UNDERSTANDING NON-RESPONSE IN PSYCHOTHERAPY: A META-SYNTHESIS

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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: The efficacy of psychotherapy has been well established. There is growing research focusing on the negative outcomes of psychotherapy, with an estimated 10% of clients who deteriorate as a result of psychotherapy. However, there remains an overlooked population, those who show no response after psychotherapy, which has a widely variable estimated prevalence between 14-56% across the literature. This qualitative evidence synthesis (QES) aimed to synthesise the available evidence exploring client and therapist experiences of psychotherapy non-response.

Method: Seven databases were systematically searched for studies using qualitative data to explore non-response. Twenty-one studies met the inclusion criteria and were analysed using the QES method Thematic Synthesis. This involved three stages of line-by-line coding, descriptive theme development, and generation of analytical themes, to develop a conceptual understanding of psychotherapy non-response from both client and therapist perspectives.

Results: Six overarching client perspective themes and 18 subthemes were identified (1. Hopes and fears, 2. A difficult task, 3. Disconnected relationship, 4. Staying involved, 5. Therapy was not worth the investment, and 6. On a trajectory for improvement). Four overarching therapist perspective themes and 10 subthemes were identified (1. High expectations, 2. Experiencing a disconnect, 3. Feeling threatened, and 4. Holding onto hope). This was synthesised into a proposed model of non-response.

Discussion: A large overlap with the deterioration and harm literature was found. There were varied experiences of non-response which has implications for the use of qualitative outcome measurement. The experience of non-response appears to involve both clients and therapists holding something back from the therapeutic relationship. Importantly, non-response appears not to be an absence of effects, but a range of experiences which can potentially be harmful. Clinical and research implications are discussed.

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CHAPTER ONE: INTRODUCTION

Introduction to the Chapter

The aim of this qualitative evidence synthesis (QES) is to synthesise the available evidence exploring client and therapist experiences of psychotherapy non-response. By synthesising the literature, it is hoped to create a further conceptual understanding of psychotherapy non-response. It is hoped that this QES will help to identify what further research is needed in the area of psychotherapy non-response in order to promote improvements in psychotherapy efficacy. The following introduction chapter will outline the context in which this QES is set, including the consideration of the aims of psychotherapy, the relationship between psychotherapy and change, and the importance of client factors implicated in change. An overview of how non-response in the psychotherapy literature is defined, and predictors of non-response are also explored. The concepts of non-response and deterioration and harm are explored with consideration of similarities and differences. This chapter will conclude with an introduction to the qualitative approach to research and methods of QES.

Context

The efficacy of psychotherapy has been well established (Schefft et al., 2019; Huhn et al., 2014; Smith & Glass, 1977). However, recent research that examined evidence across meta-analyses of randomised controlled trials (RCTs) of psychotherapies showed that although 80% of the literature evidenced significant efficacy for psychotherapy, only a small number of these studies provided 'convincing evidence'. This was due to issues including large heterogeneity within combined trials and small study bias (Dragioti et al., 2017). Furthermore, there is growing research focusing on the negative outcomes of psychotherapy (Crawford et al., 2016), with an estimated 10% of clients deteriorating as a result of psychotherapy (Lambert & Ogles, 2004). Although increased interest in this area is positive for improving psychotherapy outcomes for clients, there is an overlooked population who are those that show no improvement after the psychotherapy process. That is, not those who have experienced harmful effects that have resulted in reliable deterioration, but those that show no change. Often these clients have been included in the negative outcome research rather than being considered as a separate population with a different therapy experience and outcome. Non-responders differ in their experiences to those who have deteriorated and experienced a harmful therapy (Mohr, 1995). It is imperative to research this client group as their sub-optimal experiences may: act as a barrier to seeking further support; be time consuming for the client and service; not be economically effective and not result in any meaningful client change. In order to elaborate the experience of non-response, a consideration of the measurement of outcome in psychotherapy will now be presented.

Aims of Psychotherapy

A widely cited definition of psychotherapy by Wampold (2001) emphasises the curative intention of psychotherapy as a means to alleviate client's distress, thus with the aim to bring about positive change. Psychotherapy aims to support the client with a change in perspective about their future through a process of alliance which involves stages of; engagement, searching for patterns and meaning, implementing change strategies and therapy termination (Beitman et al., 2005). There is acceptance that a main aim of psychotherapy is client change, which is common across all psychotherapy modalities. Miller et al. (2005) wrote that clients seek a change, regardless of the type of therapy, thus emphasising the importance of an outcome-informed approach to psychotherapy. To explore the phenomenon of change, much research has concentrated on psychotherapy outcomes, in order to establish both what changes occur and what may account for the given change. Hill et al. (2013) explored the difficulties with outcome research, they noted that psychotherapy itself is extremely complex in nature due to variations of many factors such as the individual client and therapist; the psychotherapy approach; the alliance; and cultural variations. Although the effectiveness of psychotherapy has been widely evidenced, Hill et al. comment that the complexity of change may not be captured across much of the research due to the majority use of statistical methods of capturing change with limited additional idiosyncratic exploration.

