderstanding. Mark described intentionally scoring higher to communicate his distress at ending and wish to continue. However, Catherine explained that his high score helped her to justify the decision not to offer more and this miscommunication seemed to add to Mark's sense of being abandoned.

This fits with existing criticisms of standardised outcome measures in terms of how the interpersonal processes of therapy may influence how the measures are used and limit the reliability of the scores (McLeod, 2011). For instance, research suggests that it is common for scores to increase at the final session for reasons such as the one given by Mark. For example, a study of over 27,000 clients using the Outcome Stability Index, which assess unstandardized residual variance of the final session score (i.e. divergence from what would be predicted based on previous scores) found that 33% of scores had poor stability, with these scores being more severe than expected. This tool may therefore prove useful in future psychotherapy research and studies of non-improvement. The findings also possibly suggest that clients scoring at the extreme ends of the measure may have more difficult experiences

of outcome measurement than other clients, in line with an earlier study that reported that receiving negative feedback through case tracking, such as worsening or unchanging scores, predicted a negative final outcome (Errázuriz & Zilcha-Mano, 2018). However, further quantitative and qualitative research is needed to investigate client experiences of case tracking and the impact on clinical outcomes.

What themes emerge from the accounts of client-therapist dyads regarding the interpersonal processes involved in these therapies?

'A mixed bag': 'opening up' and 'closing off'

Psychotherapy research has consistently demonstrated that the therapeutic alliance is the most reliable predictor of therapeutic outcomes (Horvath, Del Re, Fluckiger & Symonds, 2011; Wampold, 2001). In the present study, the participants' descriptions of the quality of the therapeutic relationship varied considerably across the three pairs. In line with the existing research, the dyad who described the relationship the most positively (Emily and Sophie: 'feeling safe enough to explore'), also seemed to experience the most change in therapy, whereas the pair who described the most difficulties in the alliance (Mark and Catherine: 'reacting to threat') seemed to experience little change, with the more ambivalent pair falling somewhere in-between (Angela and Jane: 'fragile alliance'). Two key factors that seemed to influence the dyads' experiences of the alliance and the outcome were the degrees of 'opening up' and 'closing off' in therapeutic relationship. These themes captured the varying extents to which the client disclosed their distress and shared relevant life experiences, how receptive the therapists were to the clients' distress and how prevalent negative interpersonal processes were, such as rejecting, dismissive or passive behaviour.

Real relationship vs pseudo-alliance

The value of being open and the detrimental impact of closing off in the dyads' accounts fits with the concept of the 'real relationship'; this has been defined as the ability of the client and therapist to be genuine and accurately attuned to the other's feelings and intentions (Gelso, 2002; Greenson, 1967). A recent meta-analysis of 16 studies found a moderate correlation between both client and therapist ratings of the real relationship and the final outcome on standardised measures (r=.38) (Gelso, Kivlighan & Markin, 2018). In the present study, Emily and Sophie, who appeared to be the most satisfied with the outcome of the therapy, described having an authentic relationship ('genuine connection and

collaboration', 'sharing initial fears'), whilst the least satisfied pair, Mark and Catherine, described feeling defensive and distant ('holding back and the threat of destructive anger', 'contempt and the threat of invalidation').

Other qualitative studies looking at the process and outcome of therapy have suggested that the tone of the alliance is established early on and then has a cumulative impact on the outcome over time (Strupp, 1980; Werbart et al., 2019). This also seemed to be the case in the present study and comparing the paired accounts provides some context to the types of issues that may influence this process. In the more successful therapy, Sophie liked Emily "straight away", due to perceived similarities between them, such as Emily's high level of day-to-day functioning, which made it feel like she could "almost be a friend". In contrast, for the other two dyads, the initial interaction was marked by difference. Catherine felt "resigned" to failure as she felt pressure from him to provide a "fix" she didn't believe was possible, and Mark felt "on the defensive" following a reference she made to an incident documented in his notes that he thought "prejudiced" her against him. Similarly, Jane described feelings of inadequacy and "frustration" in the face of Angela's desperation for a "cure" that made it difficult to establish the collaborative relationship that Jane saw as essential for progress.

The importance of an authentic and trusting alliance in the findings of the present study is also in line with those from previous qualitative studies on 'non-improvement'. These studies found that clients perceived emotional disclosure, and the associated empathic and validating responses from their therapists, as helpful experiences, regardless of their overall assessment of the impact of the therapy; for instance, this was captured in themes such as 'talking is good', 'good therapeutic relationship' and 'valued therapist's non-judgemental stance' (De Smet et al., 2019; McElvaney & Timulak, 2013; McLeod, 2017; Werbart et al., 2015). The benefit of opening up has also been demonstrated by studies of therapist and client in-session behaviours, such as facilitation of emotional processing, emotional disclosure, empathy and validation, that have found these behaviours to be positively associated with good outcomes on standardised measures (Chui et al., 2016; Fisher et al., 2016; Iwakabe et al., 2000; Malin & Pos, 2015; Najavits & Strupp, 1994). The contribution of the present study is the finding that similar process of change can occur in therapies where the outcome measure suggests no change has taken place. This stands in contrast to Werbart et al.'s (2019) dyad study where good agreement on goals, shared

understanding of the problem and positive working alliance were characteristic of reliable improvement cases, but not no change. The overarching theme of Emily and Sophie's accounts, 'a risk worth taking', is particularly relevant here, as it signifies the therapeutic value of engaging with difficult material and allowing vulnerability in therapy. In addition, the theme 'tentative process' in Angela and Jane's accounts demonstrates the power of normalising and validating distressing thoughts.

In contrast, the prevalence of non-disclosure, and difficult interpersonal dynamics that tended to go unspoken, in two of the dyads resonates with the concept of 'pseudo-alliance'. This has been defined as a superficial alliance in which there is an outward appearance of working together, but the avoidance of conflict and self-exposure is prioritised over authentic interaction (Bender, 2005; Doran, 2016). The types of non-disclosure discussed by participants in the present study were similar to those in an earlier large study of non-disclosure: hiding difficult feelings towards the therapist or therapy (Mark and Angela) and minimisation of the presenting difficulties (Emily) (Blachard & Faber, 2016; Hook & Andrews, 2005). That the clients in the present study reported holding back in therapy supports the findings of existing qualitative studies that suggest non-disclosure contributes to lack of improvement, although with the caveat that the participants' understandings of the outcome were more complex than simply no change (De Smet et al., 2019; Radcliffe, Masterson & Martin, 2018; Weerbart et al., 2015; Werbart et al., 2018).

For instance, a study of 'no reliable change' clients contained the theme 'experiencing distance to the therapist', which signified clients' struggles to allow emotionally vulnerability. The authors described how their client seemed to react aversively to their attempts to get close, whilst perceiving the therapist as judgemental (Werbart et al., 2015). Another study using the same design had theme 'the patient's resistance', which signified holding back of feelings and avoidance of therapy tasks (De Smet et al., 2019). Comparably, Radcliffe et al.'s study included themes such as 'fear of judgement', 'fear of losing self-control', 'hiding' and 'passivity', all of which added to a sense of emotional avoidance and things left unsaid. These themes of distance and fear not only resonate with the sense of threat and the dynamic of push and pull described in Mark and Catherine's accounts, but also with Angela and Jane "feeling vulnerable" in the relationship and "struggling towards collaboration". Again, the findings of the present study suggest that this was a two-way process, as two of the three therapists also described feeling distant from

their client at times; for example, Catherine experienced “hopelessness”, as well as moments of “contempt”, whilst Jane described finding the dynamic of therapy with Angela “weird” and some of her feelings difficult to make sense of, with the resulting “frustration” seeming to make it harder to empathise on occasion.

In addition to the parallel between the findings of the present study with other studies of client experiences, the results also bear some resemblance to the core category of a recent study of therapist experiences of no reliable change therapies. The authors’ theme of ‘only having half the patient in therapy’ also suggested that whilst attending regularly, the clients were not fully engaged (Werbart et al., 2018). However, whilst non-disclosure was discussed in all three dyads, the quality of engagement was more variable in the present study than what Werbart et al.’s finding suggests. The overarching theme of Angela and Jane’s accounts, ’dipping a toe in the water’, resonates most with this theme, as it suggests an experience of testing the water, but fearing full immersion and keeping most of one’s self back. Although the master themes of Mark and Catherine’s accounts, ‘reacting to threat’ and ‘pulling away and leaning in’ reflect a similar idea, it seemed that for this pair, patterns of attack, defence and withdrawal kept them at such distance that there was less real engagement than in Angela’s account or Werbart et al.’s study. It is important to note that unlike in Werbart et al., it was not just the client who struggled to fully engage; Catherine also described difficulties around this, as encapsulated in the themes of ‘despair’ and ‘experiential avoidance and the threat of overwhelming distress’.

The inclusion of paired accounts in the present study allowed the role of key processes indicated in earlier studies to be explored from both perspectives. Regarding the therapists’ awareness of the clients’ non-disclosures, Catherine felt it likely that there were unresolved ruptures, whereas Jane had a vague sense that something was being held back that she couldn’t pinpoint and Sophie did not report any sense of non-disclosure. Of the two that did have some awareness, neither described how they approached this; for instance, whether or not they tried to discuss this with the client. Earlier studies suggest that therapists struggle with negative emotions towards the client in no-change therapies and that clients in these therapies sometimes experience their therapist as passive or judgemental (Hopper, 2015; Radcliffe, Masterson & Martin, 2018; Werbart et al., 2015; Werbart et al., 2018; Werbart et al., 2019). The present findings suggest that the frustration, anxiety and hopelessness experienced by the therapists may have limited the change achieved in therapy.