There has been a shift in research focus from 'what works', to how therapy brings about change. This has been explored through researching mechanisms of change, which are the theoretical explanations for why change occurs and are proposed to be different for diverse types of therapy (Kazdin, 2006). The therapeutic alliance has been one of the most researched transtheoretical factors and has been shown to have a consistent effect upon treatment outcome (Grencavage & Norcross, 1990; Horvath et al., 2011; Norcross, 2010). Further proposed factors include increased cognitive insight (i.e., increased knowledge and understanding of difficulties) and affect awareness, which have showed to be positively associated with successful outcome across psychotherapies (Høglend & Hagtvet, 2019). However, these treatment components cannot be explicitly reported as mechanisms of change due to methodological limitations of researching such complex mechanisms (Kazdin, 2007). Nevertheless, it is important that research continues to explore the empirical basis of mechanisms of change in order to improve interventions and provide evidence-based understanding for how change may occur.

Psychotherapy and Change

As discussed, a key aim of psychotherapy process is client change (VandenBos, 1986). The process of change has been explored across all therapy modalities through identifying factors that are common across approaches (Grencavage & Norcross, 1990). Rosenzweig (1936) noted

the equivalence of efficacy and argued that therefore similar elements must be contributing to the change despite what the proponents of the different approaches were arguing 'worked'. Since this, the hypothesis has been conceptualised and explored differently by researchers with one of the primary areas of empirical consideration given to the therapeutic alliance (Cuijpers et al., 2019).

Lambert and Ogles (2004) provided a theoretical overview of common factors from the existing literature and proposed three categories of common factors: support (i.e., therapeutic alliance), learning (i.e., insight), and action (i.e., taking risks). Wampold (2015) later proposed the contextual model of psychotherapy which outlines common factors including the therapeutic alliance, empathy, therapy expectations, and therapist effects. Wampold looked at meta-analytic findings exploring factors that account for client change and concluded that these factors are important in understanding outcome variance, as they expand understanding of the mechanisms of change. The therapeutic alliance has three proposed components: a bond between the therapist and client, an agreement about therapy goals, and lastly an agreement on the tasks of therapy (Bordin, 1979). Using this understanding of therapeutic alliance, Wampold (2015) reported that alliance is typically correlated with final outcome with a medium sized effect, using Cohen's d (Cohen, 1988). Therapist expressed empathy is another recognised common factor, this enables collaboration and effective social interaction, and has evidenced a relatively large effect size of d=.63 across studies (Wampold, 2015). In addition to this, other related constructs such as positive regard/affirmation (d=.56) and congruence/genuineness (d=.49) have been shown to have a medium effect on final outcome across the literature (Farber & Doolin, 2011; Kolden et al., 2011). Expectations are another proposed common factor and although difficult to meaningfully examine in experimental literature, a meta-analysis reflected a small but statistically significant effect (d=.24) between expected and achieved outcome from the client's perspective (Constantino et al., 2011).

In exploring the impact that common factors may have upon outcome, Lambert (1992) estimated common factors explain approximately 30% of the variance; the client and surrounding life factors explaining approximately 40% of variance; client expectations explaining approximately 15% of variance, and specific therapy techniques accounting for approximately 15% of final outcome variance. More recently, a meta-analysis of 31 studies explored the empirical basis of Lambert's variance estimates in clinical trials exploring outcome in clients with depression. They comparably found that common factors accounted for 49.6% of improvement; the client and their environmental factors accounted for approximately 33.3% of improvement, and specific therapy factors accounted for the remaining 17.1% of improvement (Cuijpers et al., 2012).

Measuring Change

The concept of change has developed throughout the history of psychotherapy, with early researchers such as Strupp (1963) who explored the efficacy and effectiveness of psychotherapy in the context of the debate about specific or non-specific factors as responsible for change (Eysenck, 1964). In the modern era, the profession has moved towards routine outcome measurement with the aim of evidencing outcome (Miller et al., 2013). As outcome is dependent upon how change is operationalised in the first instance and as not all therapies aim for symptom reduction as a marker of success, the measurement of change remains an area of contention for some.

Change can be measured throughout the therapy process using standardised outcome measures and idiosyncratic measures that are individual to client's particular difficulties. Examples of standardised routine outcome measures that are widely used include the normed and validated Outcome Rating Scale (Miller et al., 2003) which has evidenced moderate to high internal consistency for its use as a screening and monitoring measure (Harris et al., 2019). Research has shown that the use of routine outcome measures supports treatment outcome for clients, for example therapists who received client progress feedback via outcome measures significantly increased the rate of clinically significant and reliable change, and decreased deterioration rates (Lambert, 2001). This reflects the importance of the use of outcome measurement in psychotherapy practice and research as it allows for the adjustment of the intervention resulting from client feedback (Miller et al., 2013). This measurement is useful for statistical analysis of client improvement, non-response, or deterioration. As measures are standardised, they can be helpful for those who commission services to observe average treatment success rates across groups. Reliable change on clinical measures provides a different way to conceptualise change, which is that change in scores needs to surpass that which can be explained by errors of measurement i.e., the unreliability of the outcome measure (Evans et al., 1998; Morley & Dowzer, 2014).

Hansen et al. (2002) describe some limitations with standardised measurements of change. For instance, for client change to be clinically significant, the client must be in the clinical range of a measure in the first place. Hansen describes that this may be not the case for some, but that does not mean that their daily functioning is not significantly impacted. Hansen continues, the same can be said for those not reaching the 'non-clinical range' post therapy, as individuals with chronic difficulties for example, may remain in the clinical range on measures despite making improvements that they would see as meaningful. Additionally, what is viewed as a positive outcome in psychotherapy is dependent upon the socio-cultural norms of mental illness

and what constitutes a positive outcome (Hill et al., 2013). McLeod (2011) argued that self-reported changes on routine outcome measures may not accurately reflect real life changes as a result of therapy and may be reflective of the 'hello-goodbye effect', which is a bias where clients may exaggerate their difficulties in order to appear eligible for therapy and overstate their success post-therapy to please their therapist (Salkind, 2007).

Barlow (2010) reflected that routine outcome measures are better able to detect positive change rather than negative change. Therefore, McLeod (2011) argued that client experiences may be better explored through interview techniques, noting that these techniques are better able to detect unsuccessful therapy. Similarly, Hill et al. (2013) argued that standardised outcome measures do not capture the complexities of individual change and subsequently recommended the inclusion of qualitative and individualised approaches to outcome measurement. Further to this, it appears unclear what a significant change in outcome scores pre to post therapy looks like in a client's life outside of therapy (Blanton & Jaccard, 2006). Thus, client perspective is important in the evaluation of therapy outcome, this is further detailed in the next section.

The Importance of Client Factors

Change from the perspective of the client therefore seems to be critical, considering that there may be a gap in understanding the real-life impact of 'significant' changes, potentially due to the positivist approach to traditional measures of change. Therefore, considering the 'client theory of change' (Duncan & Miller, 2000) is important, as clients are not passive entities whom therapy is imposed upon, they are active participants with perceptions of how they expect change to occur. Researchers Tallman and Bohart (1999) exemplified the importance of client factors of change using a metaphor of a gym. Individuals seeking to better their physical health attend gyms to achieve this goal (alike positive therapeutic change in psychotherapy), the gym offers an array of gym equipment to help the individual achieve their fitness goals (alike differing therapy modalities). Whether the goals will be met depend on the individual's motivation to achieve the goal, use of the equipment and commitment to continue with the work, these factors are much more important it would seem than the specific equipment chosen, although of course the equipment plays a role.

Client feedback on the process of therapy appears to be crucial for a rich understanding of what works and what does not in the therapy room, as client factors likely account for a large proportion of outcome variance (Cuijpers et al., 2012; Lambert, 1992). Further to this, evidence suggests client factors are one of the strongest predictors of therapy outcome (Bohart & Wade, 2013). As described above, client and extra-therapeutic change factors have been reported to account for approximately 33-40% of the variance in final outcome, these factors include both

internal client characteristics and environmental factors around the client that impact change (Lambert, 1992; Norcross & Lambert, 2011). These include the characteristics a client brings to therapy such as motivation, readiness to change, inner strength, social support, community involvement and stressful life events (Sprenkle & Blow, 2004). In an experimental study, Bohart and Wade found client characteristics that were predictive of improved therapy outcome included coping style; psychological mindedness; client motivation; attachment style; and level of self-criticism and perfectionism. This reflects the importance of the client being at the centre of therapy and the need to incorporate their views of change and evaluation of the therapy process.

Additionally, there is evidence that therapists are poor predictors of client negative outcome (Hannan et al., 2005; Hatfield et al., 2010). Hannan's (2005) research compared the clinical judgements of 48 therapists with an algorithm which detected when clients were at risk of deterioration. The algorithm was able to correctly predict 90% of clients who deteriorated (although did over-estimate negative therapy effects) whilst therapists only correctly identified one out of 26 clients who went on to deteriorate. This reflects a difficult task in the therapy room when trying to identify those at risk of non-response when solely based on clinical judgement. Further to this, therapists have also shown to attribute client deterioration to the client rather than to them as therapists or the therapy process (Shepherd et al., 2012). These studies focused on client deterioration; however, they may help to highlight the weaknesses in therapist judgement more broadly and thus may be applicable to the understanding of predictors of non-response. Coffman et al. (2007) explored the experiences of clients classed as 'non-responders' who had attended cognitive therapy for depression, alongside their therapist's perceptions of their client's change. A discrepancy was apparent, as clients tended to rate lower levels of change than therapists, which supports that therapists may also be poor predictors of non-response in psychotherapy.

What Might Successful Therapy Look Like?