For example, Mark described experiencing some dismissiveness, invalidation and passivity from Catherine, despite Catherine thinking that her difficult feelings towards him had not come across. Similarly, whilst Angela did not report any overtly negative experiences of Jane, she did feel some topics were not fully explored and was disappointed to be ending after 12 sessions when she had not yet disclosed a significant trauma. Jane felt she had done as much as she could, but she referenced feeling stuck as part of her decision to end. These findings recall those of Werbart et al.'s (2019) dyad study, in which unresolved ruptures in the alliance, difficulties collaborating and poor agreement on the goals or focus of therapy were characteristic of no change therapies. It is also in line with earlier studies that have demonstrated a link between client and therapist in-session hostility, such as subtle expressions of rejection, frustration and disinterest, on clinical outcomes (Chui, Hill, Kline, Kuo & Mohr, 2016; Najavits & Strupp, 1994; von der Lippe et al., 2008). In addition, although Emily did not report picking up on Sophie's anxieties about whether she ought to be working with her, she did articulate feeling "guilty" about taking up her time and they agreed to end after 10 sessions, despite Emily seeming to have some unresolved issues. However, in addition to Sophie's anxiety about the service criteria, there was also a sense in which her positive feelings towards Emily may have meant that Sophie missed some ways in which Emily was not allowing herself to fully engage. The finding that a therapist's positive experience of a therapy can also close down potential therapeutic avenues provides an interesting contrast to the existing studies that have focused on the detrimental impact of therapists' negative emotions, such as hopelessness and frustration (Chui, Hill, Kline, Kuo & Mohr, 2016; Hopper et al., 2015; von der Lippe et al., 2008; Werbart et al., 2015; Werbart et al., 2018). This dyad also provides a detailed example that compliments the theory put forward in Werbart et al.'s (2019) dyad study that positive transference may also limit progress in therapy.

Attachment and engagement in therapy

In a theory informed by psychoanalytic, cognitive and developmental ideas, Bowlby (1969) put forward that humans have an innate drive to form emotional attachments to those around them. He suggested that early experience of having our needs met or unmet by our primary caregivers shapes our 'internal working models' of self, other and world. In this sense, early attachment is thought to influence a child's self-worth and expectations of how others will respond to their needs; these assumptions are believed to have a considerable

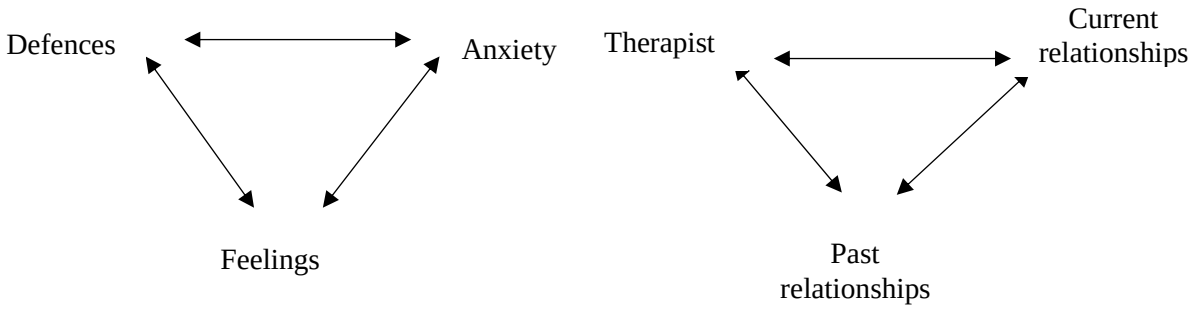
influence throughout life on how people relate to others. Broadly speaking, attachment styles can be secure or insecure and there are different subtypes of insecure attachment. For adults, this is anxious-preoccupied (clingy, needy and placating, fearing abandonment), dismissive-avoidant (independent, fearing rejection) and fearful-avoidant (unstable and fluctuating view of self and other, wanting and fearing closeness) (Bartholomew & Horowitz, 1991). Bowlby later applied the tenets of attachment theory to psychological therapy, arguing that a key task of the therapist is to provide a temporary attachment figure and safe base from which the client can explore their feelings and through which internal working models can revised (Bowlby, 1988).

In the present study, the clients all described experiences of not having their emotional needs met in childhood, which implies that these were not secure attachment relationships. Although Emily seemed for the most part, to still be able to form a trusting and open relationship with her therapist, for Mark and Angela, their experiences of insecure attachment seemed to mean that the intimacy of the therapeutic relationship felt threatening. This appeared to lead to a reversion to learned self-protective strategies such as withdrawing, placating and attacking the therapist, that ultimately seemed to perpetuate their difficulties in getting their needs met. This theory fits with an emerging body of research that has evaluated the influence of attachment styles on clinical outcomes; for instance, a recent meta-analysis of 3,158 clients from 36 studies suggests that clients with insecure attachment styles achieve poorer outcomes in therapy than clients with secure attachment styles (Levy et al., 2018). Interestingly, another study found that therapist attachment anxiety in the therapeutic relationship had a significant negative impact on their ratings of real relationship ($p=0.001$) and on client self-reported outcomes ($p=0.003$). Similarly, secure attachment has been associated with better quality engagement and outcomes; for example, Miller-Bottome et al. (2019) found that client in-session secure attachment was associated with the repair of ruptures in the alliance according to both client and therapist self-report. The findings of the present study resonate with this, as the clients of the two therapists who described feeling insecure in the therapeutic relationship reported significant difficulties with non-disclosure, which is suggestive of issues establishing a real relationship, and they spoke less favourably about the outcome than the client of the therapist who did not report feeling insecure in the alliance.

Therapy as a threatening experience

All of the participants described therapy as a threatening experience to some extent; this is demonstrated in the dyad themes 'reacting to threat' (Mark and Catherine), 'feeling vulnerable' (Angela and Jane) and 'sharing initial fears' (Emily and Sophie). Across many psychological theories and therapies, anxiety is conceptualised both as a target for therapy and necessary component for effective engagement. For example, overcoming experiential avoidance in Acceptance and Commitment Therapy, managing the threat system in Compassion-Focused Therapy and the use of exposure work in Cognitive Behavioural Therapy for PTSD (Blackledge & Hayes, 2001; Ehlers & Clark, 2008; Gilbert, 2009. In psychodynamic therapy, of which there are many variants, the core task of therapy is to overcome the defences the client has unconsciously developed to prevent them from experiencing the painful emotions that drive their difficulties, so they can connect with these avoided feelings and find healthier ways of relating to others (Davanloo, 2005; Malan, 1979; Stiles et al., 1990). In this sense, therapy is viewed as a process of learning to open up instead of shutting down with anxiety and defences. These ideas are summarised in Malan's (1979) triangle of conflict and person (see Figure 6).

Figure 6. Triangle of conflict and person adapted from Malan (1979).



The triangle of conflict puts forward that the process of the therapist helping the client to become more aware of their defences and get closer to their avoided feelings triggers anxiety in the client and that this must be dealt with first before continuing to explore the underlying difficult feelings. A key part of the therapist's role is therefore to be vigilant to signs of anxiety so that they can encourage the client to attend to it, rather than neglecting it or dismissing it whilst being completely overwhelmed. The regulation of anxiety is considered essential in enabling the client to safely and effectively process the avoided

feelings. The triangle of person suggests that the therapeutic relationship that the client develops with the therapist will have resonance with both their current relationships and early attachment figures. The two triangles are connected, as the nature of the client's defences and content of the avoided feelings are thought to relate to the client's early experience. In addition, the dynamics of these past relationships are considered to have a powerful influence on the client's interactions with the therapist and the therapist's experience of the client.

Although none of the clients in the present study were receiving this approach to therapy specifically, the presence of anxiety in all of the accounts, and the different ways in the which the dyads responded to this sense of threat, is resonant of the theory above and seemed to have an impact on the degree of change each dyad experienced. This was most striking in Mark and Catherine's accounts; he described not being "in touch" with the feelings that "matter", trying to "dig" to get to these feelings and feeling "frightened" by this. It seemed that the sense of threat this created sometimes led to dissociation, as Mark described feeling disoriented after sessions and forgetting what happened; similarly, Catherine described him getting "dysregulated". At other times, the threat seemed to fuel the dynamic of attacking and defending that they described getting drawn into.

For Angela and Jane, who had more ambivalent views on the outcome, the impact of threat seemed to be a more implicit process of fearing emotional vulnerability and holding back, rather than the more overt defensiveness suggested in Mark and Catherine's accounts. Angela came to therapy with a vague sense of "dread" and being "evil" that she struggled to articulate and couldn't place, which evokes a sense of avoided feelings around the distressing early experience she later disclosed in the interview. Angela reflected on how discussions in therapy brought up anxieties around invalidation and dismissal, and Jane described her as placating and passive, which seemed to work to keep these feelings unexplored. In this sense, both Mark and Jane's accounts recall Werbart et al.'s (2018) conclusion that the therapists in their study struggled to bring important cut-off feelings that were central to the problem into the room, with the present study demonstrating how these this idea was suggested in both the clients' and the therapists' experiences.