As the aim of psychotherapy is to produce positively meaningful change for clients, it is useful to consider the factors that research has suggested relate to good outcomes (Pivolusková et al., 2019). A QES by Ladmanová et al. (2021) exploring client-reported helpful and hindering events in psychotherapy found twelve helpful categories (e.g., gaining a new perspective on the self; feeling heard, understood, and accepted; developing new skills/coping strategies; becoming more in touch with own emotions; feeling safe with and trusting the therapist; and feeling engaged in the therapeutic process). Ladmanová et al. state that these events highlight what supports clients to engage with the process of therapy (building trust and opening-up) and the relational elements that help to consolidate therapeutic gains (feeling accepted and validated), with the agency of

clients emphasised as an important contributor to these events as well as therapist factors. These findings were largely consistent with the findings of a previous QES exploring client experience of psychotherapy, spanning 42 primary studies (Levitt et al., 2016). Levitt et al.'s findings highlighted that when therapists were authentically caring and accepting, clients felt safe to explore threatening topics and explicitly naming power imbalances and the roles they held in the relationship resulted in a more collaborative experience, thus promoting client agency.

In a mixed methods study comparing successful to less successful cases, Werbart et al. (2019b) found that in the successful outcomes there was a shared understanding of client difficulties and the goals of therapy, within the context of a supporting yet challenging (active) therapeutic relationship where therapists were able to adjust their approach to meet clients' needs. These findings appear consistent with Råbu and Moltu (2020) who found upon client-therapist dyad interviews that engaging each other was the overarching ingredient of a successful therapy, which was developed through the ability to open-up, trust the relationship and process, and creating a space for discussing emotionally overwhelming content. Similarly, another study exploring client perceptions of what worked for them in psychotherapy showed that the ability to express themselves both emotionally and verbally was paramount to effective therapy from the client's perspective (Tzur et al., 2019).

A further mixed methods study by De Smet et al. (2020) explored the experience of participants who were statistically classified as either recovered or improved according to the Jacobson and Traux (1991) method. A nuanced experience of successful outcome emerged. Participants explained feelings of empowerment and increased ability of 'finding a personal balance' (increased self-understanding and improvements in interpersonal relationships); however, there was also an overarching theme of experiencing an ongoing struggle, notably this was seen more so in the 'improved' rather than 'recovered' participants. The authors noted that this highlighted the importance of acknowledging the statistical indications of improvement within the context of a person's narrative, as in this study, statistical classifications did not capture the more negative nuances which were identified upon interview. Therefore, the categories of outcome used for routine measurement may arguably lack complexity to reflect the complex experience of therapy outcome.

Deterioration and Harm

It is estimated that between 5% and 10% of clients experience decline as a result of therapy (Barkham et al., 2001; Crawford et al., 2016; Hansen et al., 2002; Lambert & Ogles, 2004). As Castonguay et al. (2010) wrote "however painful it may be, it is important for those of us who are psychotherapists to recognise that we have all likely harmed one or more of our

clients" (p. 34). Although uncomfortable, it is imperative to consider the risk of harm that psychotherapy carries in order to abide by ethical and competency requirements (Linden, 2013; Wolpert, 2016). There are inconsistencies with the conceptualisation and definition of adverse effects, deterioration, and harm therefore, researchers have recommended the use of standardised definitions for research in the area (Lambert, 2011; Parry et al., 2016). Despite these difficulties, there has been an increase in research into the area of harmful therapy. Farquharson (2020) for example summated that research thus far has provided potential therapist factors that are associated with negative effects. These include the underestimation of client presenting difficulties; lacking empathy; lack of focus; unethical behaviour; and adverse emotional reactions to clients. Crawford et al. (2016) importantly reported clients who are from ethnic and sexual minority groups are more likely to experience harmful therapy. Additionally, in the context of group psychoanalysis, a review reported factors associated with harm included the misuse of power and inappropriate interpretation (Maratos & Bledin, 2021). The authors suggested the lack of consideration of such factors may represent a defence or a way of coping with this phenomenon.

Curran et al. (2019) aimed to produce a client perspective model of process factors that may lead to negative and/or harmful therapy effects (defined in their review as lasting negative effects of therapy). Curran et al. proposed factors associated with harm which included a lack of cultural validity; unmet goals and expectations; therapist malpractice/boundary violations; misuse of power; and pathologising clients, which led to clients feeling disempowered and devalued. In response to the therapy harm findings, recommendations have included appropriate use of therapist supervision and training to support the client's voice to be heard; risks as well as benefits should be fully explained to ensure informed consent; and routine monitoring of adverse effects and deterioration should be included in service/organisational audit and research (Curran et al., 2019; Parry et al., 2016). It is important to highlight the impact of service factors, as thus far the focus appears to have been on client and therapist factors (Hardy et al., 2019). The following section will now consider how non-response is currently conceptualised as this has been proposed as a different phenomenon to deterioration and is the focus for the current review (Lambert, 2011).

Defining Non-Response

Across the literature the estimated prevalence of psychotherapy non-response is widely variable, from 14-56% (Morton, 2019). Morton noted that such variability may reflect the varied outcome measures, different service contexts and psychological interventions used across the literature. The difficulties with operationalising and measuring change outlined above are also likely to play a role in this variability. It comes as no surprise then that non-response is equally as

complex a phenomenon to conceptualise. There is some consensus in the literature that defines non-response as a lack of reliable and or clinically significant symptom reduction (Carr et al., 2017; Crowe & Luty, 2005; De Smet et al., 2019; Hansen et al., 2002; Harvey, 2014; Lorentzen et al., 2011; Mohr et al., 1990; Morton, 2019; Reuter et al., 2015; Stiles et al., 2015; Van et al., 2008; von Below, 2020; Werbart et al., 2015; Werbart et al., 2019a; Werbart et al., 2019b). This is a positivist perspective of non-response which is grounded in the quantitative paradigm. Linden (2013) defined 'treatment non-response' as "a lack of improvement in spite of treatment" (p.288). Linden stated that non-response is an unwanted event that may or may not be an adverse treatment response or malpractice reaction. Therefore, this conceptualisation includes adverse outcomes from therapy, and although Linden's research focused on negative side-effects of psychotherapy, this definition has shaped studies of psychotherapy non-response. This may have led to the psychotherapy non-response literature including clients who have experienced both non-response and deterioration and these experiences are at times hard to distinguish (e.g., Werbart et al., 2019a; Bowie et al., 2016).

Some studies have used statistical analysis to distinguish a non-response group. For example, Stiles et al. (2015). This study included a large data set and gave an estimate of the proportion of non-response as a result of psychotherapy within psychology services in the National Health Service (NHS). The authors conducted a large outcome study of 26,430 adult clients across primary and secondary psychological services. The researchers compared treatment duration with degree of improvement using the Clinical Outcomes in Routine Evaluation outcome measure (CORE-OM) which is a global measure of psychological distress, risk, and functioning (Evans et al., 2000). Clients scored above the clinical cut off point prior to treatment and, of those with planned endings, 18.8% experienced no reliable change as a result of psychotherapy. This focus on planned endings suggests that the non-response rate is higher than reported, as it may be assumed that those not feeling benefit from their treatment may leave sooner than planned. Additionally, these clients scored higher than clinical cut off prior to therapy, which was necessary for measurement of clinically significant change (Jacobson & Traux, 1991). However, research has suggested that non-responders are more likely to have lower initial distress (Lorentzen et al., 2011), therefore this may be an under-estimation of non-response. This area would benefit from further investigation of whether non-response rates are higher in particular settings, there is tentative evidence that this may be the case for secondary care versus primary care (Evans et al., 2017; Gyani et al., 2013).

An interesting consideration is the addition of qualitative measures of non-response to understand change at a person-centred level. Various studies looking at unhelpful therapeutic experiences and outcomes have used the Client Change Interview (CCI) schedule (Elliott et al.,

2001) alongside standardised outcome measures such as the CORE-OM (Evans et al., 2000) to add context to the outcome category. Qualitative interviews such as the CCI are post-therapy semi-structured interviews that explore the experience of change, helpful and hindering therapeutic experiences, and what clients attribute any change to. De Smet et al. (2019) queried how representative statistical definitions of outcome are in capturing the clinical meaning of outcome for individuals, therefore the addition of a qualitative measure may help to bridge the gap in understanding and capturing nuanced and meaningful change for clients.

Predictors of Non-Response

Despite the increasing interest in psychotherapy non-response, there is little research on the predictors of lack of change, with literature focusing on positive and negative outcome predictors (Lorentzen et al., 2011). It is important to consider factors leading to no change, as although we can learn from the literature on predictors of positive outcome such as the therapeutic alliance; therapist empathy; client attachment style; and level of self-criticism (Norcross, 2002; Bohart & Wade, 2013), and of negative outcome predictors such as premature interpretations, and client inadequate social support (Castonguay et al., 2010; Whipple et al., 2003), the literature directly investigating non-response is sparse so it cannot be said with any certainty that such predictors are also relevant for non-response. Therefore, it is important that non-response and its potential predictors are investigated as separate phenomena with potentially different pathways to this outcome than has been highlighted by past literature looking at successful and adverse outcomes.

Research into this area thus far has proposed some possible predictors of non-response. For example, Van et al. (2008) proposed predictors of non-response including clients aged over 40 years, chronicity of mental health difficulties, and non-adherence to treatment. Reuter et al. (2015) investigated predictors of non-response in inpatient psychotherapy and concluded similar predictors of non-response in outpatient settings; moderate distress pre-treatment, previous non-response to psychotherapy, and lack of early response (defined as within the first eight sessions or first month of psychotherapy). However, as this was a retrospective study, the variables that the researchers were able to investigate were limited, therefore there may have been other important variables related to non-response such as therapist factors that, due to this study design, could not be considered.

Clients with interpersonal difficulties including problems in establishing a therapeutic alliance have also been found as potential predictors of non-response (Crits-Christoph et al., 2005; Horvath et al., 2011). A systematic review of 2,719 NHS primary care clients who accessed psychological therapy and counselling services further found non-response was associated with;

unemployment or receiving benefits, more symptoms which had persisted for a longer period and very high and low intake severity (as opposed to a moderate severity; Harvey, 2014). The latter of which has been supported previously by Lorentzen et al. (2011), who reported non-responders appeared to have lower initial distress. Interestingly, Harvey also noted that although risk was not associated with non-response, therapists with a higher risk caseload were more likely to have clients who did not respond to therapy. Although these results cannot be extrapolated further than primary care, the latter novel finding provides an interesting rationale for further research exploring risk as a factor of non-response in psychotherapy in other settings, particularly as other research has suggested a possible higher proportion of non-response in secondary care (Evans et al., 2017; Gyani et al., 2013).