In contrast, Emily and Sophie experienced anxiety primarily at the start of therapy, when they worried that exploring difficult past experiences might lead to deterioration. With

regards to her difficult early experience, Emily said she "didn't take it seriously" before therapy and had "never thought of it as abuse". Despite the anxieties that showed up at the prospect of discussing these experiences, the threat seemed to subside as the therapeutic relationship developed and with exposure to difficult memories, and she was able to confront the past and experience sadness for how she treated. When interpreting the data in light of this framework, it makes sense that Emily seemed to experience the most change in therapy.

Regarding the triangle of person, this seemed to connect to the nature and source of the threat they experienced in therapy. All three of the clients made connections between traumatic experiences in their early attachment relationships, such as abusive or neglectful parenting, and their anxieties about opening up in therapy. For instance, they each disclosed experience of having their feelings invalidated and being physically punished in response to emotional expression during childhood. Whilst closing off in therapy seemed to be in some ways an unconscious process, in sense of being cut off from difficult feelings, client participants reflected on how their early experience shaped the response they anticipated from their therapist and led to more conscious decisions not to disclose. For example, Mark made links between experiences of being beaten as a child and feeling it was too "dangerous" to express his anger in therapy. Similarly, the passivity and insecurity that Jane experienced from Angela makes sense in the context of her having been beaten for crying as a child. In addition, Angela made a tentative connection between a previous experience of being told that what happened to her as a child did not matter and non-disclosure in therapy. Emily described that an initial barrier to engagement in therapy was growing up in a family where emotional expression is viewed as "weak" and she was labelled an "emotional wreck" for getting upset. She recognised that this created a pull to dismiss her distress as "silly", but with the help of strong therapeutic relationship, she seemed to overcome this to some extent by using self-compassion, despite the fact that tearfulness appeared to continue to be a source of shame for her.

Clinical Implications

Although the client participants were recruited into the study on the basis that their standardised outcome measures showed no reliable change, the dyads' experiences fell on a continuum of self-rated improvement. This highlights that it is important to be aware of the potential for such measures to overlook changes that clients experience when using them in

therapy, service evaluation and clinical research. It also confirms the value of using a range of measures. The degree to which outcome measures were used consistently varied across the psychological therapies services in which recruitment took place. The participating therapists chose to use case tracking; however, many of the therapists approached reported only using the CORE pre and post because it was a service requirement. Many of them said they did not make use of the scores therapeutically and in some services, the therapist did not even see the scores, as the measures were submitted by the client to administrators. The finding that clients may be distressed by their scores or use the measure to communicate their distress at ending, emphasises the importance of having conversations with clients about their scores if asking them to complete these measures, in line with existing guidance (Thew et al., 2015; Unsworth et al., 2012). Given that neither of the clients who described feeling guilty because of their low scores disclosed this to their therapist, it may be useful for therapists to pre-empt this difficulty when clients are scoring low.

Whilst attachment styles were not measured in the present study, the qualitative findings suggested that attachment difficulties may have had an impact on the therapeutic alliance and engagement in therapy, particularly through non-disclosure and difficult interpersonal process. This suggests that it may be useful for therapists to routinely help clients reflect on their attachment styles and how it might impact on the therapy; this approach is built in to some therapeutic models, such as Cognitive Analytic Therapy, but it may a helpful integration across therapeutic modalities. Similarly, the findings suggest the usefulness of allowing time in supervision for therapists to reflect on attachment styles and consider how these might be playing out in therapy.

Related to this, the findings highlight the importance of therapists being able to detect and willing to address ruptures in the alliance. In two of the dyads, there were clearly some difficulties in the therapeutic relationship, particularly with regards to clients not being open with their therapists about their priorities for therapy, their thoughts about how it was progressing and their feelings towards the therapist. Both therapists in these dyads sensed that their clients left important things unsaid, but it was not clear how they deal with it; for example, whether they explicitly discussed this with the client, normalising it and inviting the client to be more open. Although the study did not collect data on whether sessional measures of the alliance were used, none of them reported having done so. Several researchers have argued that using such measures helps clients to disclose issues in the

relationship and dissatisfaction with therapy, by welcoming feedback that might be difficult to hear. Given that the clients in this study reported anticipating dismissive, aggressive and rejecting responses from others, this seems a particularly useful strategy.

The clients also referred to expectations they had about what therapy would be like and preferences regarding the focus or type of approach. Research has shown client expectations and preferences to have a significant impact on therapy outcomes (Lindhiem et al., 2014; Swift & Callahan, 2009). It was unclear to what extent these were considered when deciding what therapeutic approach to offer. As in the existing dyad study, there was a sense that the clients who reported getting less out of therapy may not have had a good match or that there was less negotiation and accommodation to the client (Werbart et al., 2019). For instance, one of Angela's goals for therapy was to gain more "insight" into her thoughts and feelings; during the interview, it became apparent that she had difficult childhood experiences she wanted to discuss that were highly relevant to her distress, but she struggled to bring up. In this sense, a third-wave approach focusing on the present and mindful acceptance may not have been ideal. Similarly, an intervention that included tasks such as reflecting on the role of maladaptive patterns of relating to others and writing a therapeutic letter to his therapist may not have been the most accessible for Mark. Although he did report experiencing relational difficulties, both he and Catherine reflected on his significant problems with accessing, tolerating and articulating distressing feelings. With the benefit of hindsight, a more stripped-back approach focusing on labelling emotions and developing distress tolerance may therefore have been a helpful starting point. In contrast, the trauma and compassion-focused approach that Emily received was well-aligned with her goals around coping with the difficult feelings and memories stirred up by becoming a mother.

Strengths and Limitations

Research design

This study makes a unique contribution to the existing literature in a several ways. To the best of my knowledge, it is the first study of experiences of 'non-improvement' in therapy to explore the perspectives of matched pairs of clients and therapists in detail using IPA. Of particular relevance is the NHS secondary care context from which the participants were recruited, as previous studies of client experiences of 'non-improvement' in the NHS have either been from primary care samples or have been clients who self-identified as not

having improved, with no quantitative data available for comparison. It has been observed that clients showing no improvement on outcome measures are often are often lost to follow up, so access to the perspectives of these clients is valuable (Steiner, Kruss & Leichsenring, 2016). In addition to the group analysis traditionally offered by IPA studies, which synthesises the most salient aspects of the experience under study across the whole sample, this project also provides detailed case studies of each pair, in order give a more nuanced account of the processes shaping experiences of therapy and understandings of the outcome. One area that was not explored was to compare the experiences of the clients, as a group, and those of the therapists. This was felt to be beyond the scope of the project and the priority was to explore the relationship between the paired accounts; however, this may make a useful addition to future studies.

One of the key aims was to explore non-improvement, as defined by standardised measures, open-endedly to see how subjective experiences compared to the statistical outcome. The sample recruited was not as homogenous as expected, as the degree of change the dyads felt they experiences seemed to fall on a continuum. Whilst this is an interesting and useful finding, it posed some challenges during the group analysis, where the focus is primarily on areas of convergence. Future studies might find it useful to either focus on how subjective experiences compare with the measures, or to explore the experiences of clients who have achieved no reliable change on the measure and agreed that little changed in therapy. The participants also had different types of therapy, including integrative interventions; however, this is representative of the reality of the NHS and all the clients were seen by a clinical psychologist.

Sampling and Recruitment

The study is based on a small sample of 6 participants (3 dyads). This is less than the guideline suggested by Smith, Flowers and Larkin (2009) of 8 participants, but as this number is based on a traditional IPA design and the present design included a more complex analytic strategy, the sample achieved was felt to be sufficient. The recruitment and data collection period spanned 16 months. A key factor limiting recruitment was resistance from therapists in the services approached. The 3 therapists who gave an interview were the only ones to sign up for the study out of the 6 large NHS Trusts in which recruitment took place. Feedback was sought from therapists who chose not to opt-in through the recruitment phase;

they reported issues such as not having access to the outcome data and anxieties about asking clients to discuss an experience that may have been difficult. Given that only a small number of therapists out of the large pool of potential participants approached took part in the study, the therapist sample was highly selective. The participating therapists appeared to be somewhat unique in their sessional use of outcome measures, as the service requirement was only to obtain a pre-therapy and post-therapy measure. In contrast, many of the therapists who did not participate reported either struggling to obtain the minimum requirement of pre and post data, or administering the measure, but not using it therapeutically i.e. not discussing it with their clients. As the use of case tracking was not the norm, the participating therapists differed to their peers somewhat in their approach to therapy, which may make the findings to some extent less generalisable. Future research would benefit from including therapists not using case tracking, as well as those with a particular interest in outcome measurement. Similarly, the fact that therapists had to be recruited first, due to confidentiality, limited the number of clients that could be approached. It was considered that this approach may lead to cherry-picking of cases where more change had occurred that the measures suggested; however, a variety of experiences were captured in the study, including a client who was very dissatisfied. It was notable that only 1 of the clients who was approached from the study decided not to opt-in and those who took part expressed finding it a useful opportunity.

Data collection

The use of semi-structured interviews led to rich material. As always with this method, it is difficult to know whether participants reported their experience as they felt it at the time, or this was revised in the period since discharge, including some aspects being forgotten. However, all interviews took place within a few months of therapy ending and there was good agreement between client and therapist on key aspects; for example, understandings of the outcome and perceptions of the alliance. A follow-up interview would have been helpful to explore anything participants remembered in the time since the first one or struggled to disclose. This would be a useful consideration for further research.

Data-analysis, quality checks and reflexivity

In accordance with the guidelines developed by Elliott et al. (1999) for evaluating qualitative research, a number of measures were taken ensure the quality of the study. Table

4 sets out these standards and the steps I have taken to address them, to allow the reader to further consider the strengths and limitations of the findings.

Table 4.Quality measures of qualitative research (adapted from Elliott et al., 1999)

	Guideline	How it was met
1.	Owning one's perspective	I provided a reflexive statement detailed my interest in and perspective on topic of research, which was developed following a reflexive interview with a colleague. I kept a reflexive journal to record my impressions following the interviews and consider how my position influenced the emerging themes
2.	Situating the sample	I have included a pen portrait for each dyad to provide contextual information about the participants and make my experience of the interviews transparent.
3.	Grounding in examples	I have included supporting quotations in the pen portraits and write-up of themes in the analysis section. In addition to the group analysis, I have provided a detailed account of the experience of each dyad in the group. Examples of the analytic procedure are also included (Appendix XI).
4.	Providing credibility checks	The themes were developed in consultation with my research supervisors who had access to the full transcripts. Direct quotes from participants are included to support all of the themes and tables detailed the themes of individual participants are also included (Appendix IX).
5.	Coherence	The findings are presented firstly at the dyad level (each with an overarching theme summarising the experience) and then at the group level, with all themes supported by direct quotations. Although a model is not provided, the continuum of experiences in the discussion (Figure 5) contributes to the coherence of the findings.

6. Accomplishing general vs specific research tasks	The analysis of the dyads gives a detailed account of the individual stories, giving equal coverage to the client perspective and therapist perspective as far as possible. A brief group analysis addressing the commonalities is also provided, with the 4 themes being present in all 6 participants' accounts as evidenced with quotes.
7. Resonating with readers	In the analysis, care was taken to avoid psychological jargon and stay close to the experience. In following the above guidelines, it hoped that the reader has provided a valid and trustworthy account that enhances their understanding of the subject.

Future Research

This small exploratory study was the first investigation of client-therapist dyads' experiences of 'non-improvement' and further research with a larger number of dyads would therefore be useful. Additional research on dyads from NHS services would be particularly helpful, as in this context time-limited therapy and high level of client complexity are the norm, whereas the few existing studies on this topic have mainly come from psycho-analytic clinics offering long-term therapy and NHS primary care services (McElvaney & Timulak, 2013; McLeod, 2017; Werbart et al., 2015; Werbart et al., 2018; Werbart et al., 2019). The clients in the present study had diverse experiences of therapy despite sharing the same statistical outcome; whilst future studies comparing subjective experiences with the outcomes on standardised measures would be useful, future studies of non-improvement may wish to seek a more homogenous sample. For example, by seeking participants who achieved no reliable improvement on the measures and agree that this reflect their understanding of the outcome. Studies of dyads from specialist services, such as forensics, psychosis and physical health, would also be welcome to explore factors that may be unique to these areas. Further studies may benefit from using mixed-method designs; for example, by combining qualitative interviews with standardised measures of relevant to non-improvement, such as measures of attachment style and the therapeutic alliance. Furthermore, longitudinal designs in which participants experiencing lack of change are

interviewed shortly after therapy and at again a later time-point would provide an insight into how clients cope with this experience and whether their perspective changes over time.

Conclusion

This study explored the therapy experiences of client-therapist dyads where the standardised outcome measures suggested no significant change had taken place. For the participants in this study, experiences of the therapy and understandings of the outcome were much more complex than suggested by the outcome measures. Each dyad's story was different and as a group, the accounts suggest that the experiences of clients and therapists of therapies that share the statistical outcome of no reliable change fall on a continuum of improvement and satisfaction. These findings caution against making assumptions about subjective experience based on standardised measures. The detailed analysis of the accounts of individual dyads suggested the importance of a trusting, authentic and collaborative therapeutic relationship in facilitating meaningful change.

Final reflections

I would like to bring this thesis to a close by returning to the idea of researcher reflexivity and sharing my experience of the process. Conducting the interviews was an anxiety-provoking, but interesting experience. It was a privilege to hear the participants' stories and be afforded a rare insight into clients' post-therapy reflections and other therapists' work. Throughout the process, but particularly during the interviews, I noticed a strong pull to think and respond more as a therapist than a researcher. For example, when Angela tearfully discussed the difficult childhood experiences that she had not been able to address in therapy, I wanted to explore this with her and help her make sense of this. Similarly, when analysing the data, I was aware of a tendency to begin formulating and I often thought about what I would have done, or have done, as a therapist in the types of situations they described. Above all else, I have been struck by the impact that undertaking this study has had on my clinical practice. For instance, I have become increasingly conscious of the fact that clients so often do not get what they hoped for in therapy and that important conversations are often left unsaid. It is not always easy to know exactly how to use this insight on a practical level and becoming more questioning of my own practice and therapy outcomes has been an unsettling experience at times. However, I feel that I am

beginning to find ways to bring the issues raised here into the therapy room and have franker discussions with my clients, for which I am extremely grateful to all of the participants.

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APPENDICES

APPENDIX I: Participant Recruitment Invitations

[version 2 13.05.2017]

Recruitment email to all therapists in the participating services

Subject: Research project – client and therapist experiences of therapy

Main body:

Research invitation: Client and therapist experiences of psychological therapy in which the outcome measures do not demonstrate change

Dear all,

My name is Claire Morton and I am in the second year of the Doctorate in Clinical Psychology programme at the University of Leeds. I am writing to invite you to take part in my thesis research project, which is qualitative study of experiences of therapy in client-therapist dyads.

Research in NHS psychology services suggests that somewhere between 18-36% of clients do not experience significant change in therapy, as assessed by standardised outcomes measures. However, little is known about how well these questionnaires capture the client's experience, whether there were any benefits that were not reflected in the measures or what might have needed to happen for the client to have benefitted more from their therapy.

I am hoping to recruit therapists who are willing to be interviewed about their experience of a recent piece of work in which the outcomes measures did not demonstrate reliable improvement. Participating therapists will be asked to identify any clients who meets the criteria either from their recently discharged cases or clients discharged over the coming months, so that they can be invited to the study. All participants will be offered a £15 voucher for Amazon or W H Smiths for taking part in the study.

Please see the information sheet attached for further information about the study. If you are interested in taking part you can register your interest, or ask any questions you may have, by replying to this email or calling 07944214544.

Many thanks for taking the time to consider this,

Claire Morton

Psychologist in Clinical Training.

[version 2 13.05.2017]

UNIVERSITY OF LEEDS

NHS Bradford District Care
NHS Foundation Trust

[Address of Psychology service]

Invitation Letter:

Client and therapist experiences of psychological therapy in which the outcome measures do not demonstrate change

Dear [participant name],

We are writing to inform you about a research study being carried out in the service and ask you to consider taking part in it.

You have been contacted as you have recently completed a course of therapy with the Psychological Therapy Service at Bradford District Care NHS Foundation Trust and have completed some outcome questionnaires during your therapy. We already know something about the experiences of people whose outcome questionnaires show a significant improvement, and there is some research about those whose scores on the outcome questionnaires get worse. However, we do not know very much about the experiences of people whose outcome questionnaires show little or no change at the end of therapy.

The research study you are being invited to take part in finding out more about the experiences of people whose outcome questionnaires do not demonstrate much change. It doesn't matter whether or not you agree with the outcome questionnaire that not much has changed as a result of your therapy, as the researcher is interested in the different types of experiences that people whose scores fall into this category may have had in therapy. As research suggests that clients and therapists sometimes have different perspectives, the researcher will also be speaking to the therapists of those taking part. It is hoped that from this research, we will be able to make recommendations about improving peoples' experiences of therapy and developing better outcome measures, both in this service and more generally. All participants will be offered a £15 voucher for Amazon or W H Smiths for taking part in the study.

Please see the information sheet enclosed for further information about the study. If you are interested in taking part, please email umcem@leeds.ac.uk or contact the researcher on 07773033391. Alternatively, you can return the slip at the bottom of this letter in the stamped addressed envelope provided. By responding to this letter you are not committing yourself to take part in the study, but simply registering your interest and consenting to being contacted by the researcher to discuss this

Opt-in Slip

I have read the Participant Information Sheet and I am interested in taking part in the research project.
I consent to being contacted by the researcher, Claire Morton, to discuss this further and arrange an interview date/time as appropriate.

Name: _____

Preferred Contact Type (please tick):

☐ Telephone (please provide contact number) _____

☐ Email (please provide email address) _____

Please return this slip using the stamped and addressed envelope provided.

APPENDIX II: Semi Structured Interview Guides

[version 2 13.05.2017]

Client Interview Schedule:

Client and therapist experiences of psychological therapy in which the outcome measures do not demonstrate change

1. Tell me a little bit about yourself.

Possible follow up questions:

What do you do? What's important to you? How do you see yourself?

2. What led you to sign up for the study?

How did you feel about taking part/how did you decide?

3. Can you tell me how you came to be in therapy?

Can you tell me about the difficulties you were having?

How did you feel/what did you think about being referred for therapy?

What were your expectations/understanding of what therapy would involve?

How did you find the initial meeting? What did you agree? What were your goals?

How did you find the early part of therapy/ thoughts and feelings during first few sessions?