Experience of Non-Response

Although research is starting to address the predictors of non-response in psychotherapy, it is also important to consider what this actually means for clients and their therapists, how they make sense of experiences of non-response and the factors which predicted this outcome. Studies that have explored these lived experiences have often used self-identification or definition of non-response, either from their or their therapist's perspective (von Below & Werbart, 2012; Hopper, 2015; Radcliffe et al., 2018; Bowie et al., 2016; Crowe & Luty, 2005). Other research qualitatively explores the experiences of clients who have been identified as non-responders through outcome measure scores indicating no reliable change (De Smet et al., 2019; MacLeod, 2017; Morton, 2019; Werbart et al., 2015; Werbart et al., 2019a; Werbart et al., 2019b).

Previous Doctoral theses have explored the experience of client perspective (Radcliffe, 2014), therapist perspective (Hopper, 2015), and therapist-client dyad perspectives (Morton, 2019). Findings from these studies suggest that clients may enter therapy with high expectations of what therapy can change for them, and these expectations were often left unmet. There was overlap in Radcliffe (2014) and Morton's (2019) findings of the client experience of non-response as there were mixed experiences of the therapeutic relationship; some clients experienced a positive alliance, whereas others were left feeling misunderstood and judged. The therapist and therapy often did not match clients' expectations for their therapy and with clients' feeling emotionally overwhelmed, they were left with disappointment that their problems remained. Notably in each study, clients (and therapists) were able to describe positives that had been experienced, indicating a complex picture of change and outcome. These findings are congruent with Werbart et al. (2015), which explored the experience of young adults who met no reliable change after treatment for depression. The participants in this study were left with a feeling of 'spinning one's wheels' as therapy did not meet expectations and despite some improvements,

core problems remained. Similarly, De Smet et al. (2019) reported client non-response was reflective of a 'stalemate': a want to change but an inability to proceed.

Although the qualitative therapist non-response literature is more limited than client experience, literature thus far has provided important implications. A doctoral thesis, Hopper (2015) explored the experience of seven therapists and found a core theme of therapist's hope being destroyed by their experience of non-response. Therapists experienced both internal and external pressures to achieve change which resulted in high expectations and a sense of personal responsibility for therapy success. Alike Werbart's et al. (2015) finding, therapists often managed the anxiety of this therapy by underestimating the client's difficulties. Partly due to fear of criticism, therapists in Hopper's study expressed a general avoidance of seeking appropriate support for the difficult case and subsequently experienced difficult emotions upon therapy termination. Another study exploring therapists' experience of non-response (Werbart et al., 2019a) concluded an overarching theme of experiencing the client as holding back which they conceptualised as "having half of the patient in therapy" (p. 899). Again, Werbart et al. described a sense of contradictory relationships with positives expressed alongside distance in the alliance.

In a Doctoral thesis exploring client-therapist dyad experiences of non-response, Morton (2019) proposed a continuum of change and non-improvement which became clear from the divergent experiences that each dyad faced, despite experiencing the same outcome of no reliable change. Across the dyads, there were themes of 'opening-up', 'closing off'. 'growing' and 'struggling' which was encapsulated by the author as the overarching theme 'a mixed bag' which again reflects the complexity of outcome and highlights the importance of qualitative exploration of such experiences.

Von Below (2020) synthesised four non-response studies which were conducted in the context of the Young Adults Psychotherapy Project (YAPP) in Sweden. Von Below proposed a tentative model derived using grounded theory methodology to support the understanding of lack of improvement and dissatisfaction after psychoanalytic psychotherapy in young adults who took part in the longitudinal study. The synthesis also included one study exploring therapist perspective. Von Below described that overall, clients described feeling misunderstood whereas therapists felt clients were not committed to the therapy process. A key finding in this study was the limited use of reflection during therapy, as seen by overseeing the participants interview transcripts (the research design), von Below proposed that a key mechanism in non-response may therefore be a lack of mentalisation ability in clients. This study provides a helpful model of understanding lack of improvement; however due to the specificity of the synthesis, the current

review hopes to build upon the literature by synthesising a larger set of studies with a wider range of participant groups, therapy modalities and therapeutic settings.

The experiential literature reviewed thus far on the experiences of non-response have highlighted the importance of understanding the process of non-response through a qualitative lens. Synthesising the evidence thus far will be helpful for therapists to learn to identify what may be occurring in the therapy and importantly, reflect on this at a stage in therapy where there is an opportunity to correct the experience. Research thus far appears to indicate that non-response is not simply the lack of any effect, in fact it appears to be a complex process with costs for both clients, therapists, and services. It is imperative that the perspective of clients are explored, as client factors appear to account for a large proportion of variance and exploration of lived experience supports the explanation of nuanced outcome experiences. It is important to also include the synthesis of available therapist experiences of non-response as it is therapists who arguably hold the power in the relationship to address the issues. This also has direct implications for clinical supervision and training (both in organisations, and in Clinical Psychology Doctoral programmes; DClinPsy). The chapter will now explore qualitative research methods, which were chosen for the exploration of client and therapist non-response for the current QES.