4. How did you find therapy overall?

What was your understanding of what impact therapy was having? What made you think/feel that? At what point did you feel therapy was/wasn't working? What signs did you notice in yourself/the therapist?

What impact did therapy have, if any, on your life?

Did you experience of therapy change over time? Can you tell me about any times that your experience changed/any turning points?

Can you tell me about any moments in therapy that really stood out for you?

Can you tell me about any points at which the therapy felt stuck/unhelpful? What made you stay in therapy?

Can you tell me about points at which therapy felt particularly helpful?

Can you tell me about any unexpected benefits or issues?

5. Can you tell me how therapy came to an end and how that was for you?

What were your thoughts/feelings about ending?

You were selected for the study on the basis of your outcome questionnaire scores – do you remember filling them out? What was that like? What are your thoughts/feelings about the fact that your measures showed little/no change, how does that fit with your experience? Did you discuss the scores with your therapist?

Do you have any thoughts about what could've made therapy more helpful/what might've improved your experience of therapy?

What did you learn, if anything, from having therapy? E.g. about yourself/therapy/mental health.

Have your thoughts/feelings about your therapy changed at all since ending/during the interview?

Did you feel you achieved your goals?

Looking back, would you do anything differently?

6. Can you tell me what life is like for you now?

What's next for you? Have you had any further therapy? What are your thoughts/feelings about further therapy?

7. Is there anything else you'd like to tell me/ that feels important that I haven't asked about?

[version 2 13.05.2017]

Therapist Interview Schedule:

Client and therapist experiences of psychological therapy in which the outcome measures do not demonstrate change

1. Tell me a bit about yourself as a therapist?

2. Why did you decide to sign up?

3. Can you tell me how you came to be working with X?

What was the initial meeting like? What were you thinking/feeling?

What was the process of contracting like and what did you agree? What were the client's goals/your hopes for the client?

What was the early part of therapy like? What were your thoughts and feelings did you have/ what decisions did you make during the first few sessions? Can you tell me about how the alliance developed in the early part of therapy?

What was the middle part of therapy like?

3. How did you find therapy with this client overall?

What was your understanding of what impact therapy was having? What made you think/feel that? At what point did you feel therapy was/wasn't working? What signs did you notice in yourself/the client?

Did your experience of the therapy change over time? Can you tell me about any times that your experience changed/any turning points? What impact did the work have on you?

Can you tell me about any moments in the therapy that really stood out for you?

Can you tell me about any points at which the therapy felt stuck/ particularly challenging? How did you use supervision then?

Can you tell me about your thoughts/feelings/decisions about continuing to offer therapy?

Can you tell me about points at which therapy felt particularly helpful?

Can you tell me about how you used supervision during your work with this client?

4. Can you tell me how therapy came to an end and how that was for you?

Did you achieve the goals you set at the start? Can you tell me about any unexpected changes?

What were your thoughts/feelings about ending?

Your client was selected for the study on the basis of their outcome questionnaire scores – can you tell me a little about how you used outcome measures with this client? How did you find that?

What are your thoughts/feelings about the fact that the measures showed little/no change, how does that fit with your experience?

Did you discuss the scores with the client? What was that like/can you tell me a bit more about why you didn't?

Do you have any thoughts about what might have needed to happen for the client to benefit more from therapy?

Can you tell me about what you feel you learnt from working with this client? E.g. about yourself or therapy in general.

Have your thoughts/feelings about your work with this client changed at all since ending/during the interview?

Looking back, would you do anything differently?

5. Can you tell me about the process of identifying clients for the study?

How did you find it? How did you make decisions about putting clients forward?

6. Is there anything else you'd like to tell me/ that feels important that I haven't asked about?

APPENDIX III: Demographic Questionnaires

[version 2 13.05.2017]

UNIVERSITY OF LEEDS

Questionnaire:

Client and therapist experiences of psychological therapy in which the outcome measures do not demonstrate change

Below is a brief questionnaire that asks for some basic information about you. If you are happy to provide this information, it will be useful for providing some context to the research.

Gender:

Age range: 18-24; 25-35; 36-45; 46-55; 56-65; 66-75; over 75

Ethnicity:

Employment status:

Occupation (if applicable):

Level of education:

Current living situation: Living alone; Living with partner; Living with relatives; Shared house; Other

[version 2 13.05.2017]

UNIVERSITY OF LEEDS

Questionnaire:

Client and therapist experiences of psychological therapy in which the outcome measures do not demonstrate change

Below is a brief questionnaire that asks for some basic information about you. If you are happy to provide this information, it will be useful for providing some context to the research.

Gender:

Age range: 18-24; 25-35; 36-45; 46-55; 56-65; 66-75; over 75

Ethnicity:

Job title:

Number of years qualified:

Number of years in current service:

Therapeutic orientation:

Number of working hours per week:

Service cap on number of sessions offered:

APPENDIX IV: NHS REC Approval Letter

NHS
Health Research Authority

North West - Greater Manchester West Research Ethics Committee
Barlow House
3rd Floor
4 Minshull Street
Manchester
M1 3DZ

Telephone: 0207 104 8021

01 June 2017

Miss Claire Morton
Clinical Psychology Training Programme
Leeds Institute of Health Sciences
Level 10, Worsley Building
University of Leeds
Leeds
LS2 9NL

Dear Miss Morton

Study title: **Experiences of 'non-response' in psychological therapy: a qualitative study of client-therapist dyads. On the information sheets and consent forms, the title of the study is stated as 'client and therapist experiences of psychological therapy in which the outcome measures do not demonstrate change' in order to make it easier for participants to understand.**
REC reference: **17/NW/0299**
IRAS project ID: **219943**

Thank you for your submission. I can confirm the REC has received the documents listed below and that these comply with the approval conditions detailed in our letter dated 12 May 2017

Documents received

The documents received were as follows:

Document	*Version*	*Date*
Interview schedules or topic guides for participants [Client Interview Schedule]	2	13 May 2017
Interview schedules or topic guides for participants [Therapist Interview Schedule]	2	13 May 2017
Letters of invitation to participant [Client Opt-in Letter]	2	13 May 2017

Approved documents

The final list of approved documentation for the study is therefore as follows:

Document	*Version*	*Date*
Covering letter on headed paper [Cover Letter]	1	24 April 2017
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [University of Leeds Indemnity Agreement]	1	08 September 2016
Interview schedules or topic guides for participants [Client Interview Schedule]	2	13 May 2017
Interview schedules or topic guides for participants [Therapist Interview Schedule]	2	13 May 2017
IRAS Application Form [IRAS_Form_25042017]		25 April 2017
Letter from sponsor [Confirmation of Sponsor Review]	1	29 March 2017
Letters of invitation to participant [Client Opt-in Letter]	2	13 May 2017
Letters of invitation to participant [Therapist Opt-in Email]	2	13 May 2017
Non-validated questionnaire [Client Demographic Questionnaire]	2	13 May 2017
Non-validated questionnaire [Therapist Demographic Questionnaire]	2	13 May 2017
Participant consent form [Client Consent Form]	3	29 May 2017
Participant consent form [Therapist Consent Form]	3	29 May 2017
Participant information sheet (PIS) [Client Information Sheet]	3	13 May 2017
Participant information sheet (PIS) [Therapist Information Sheet]	3	13 May 2017
Participant information sheet (PIS) [Therapist Recruitment Protocol]	1	03 April 2017
Referee's report or other scientific critique report [Research Panel Feedback - Peer Review]	1	19 September 2017
Referee's report or other scientific critique report [Information Letter - DClin Research Panel]	1	09 April 2017
Referee's report or other scientific critique report [Information Letter - Trainee Clinical Psychologist Research]	1	
Research protocol or project proposal [Research Protocol]	2	27 March 2017
Summary CV for Chief Investigator (CI) [CV Claire Morton]	1	18 April 2017
Summary CV for supervisor (student research) [CV Ciara Masterson]	1	23 November 2015
Summary CV for supervisor (student research) [CV Carol Martin]	1	21 May 2015

You should ensure that the sponsor has a copy of the final documentation for the study. It is the sponsor's responsibility to ensure that the documentation is made available to R&D offices at all participating sites.

17/NW/0299 **Please quote this number on all correspondence**

Yours sincerely

Anna Bannister
REC Manager

E-mail: nrescommittee.northwest-gmwest@nhs.net

Copy to: *Faculty Research Ethics And Governance Administrator*
Ms Anne Gowing, Leeds Teaching Hospitals NHS Trust

APPENDIX V: R&D Approvals

Experiences of 'non-response' in psychological therapy

Grounded-Research (ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST) <rdash.groundedresearch@nhs.net>
Tue 23/10/2018 13:16
Claire Morton [RPG]; BELL, James (ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST) <james.bell12@nhs.net>

Dear Claire,

Full Study Title: Experiences of 'non-response' in psychological therapy: a qualitative study of client-therapist dyads.
On the information sheets and consent forms, the title of the study is stated as 'client and therapist experiences of psychological therapy in which the outcome measures do not demonstrate change' in order to make it easier for participants to understand
IRAS ID: 219943 / RDaSH 0152

Your letter of access for RDaSH expired on 30th June 2018. I know you expected your study to have been completed, but if for any reason you require an extension to the access please let me know.

If you study has closed please could you confirm the end date of recruitment and the close date for the study. Also, if a summary of the findings is available it would be great to see your results.

Kind regards
Jeannie

Jeannie McKie
Research Governance Manager

Grounded Research
Rotherham Doncaster & South Humber NHS Trust
Tickhill Road Site
Balby
Doncaster DN4 8QN
Tel: 01302 798456
Mobile: 07500815779
Email: j.mckie@nhs.net

Please note my usual working days are Monday, Tuesday, Thursday, Friday

RE: IRAS 219943. Amendment categorisation and implementation information

You replied on Mon 19/11/2018 11:29

John Vertannes <John.Vertannes@bdct.nhs.uk>
Mon 19/11/2018 11:28
Claire Morton [RPG]

219943 Statement of Activitie...
93 KB

Thank you,

I can confirm that we have completed our process of Capacity and Capability and are happy to open this study at our site.

I have attached the BDCFT Statement of activities.

Please can you confirm receipt of this and let us know that you are happy for us to start recruitment here

#hello my name is…

John Vertannes
Data, Information Systems and Governance Officer

07957468025

IRAS 219943 Confirmation of Capacity and Capability at Leeds and York Partnership NHS Foundation Trust

You replied on Thu 20/07/2017 11:24

AUDSLEY, Sinead (LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST) <sinead.audsley@nhs.net>
Thu 20/07/2017 09:30
Claire Morton [RPG]; ISPAN, Caroline (LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST) <caroline.ispan@nhs.net>; Medicine and Health Research Governance +1 other

Statement of Activities LYPFT....
93 KB

Dear Claire

This email confirms that Leeds and York Partnership NHS Foundation Trust has the capacity and capability to deliver the above referenced study. Please find attached our agreed Statement of Activities as confirmation.

We agree to start this study today 20th July 2017.

If you wish to discuss further, please do not hesitate to contact me.

Kind regards
Sinead Audsley

Research and Development
Leeds and York Partnership NHS Foundation Trust
St Mary's House
St Mary's Road
Leeds
LS7 3JX
Tel: 0113 85 52387
Fax: 0113 85 54466

LS7 3JX
Tel: 0113 85 54462
Email: sinead.audsley@nhs.net
Twitter: @LypftResearch

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

30th June 2017

Claire Morton
Psychologist in Clinical Training
Clinical Psychology Programme
University of Leeds
Leeds Institute of Health Sciences
Worsley Building
Leeds
LS2 9NL

Research & Development
Room 311, Block 9
Fieldhead Hospital
Ouchthorpe Lane
Wakefield
WF1 3SP

Tel: 01924 316289

Ref:LOA
Email address: research@swyt.nhs.uk

Dear Claire

Letter of Access for Research

Study Title: Client and therapist experiences of psychological therapy in which the outcome measures do not demonstrate change

IRAS: 219943
REC: 17/NW/0299

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 30th June 2017 and ends on 31st May 2018 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

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

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 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

Rachel Moser

Rachel Moser, PhD
Research & Development Manager

Chair: Ian Black Chief Executive: Rob Webster
INVESTORS IN PEOPLE UNIVERSITY OF LEEDS Associated teaching trust status CUSTOMER SERVICE EXCELLENCE UK With all of us in mind.

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Research & Development Dept
Flatts Lane Centre
Flatts Lane
Normanby
Middlesbrough
Cleveland
TS6 0SZ

24th July 2017

Miss Claire Morton
Psychologist in Clinical Training
St James's University Hospital
Leeds

Dear Miss Morton

Letter of access for research: Experiences of 'non-response' in client-therapist dyads

As an existing NHS employee you do not require an additional honorary research contract with this NHS organisation. We are satisfied that the research activities that you will undertake in this NHS 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 NHS organisation that the necessary pre-engagement check are in place in accordance with the role you plan to carry out in this organisation. This letter confirms your right of access to conduct research through Tees, Esk & Wear Valleys NHS FT for the purpose and on the terms and conditions set out below. This right of access commences on **24 July 2017** and ends **28 September 2018** unless terminated earlier in accordance with the clauses below.

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

You are considered to be a legal visitor to Tees, Esk & Wear Valleys NHS FT premises. You are not entitled to any form of payment or access to other benefits provided by this organisation to employees and this letter does not give rise to any other relationship between you and this NHS organisation, in particular that of an employee.

prove your identity if challenged. Please note that this NHS organisation accepts no responsibility for damage to or loss of personal property.

We may terminate your right to attend 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 this NHS organisation or if you are convicted of any criminal offence. You must not undertake regulated activity if you are barred from such 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 NHS organisation that employs you through its normal procedures. You must also inform your nominated manager in this NHS organisation.

Yours sincerely

S Daniel.

Sarah Daniel
R&D Manager

APPENDIX VI: Participant Information Sheets

[version 3 13.05.2017]

NHS
Bradford District Care
NHS Foundation Trust

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Participant Information Sheet:
Client and therapist experiences of psychological therapy in which the outcome measures do not demonstrate change

I would like to invite you to take part in a research study about what clients and therapists who have worked together think about the therapy they have recently completed. Before making a decision about taking part, I would like to explain the purpose of the research and what would happen if you choose to participate. Please feel free to discuss the study with others if you wish and ask me any questions you have about the study.

What is the purpose of this study?
Psychological therapy services often ask clients to complete questionnaires about their difficulties before and after therapy. These questionnaires are used to give the service a sense of whether or not the client has benefitted from therapy. I am interested in speaking to people whose scores on the questionnaires do not demonstrate significant change to find out what they, and their therapists, think about the therapy. It is hoped that studying this will give us a better understanding of how well these questionnaires capture the client's experience, what might have needed to happen for the client to have benefitted more from their therapy and whether there were any benefits that were not reflected in the measure.

Who is doing the study?
The study is being conducted by Claire Morton (Psychologist in Clinical Training at the University of Leeds). The research is a doctoral thesis and part of the academic course requirements.

Why have I been asked to participate?
You have been invited as you have recently completed a course of therapy within an NHS Adult Psychological Therapies service that is participating in the study and your therapist identified you as a potential participant using the outcome questionnaires. Participation in the study is voluntary; it is up to you to decide whether or not to take part. If you do decide to take part, you will be given this information sheet to keep and be asked to sign a consent form. If you choose not to take part, you do not have to give a reason and it will not have any bearing on your future access to services. If you would like to take part, please let us know within 3 weeks from the date you received this invitation.

What will be involved if I take part in this study?
You will be asked to attend an individual interview with the researcher that will last approximately 60-90 minutes. You will also be asked to complete a short questionnaire about basic demographic information and the scores of your therapy outcome questionnaires will be made available to the researcher. With your permission, the interview will be audio-recorded and transcribed verbatim so that it can be analysed by the researcher. Your therapist will also be invited to take part in a separate interview to discuss their understanding of the outcome of your therapy.

What are the advantages and disadvantages of taking part?

You may find that having the opportunity to reflect on your therapy is a useful experience. It is hoped that the results of the study can begin to inform future practice in psychological therapies, which may be of benefit to others. You will receive a £15 voucher for Amazon or W H Smith in recognition of your participation. It is possible that discussing your experience of the therapy in the interview may be difficult for you. If this is the case please let the interviewer know so that appropriate support can be offered. You will also be provided with a list of contact details for sources of support that you can access should you feel distressed as a result of the interview at a later stage.

Can I withdraw from the study at any time?

If you change your mind about taking part prior to or during an interview, you will be able to withdraw from the study. Following an interview, there will be a limited period of 1 week for you to withdraw fully or partially form the study, as transcribing will begin after this point and withdrawal will no longer be possible. During this 1 week period, if you are worried about anything you have discussed in the interview, I will discuss the following options with you:

- Withdrawal of entire recording before transcription starts
- Withdrawal of specific responses from the analysis
- Specific responses not being directly quoted in the final report

In either case, you do not have to justify or explain decisions regarding partial or full withdrawal from the study.

Will the information I give be kept confidential?

Yes - although your therapist will be aware that you are taking part in the study, the interviewer will not tell them anything you have discussed during the interview. Your participation in the study and all the information you provide will be kept strictly confidential. The only instance in which the researcher would break the stated confidentiality is if they thought there was significant risk of harm to yourself or someone else. These circumstances will be explained to you in more detail before the interview takes place. The recording will be transcribed an independent transcriber who has signed a confidentiality agreement. During transcription any information that could identify you will be removed and your name will not appear in the final report, you will be referred to only by a name of your choosing.

The audio-recording will be stored on an encrypted device, locked away when not in use and deleted from the recorder once transcribed. In line with University requirements, the recording and transcript will be kept on a password protected server in the University for three years. Personal data, such as consent forms and questionnaires, will be stored in a locked draw at the University. The results of the study will be written up in a report as part of the Doctorate in Clinical Psychology training programme. A complete copy of the thesis will be held by the University of Leeds Library and will be available through the University of Leeds website.

What will happen to the results of the study?
The results of the study will be written up in a report as part of the Doctorate in Clinical Psychology training programme. A complete copy of the thesis will be held by the University of Leeds Library and will be available through the University of Leeds website. It is also possible that the study will be written up for publication in an academic journal and it may be presented at an academic conference in the future. Your name will not be linked with the research materials and you will not be identified or identifiable in any reports or presentations resulting from the research. 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.

Who has reviewed this study?
All research in the NHS is reviewed by an independent group of people called a Research Ethics Committee in order to protect your interests. This study has been reviewed and given a favourable opinion by North West Greater Manchester West REC. The study has also been reviewed by Everybody's Voice, which is a service-user group at the University of Leeds.