Qualitative Research Methods

Qualitative research describes the analysis of human experiences and understanding of social and cultural phenomena with participant's own words, through methods such as interview, focus groups and diaries (Ailinger, 2003). Meanings are derived through an iterative process where the researcher attempts to become immersed in the experience of the participant in order to identify patterns and constructs with the aim to develop interpretations of the described subjective experience. This is taken at face-value as legitimate data for analysis, to better understand a phenomenon (Levitt et al., 2018). As the data retrieved through qualitative methods are often classified as 'rich' and detailed, fewer participants are included in qualitative research compared to the quantitative counterpart. In this sense there is a difference as to how generalisable findings from qualitative research are compared to the large data sets whose methods are open to exact replication, with the aim of verifying hypotheses across many contexts (Levitt et al. 2018; Nye et al., 2016). However, as qualitative research aims for transferability rather than generalisation this is considered to be acceptable.

Levitt et al. (2018) report that qualitative research has made important contributions to the psychology literature, however the use and acceptance of these approaches has not always been straightforward. Researchers who held a positivist perspective, as was the majority at the time, argued that qualitative methods should not be classed as a science (Harré, 2004) due to the

unobjective standpoint and interpretive nature of this methodology. To note, the positivist epistemology is grounded in the paradigm that posits that objective truths exist, and these can be evidenced through rigorous research methods which aim to be as free from bias as possible, with the aim of replicability (Cuthbertson et al., 2020). Qualitative research on the other hand is underpinned by the epistemological stance interpretivism, which argues that knowledge and beliefs are individually or socially constructed through individual experiences. Methods of data collection that reflect this, such as interviews, are adopted. By their nature these are subjective, as the interpretivist researcher holds the belief that they cannot hold themselves as fully objective and must acknowledge their subjectivity in the interpretation of data (Cuthbertson et al., 2020).

Now accepted in the scientific field of psychology, qualitative methods can add an idiosyncratic understanding of how phenomena are experienced by the individual. Examples of qualitative research methods include: grounded theory (Glaser & Strauss, 1967); phenomenological methods (e.g., Smith et al., 2009); critical methods; ethnographic methods; case study; and thematic analysis (Braun & Clarke, 2006). Qualitative methods can be standalone or can form the basis of quantitative research by exploring a relatively unknown area, prior to exploration using quantitative methods (Levitt et al., 2018). Mixed-method research which combines both research methodologies can result in additional understanding and enhanced insights of the research area that may not have been achieved by either method alone (Creswell, 2015; Levitt et al., 2018).

Introduction to Evidence Synthesis

Evidence synthesis, otherwise referred to as systematic review, is a research method that aims to integrate results of multiple primary research papers in order to synthesise the findings to support practical decision making and advance theoretical understandings (Egger et al., 1997; Sutton et al., 2019). The Cochrane handbook states that this is achieved by the use of explicit, systematic methods which aim to reduce bias (Chandler et al., 2020). This type of review is widely used to develop clinical guidelines and policy in healthcare through rigorous methods, thus providing a robust and reliable evidence source (Munn et al., 2018).

Munn et al. (2018) report that systematic reviews are useful when the aim is to explore whether current practice or guidelines are based on relevant and quality evidence. The researchers further note that systematic reviews are an invaluable tool when there is conflict in existing practice due to contradictory research evidence, and they can inform future research in the area of interest. Grant and Booth (2009) note that it is important that systematic reviews are performed transparently for replication. The researchers continue that when quantitative methods are used, as is the case with conventional systematic reviews, this can limit the outcome to solely

effectiveness, thus not addressing more complex questions as to *why* the given intervention was found to be effective. Therefore, it can be useful to produce qualitative or mixed-method systematic reviews, in order to explore these complex questions across the literature. Grant and Booth explain that with the development of qualitative review guidance, the inclusion of wider systematic review designs has become a more accessible option for researchers.

Qualitative Evidence Synthesis

Qualitative evidence synthesis is a method of interpreting concepts from multiple qualitative research studies in order to construct new meanings, this can also be in the form of new theories and process models or frameworks to help to understand key questions in clinical practice. It has been reported that QES methods go beyond the aggregation of data, as is the aim of meta-analysis, and interpret the data with the aim of developing a new synthesised understanding of a phenomenon in the form of process frameworks which can be generalisable beyond the original conclusions (Finfgeld-Connett, 2018; Nye et al., 2016; Seers et al., 2015). Finfgeld-Connett explains that as the included studies are not replication studies, they each explore primary data in varying contexts, this heterogeneity broadens the transferability of the final interpretations. Therefore, the review must be of a homogenous sample, and as such be exploring the same phenomenon, and heterogenous enough to enhance transferability of findings.