If you agree to take part, would like more information or have any questions or concerns about the study you can contact the lead researcher via email, telephone or post using the stamped envelope provided:

Claire Morton
Psychologist in Clinical Training
Clinical Psychology Training Programme
Leeds Institute of Health Sciences, University of Leeds
1095 Worsley Building, Clarendon Way
Leeds, LS2 9NL
Tel: 0113 3432712
Email: umcem@leeds.ac.uk

Supervised by
Dr Carol Martin
Lecturer in Clinical Psychology
Email: c.martin@leeds.ac.uk
Address and telephone as above

Dr Ciara Masterson
Lecturer in Clinical Psychology
Email: c.masterson@leeds.ac.uk
Address and telephone 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 using the following details:

Faculty of Medicine & Health Research Office
Room 10.110, Level 10, Worsley Building
University of Leeds, Clarendon Way
Leeds, LS2 9NL
E-mail: governance-ethics@leeds.ac.uk
Tel: 0113 3434897

[version 3 13.05.2017]

NHS Bradford District Care NHS Foundation Trust

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Participant Information Sheet:
Client and therapist experiences of psychological therapy in which the outcome measures do not demonstrate change

I would like to invite you to take part in a research study about what clients and therapists who have worked together think about the therapy they have recently completed. Before making a decision about taking part, I would like to explain the purpose of the research and what would happen if you choose to participate. Please feel free to discuss the study with others and ask me any questions you have about the study.

What is the purpose of this study?
Increasing emphasis is being placed on the use of standardised outcomes measurement to evaluate psychological therapies services and research suggests a significant proportion of clients appear not to achieve significant change in therapy as assessed by standardised outcomes measures. However, little is known about what a lack of change on standardised measures means in real terms and several recent studies suggest that some clients who do not achieve significant change on outcome measures feel they have benefitted from therapy. I am interested in finding out what clients and their therapists think about the therapy they have recently completed and how this compares with the scores on the questionnaires. It is hoped that this will provide a better understanding of how well these questionnaires capture the client's experience, what benefits may not be reflected in the measures and what might have needed to happen for the client to have benefitted more from their therapy.

Who is doing the study?
The study is being conducted by Claire Morton (Psychologist in Clinical Training at the University of Leeds). The research is a doctoral thesis and part of the academic course requirements.

Why have I been asked to participate?
You have been approached for the study by virtue of your professional role as a psychological therapist or clinical psychologist in an NHS Adult Psychological Therapies service. Participation in the study is voluntary and if you do decide to take part you will asked to sign a consent form.

What will be involved if I take part in this study?
You will be asked to identify one or more clients that you have recently discharged whose outcome measures suggest that no significant change at the end of therapy (using information provided regarding the threshold for reliable change) so they can be approached to participate in the study. If your client decides to take part, you will attend an individual interview lasting approximately 60-90 minutes about your understanding and experience of the therapy. You will also be asked to complete a short questionnaire about basic demographic information. The interview will be audio-recorded and transcribed verbatim so that it can be analysed by the researcher.

What are the advantages and disadvantages of taking part?
You may also find that having the opportunity to reflect on your work is a useful experience. It is hoped that the results of the study can begin to inform future practice in psychological therapies. You will receive a £15 voucher for Amazon or W H Smith in recognition of your participation.

It is not anticipated that the interviews will cause significant distress. However, it is important to acknowledge that discussing an experience of therapy could involve aspects of uncomfortable reflection. During the interview, you will be able to take breaks as needed and decline to answer any questions. If the necessary, the interview may be re-scheduled.

Can I withdraw from the study at any time?

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 with you:

- 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 or full consent. After 1 week, transcribing will begin and withdrawal will no longer be possible.

Will the information I give be kept confidential?
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. Although your client will be aware that you are taking part in the study, the interviewer will not tell them anything you have discussed during the interview. The recording will be transcribed an independent transcriber who has signed a confidentiality agreement. Transcriptions will be anonymised and you will be referred to in the report only by a pseudonym of your choosing. If information is disclosed during the interview, which makes a client or another member of staff identifiable, this will be kept confidential and only unidentifiable quotes will be used in the final report.

All the data obtained in the study will be stored in accordance with the Data Protection Act 1998. Personal data, such as consent forms and questionnaires, will be stored in a locked draw at the University. The audio-recording will be stored on an encrypted device, locked away when not in use and deleted from the recorder once transcribed. The interview recordings and transcripts will be stored on the University's password protected server and kept for three years.

What will happen to the results of the 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.

Who has reviewed this study?
All research in the NHS is reviewed by a Research Ethics Committee in order to protect your interests. This study has been reviewed and given a favourable opinion by North West – Greater Manchester West Research Ethics Committee. The study has also been reviewed by Everybody's Voice, which is a service-user group at the University of Leeds.

If you agree to take part, would like more information or have any questions or concerns about the study you can contact the lead researcher using the following details:

Claire Morton
Psychologist in Clinical Training
Clinical Psychology Training Programme
Leeds Institute of Health Sciences, University of Leeds
1095 Worsley Building, Clarendon Way
Leeds, LS2 9NL
Tel: 0113 3432712
Email: umcem@leeds.ac.uk

Supervised by
Dr Carol Martin
Lecturer in Clinical Psychology
c.martin@leeds.ac.uk
Address and telephone as above

Dr Ciara Masterson
Lecturer in Clinical Psychology
c.masterson@leeds.ac.uk
Address and telephone 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 using the following details:

Faculty of Medicine & Health Research Office
Room 10.110, Level 10, Worsley Building
University of Leeds, Clarendon Way
Leeds, LS2 9NL
E-mail: governance-ethics@leeds.ac.uk
Tel: 0113 3434897

APPENDIX VII: Participant Consent Forms

[version 3 29.05.2017]

NHS Bradford District Care NHS Foundation Trust

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Participant Consent Form

Title of research project: Client and therapist experiences of therapy in which the outcome measures do not demonstrate change

Name of researcher: Claire Morton, Psychologist in Clinical Training

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 initial the applicable boxes.

Please initial here

I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these questions answered satisfactorily.	
I understand that my participation is voluntary and that I am free to withdraw at any time prior to or during the interview without giving any reason, and without there being any negative consequences. In addition, should I not wish to answer any particular question or questions, I am free to decline.	
I give consent for the data from my outcome questionnaires to be included in the study.	
I understand that in addition to the interview, I will be asked to complete a brief questionnaire with basic information about myself (e.g. age range and gender).	
I give consent for the interview to be audio-recorded. I understand that the audio recordings will be transcribed by a transcriber who has signed a confidentiality statement. After transcription, in line with university requirements, recordings and transcripts will be kept on a password-protected server in the university for three years.	
I understand that my data will be kept confidential, unless the researcher feels there is a significant risk to myself or others, and these circumstances have been explained to me. I give permission for members of the research team to have access to my anonymised responses for research quality purposes.	

[version 3 29.05.2017]

I understand that my therapist will be taking part in the study and that any information I discuss in the interview will not be shared with them.	
I give consent for direct quotes to be used in the final report. I understand that my name will not be linked with these quotes, and I will not be identified or identifiable in the report or reports that result from the research.	
I understand that after an interview there will be a limited period of time (1 week) in which I can withdraw completely from the study (with none of my data being used) or withdraw partially (with some of my data being used and any data I am unhappy about being removed, as agreed in discussion with the researcher).	
I understand that information on my care record that is relevant to the research and data collected during the study may be accessed by individuals from regulatory authorities or from the NHS Trust, in order to check that the study is being carried out correctly. I give permission for these individuals to have access to my records.	
I would like a summary of the findings emailed to the following address and will inform the researcher of any changes to my contact details. I agree to be contacted regarding this up to 12-18 months after my initial interview.	
I agree to take part in the above research project.	

Name of participant **Date** **Signature**

Name of researcher **Date** **Signature**

To be signed and dated in presence of the participant, one copy for the participant and one for the researcher.

[version 3 29.05.2017]

Leeds and York Partnership NHS NHS Foundation Trust

UNIVERSITY OF LEEDS

Participant Consent Form

Title of research project: Client and therapist experiences of psychological therapy in which the outcome measures do not demonstrate change

Name of researcher: Claire Morton, Psychologist in Clinical Training

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 initial the applicable boxes.

Please initial here

I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these questions answered satisfactorily.	
I understand that my participation is voluntary and that I am free to withdraw at any time prior to or during the interview without giving any reason, and without there being any negative consequences. In addition, should I not wish to answer any particular question or questions, I am free to decline.	
I understand that in addition to the interview, I will be asked to complete a short demographic questionnaire	
I give consent for the interview to be audio-recorded. I understand that the audio recordings will be transcribed by a transcriber who has signed a confidentiality statement. After transcription, in line with university requirements, recordings and transcripts will be kept on a password-protected server in the university for three years.	
I understand that my data will be kept confidential, unless the researcher feels there is a significant risk of harm, such as professional misconduct, and these circumstances have been explained to me. I give permission for members of the research team to have access to my anonymised responses for research quality purposes.	

[version 3 29.05.2017]

I understand that the client I identified will also be interviewed for the study and that any information I discuss in the interview will not be shared with them.	
I give consent for direct quotes to be used in the final report. I understand that my name will not be linked with these quotes, and I will not be identified or identifiable in the report or reports that result from the research.	
I understand that after an interview there will be a limited period of time (1 week) in which I can withdraw completely from the study (with none of my data being used) or withdraw partially (with some of my data being used and any data I am unhappy about being removed, as agreed in discussion with the researcher).	
I understand that my records may be looked at by authorised individuals from the Sponsor for the study and the UK Regulatory Authority in order to check that the study is being carried out correctly.	
I would like a summary of the findings emailed to the following address. I will inform the researcher of any changes to my contact details. I agree to be contacted regarding this up to 12-18 months after my initial interview.	
I agree to take part in the above research project.	

Name of participant **Date** **Signature**

Name of researcher **Date** **Signature**

To be signed and dated in presence of the participant, one copy for the participant and one for the researcher.

APPENDIX VIII: Client Participant Crisis Contact Card

UNIVERSITY OF LEEDS

Client and therapist experiences of psychological therapy in which the outcome measures do not demonstrate change

Thank you for taking part in this study. Although participating in research can be a positive experience, some people might find that talking about their experiences leaves them feeling distressed. Below is some information about sources of support you can access in this situation.

- You can make an appointment with your GP to discuss how you are feeling and what treatment options are available to you.
- If you need support urgently, you can go to A&E or dial **999**. You can also contact the First Response crisis service who can provide advice and support over phone. You can call on them **01274 221181** hours a day, 7 days a week.
- The Samaritans are a charity who provide telephone support to people experiencing distress. Although they can provide support in a crisis, you don't have to be experiencing suicidal thoughts to access their support. You can call them free 24 hours a day, 7 days a week on **116 123**.

APPENDIX IX: Individual Transcript Themes

Emily	*Sophie*	*Dyad 1*
Supportive relationship; feeling heard; feeling safe; easier than expected; flexibility; deciding together	Immediate connection; admiration; being similar; feeling motivated; giving choices, realistic goals	*Genuine connection and collaboration*
Being transparent; fear of being overwhelmed; taking a risk	Exploring fears; giving hope; fear of destablising client; seeking consent	*Sharing initial fears*
		Feeling safe enough to explore
Fear of being weak; unfamiliar territory; coping with avoidance/ minimising; opening up for the time first; being stronger than I thought; talking is good; emotions as shameful	Stuck memories; grieving for childhood; opening the box together; value of connecting with pain; re-processing the past; disconfirming her fears; new awareness; avoided anger	*Overcoming avoidance of the past*
Feeling validated; acknowledging own suffering; rescripting the memory; seeing the past with new eyes; forgiving; feeling understood	Validating; feeling compassionate; being moved; re-framing is healing; new perspective; managing expectations of others	*Validating and re-framing*
		Beginning to heal the wound

Taking better care of myself; core problem addressed; living with anxiety; different expectations; being more open with others; more in touch with feelings; on-going process	Seeing a difference; celebrating progress; self-healing; shifting beliefs; feeling stronger; internal change; feeling pleased; admiration	*Meaningful change*
Guilty and undeserving; criticising self; comparing self to others; needing to prove worth; being responsible for making the most of it; keeping it to myself; pressure to carry it on alone; unexpressed gratitude and sadness	Ambivalence, not feeling needed; fear of working outside remit; progressing too quickly; out of the ordinary; not unwell enough; pressure to end	*Hidden anxiety and guilt*
		Being left with conflicting feelings

Angela	*Jane*	*Dyad 2*
Feeling understood and validated; fears normalised; valued relationship	Feeling compassionate; interested in the client; trying to make it safe enough; giving reassurance	*Feeling secure*
Fearing rejection and dismissal; feeling undeserving	Sensing client's insecurity; questioning self; feeling inadequate; afraid of letting client down; parallel process; feeling uncomfortable; wanting to avoid	*Feeling vulnerable*
		Fragile alliance

Not being able to find the words; feeling confused; overwhelming feelings; wanting clarity	Feeling puzzled and stuck; struggling to find a focus; not knowing what is real; difficulty making sense of the problem	*Feeling muddled*
Hoping for a cure; wanting insight; leaving it to the expert; not what I thought it'd be; wanting to get rid of it; seeking rescue	Pressure to fix; lack of collaboration; feeling pushed into expert role; frustration; promoting acceptance and adjustment; unrealistic expectations; anxiety; feeling critical	*Mismatched expectations*
Things left unexplored; struggling to take charge; not getting enough out of it; anticipating invalidation	Sense of things left unsaid; feeling at arm's length; not knowing where I stand; being appeased	*Holding back*
Learning strategies; beginning to accept the limits; trying to live with it	Finding focus in the present; making it concrete; client's expectations adjusting; finding meaning- working through examples	*Edging forwards*
		Struggling towards collaboration
Beginning new relationship with feelings; being more mindful; powerful experience; feeling grateful; new insight; more expansive; fears normalised	Something seemed to shift; feeling hopeful but unsure; reaching the limits of therapy, improved relationships, new perspective	*Tentative progress*
Feeling unfinished; wanting more; still struggling; disappointment; core pain missed; uncertain future	Sensing unspoken disappointment; being left wondering; modelling 'good enough', avoiding temptation to rescue, limited but sufficient	*Distress and disappointment*
		Ambivalence at the end

Mark	*Catherine*	*Dyad 3*
Feeling broken; nothing helps; contemplating suicide	Resignation and hopelessness; giving up; getting nowhere	*Despair*
Desperate for relief; needing answers; unmanageable distress; feeling close to the edge	Anxiety and pressure; impossible task; feeling overwhelmed; unrealistic expectations; feeling responsible; demanding rescue	*Pressure to fix*
		Starting with irreconcilable demands
Feeling dismissed and invalidated; feeling blamed; therapist didn't get it/ was incompetent; anger and contempt towards therapist; feeling disrespected; rage	Feeling attacked; combative relationship; being pulled in; contemptuous – contemptible; couldn't do anything right	*Contempt and the threat of invalidation*
Fear of losing control; anger is dangerous; feeling powerless; being haunted by childhood; therapy not safe; things left unsaid	Sensing unexpressed anger; not being able to fix him; anxiety; client as powerful	*Holding back and the threat of destructive anger*
Feeling cut off; unable to find the words; acting out distress; dissociating; feeling frightened; uncontainable distress; avoidance and running away; unable to bear thinking about past	Forgetting; feeling disengaged; zoning out; unable to facilitate emotional connection; needing it to be over; unable to focus client	*Experiential avoidance and the threat of overwhelming distress*
Trying to explain; digging deep; pushing self to the limits, letting things go	Fleeting moments of connection; glimpsing vulnerability; feeling sad for client; using the formulation; reflecting on the process; accessing compassion	*Trying to connect*
		Pulling away and leaning in

APPENDIX X: Example Annotated Transcript

I: Yeah. How did it feel when you were actually doing it, can you remember what it was like?

C: The EMDR? Erm, I felt a bit silly at first, but with quite a lot of the things – I suppose I haven't really grown up in like – well I don't really like – I don't know, I've not grown up in a place where you talk about your emotions, like my mum doesn't talk about feelings, so all of it felt a little bit silly at first, but - and holding the electrodes I was like, 'well this seems like hippy dippy nonsense', but actually – I don't know, she's got a really soothing way her [therapist] and I think I felt immediately comfortable with her and like I could trust her with stuff, which is probably what you need in a therapist [slight laugh]. So, yeah, I kinda went with it because she's so, you know – she put it well, like about doing it, and yeah it did help.

I: Mmhmm. When you say that it did help, what did you notice that made you think it was helpful?

C: I suppose I felt, um, like I say, ok about how I parent, it made me think more about – I think partly it gave me like a – I don't know like - no one's ever said to me that my childhood wasn't ok, so for [therapist] to acknowledge that there was something quite traumatic about some of my childhood memories, that was kind of, oh actually – like I don't know, I felt affirmed that actually I'm not just making a mountain out of a molehill or just an emotional wreck or those kind of things, but also – I don't know whether it was the electrodes, I think it was just talking about the memory more than anything. I don't know, but yeah it just made me feel a bit like stronger about it all I guess, and like vindicated – not vindicated, I don't know what the word is, but like that it's ok to feel this way about how I was brought up because, yeah, [therapist] said words like neglect and stuff and actually, that seemed really shocking to me at the time, but like if it was another – if it was somebody else's parent now, like a friend of mine doing it, I would think, 'oh my god' at how awful it was, so hearing it from someone else was like, 'oh, actually' – so yeah, I felt kind of – 'cause I think a lot of the reason I got ill with [daughter] was partly – well a lot of it was the sleep thing, but also because I've got such low self-esteem anyway, which a lot of that comes from my mum, I think that's all kind of contributed to it, so hopefully sorting

Claire Morton [RPG]
GROUP: impact of early experience, not used to opening up; avoidance of emotion

Claire Morton [RPG]
Felt unfamiliar and exposing at times

Claire Morton [RPG]
DYAD: Supportive relationship – feeling safe in spite of anxieties

Claire Morton [RPG]
Feeling more confident/reassured

Claire Morton [RPG]
Feeling validated; acknowledgement of trauma; feeling understood; feeling connected

DYAD: Validation
GROUP: Benefits of opening up

Claire Morton [RPG]
Relationship was key; good to talk;

Claire Morton [RPG] January 11, 2019
Feeling stronger
DYAD: Healing, overcoming childhood trauma

Claire Morton [RPG]
Therapist named abuse/maltreatment

Claire Morton [RPG]
Having a clear formulation/shared understanding; new perspective