Noblit and Hare (1988) were amongst the first to approach the synthesis of qualitative data with the proposal of meta-ethnography as one method of qualitative synthesis. There are various methods of QES including; thematic synthesis (Thomas & Harden, 2008), meta-study (Paterson et al., 2001), critical interpretive synthesis (Dixon-Woods et al., 2006), meta-narrative (Greenhalgh et al., 2005), framework synthesis (Oliver et al., 2008) and meta-interpretation (Weed, 2008). Despite the varying methods available for researchers, Nye et al. (2016) describe common elements across QES as they must aim to synthesise similar constructs across studies and explore any differences that may exist between them. This ensures the development of a synthesis which is consistent across the included studies (Nye et al., 2016). Sandelowski and Barroso (2007) further explain the contrast between primary analysis and QES, as in the former the original data (i.e., transcripts) are what is analysed, whereas it is the findings rather than the original data which is analysed in a QES. Discussion of potential QES methods for the current review is considered in the method chapter below.

Summary

There are difficulties with defining change in psychotherapy research due to the complex nature of change itself, and how it is operationalised in different settings. Much of the published literature thus far has focused on identifying rates of successful psychotherapy and predictors of failures. Additionally, previous research has focused on measurement, definition, and prevalence of outcome categories therefore the client goals and perspective has been somewhat overlooked. Therefore, it is important that the clients' perspectives are explored in order to understand what it was about their experience that led to a lack of change. This could help to improve clinical practice and potentially improve outcomes for those who may have otherwise not responded. There have now been several qualitative studies exploring the experience of psychotherapy non-response from the client and therapist perspectives. It is therefore proposed that a qualitative synthesis of this literature would be useful to develop our understanding of therapy non-response for this overlooked group and by including therapist data, make suggestions on how to improve clinical practice in this area.

Therefore, the primary aim of this review was to synthesise the available evidence exploring the experiences of psychotherapy non-response. By synthesising the literature, it was hoped to create a conceptual understanding of psychotherapy non-response. The following research questions were developed using the Population, Phenomenon of Interest, and Context (PICo) tool, which was modified to suit qualitative research (Stern et al., 2014).

1. How do psychotherapy clients and therapists understand and make sense of their experience of non-response in psychotherapy?
2. What could have improved the psychotherapy experience for the client and therapist from each perspective?

CHAPTER TWO: METHOD

Introduction to Chapter

The following method section will describe the qualitative evidence synthesis (QES) methods, which includes the methodological underpinnings of this type of research, inclusion and exclusion criteria, and the process of study selection, data extraction and data synthesis. Preferred Reporting Items for Systematic Reviews and Meta-Analyses guidelines were followed (PRISMA; Moher et al., 2009), alongside qualitative evidence synthesis reporting guidelines (Enhancing transparency in reporting the synthesis of qualitative research: ENTREQ) to enhance trustworthiness of the review. The ENTREQ framework consists of 21 items covering the following five main domains: introduction, methods and methodology, literature search and selection, appraisal, and synthesis of findings (Tong et al., 2012; see Appendix A). A review protocol was registered for this review with PROSPERO International Prospective Register of Systematic Reviews (registration number: CRD42021249086).

Qualitative Evidence Synthesis

It was appropriate to firstly determine if a scoping review was a more appropriate method for the reviews' aims. A scoping review consists of a preliminary literature search in order to identify the extent to which a topic has thus far been researched and does not typically synthesise findings to create a summary or new understanding (Grant & Booth, 2009; Munn et al., 2018). Grant and Booth (2009) describe scoping reviews being open to bias as there is no assessment of quality in the research identified. Munn et al. (2018) recommend conducting a scoping review when the aim of the research is to identify available information, find gaps in the literature, to clarify key concepts and identify characteristics related to a concept. In contrast, a qualitative evidence synthesis aims to combine qualitative evidence to generate further understanding of phenomena (with the inclusion of a quality appraisal process), confirm current practices and/or identify new practices, identify further areas of research, and guide decision making (Munn et al., 2018; Sutton et al., 2019). The purpose of this review appeared to fit best with a systematic review as the aim was to develop an understanding of psychotherapy non-response, which would be transferable past the original studies with the potential to inform theory and practice.

Philosophical Perspectives and Research Methodologies

The QES research method lies within the interpretivism paradigm, which is inductive in nature and ultimately seeks to understand knowledge based upon the experiences of the individuals in the given studies (Noblit & Hare, 1988). Research that sits within the interpretivism paradigm is qualitative and uses research methods such as interviews, focus groups and

observations (Aromataris & Munn, 2020). A number of methodologies lie within this perspective such as phenomenology, grounded theory, and ethnography, all of which aim to understand phenomena. Underpinning all research are ontological and epistemological positions, that is, what the nature of reality is and how it can be known. Cuthbertson et al. (2020) note that the assumptions underlying qualitative research are that reality is subjective, that the researcher interacts with the phenomenon that is being researched and research is context bound. Cuthbertson et al. continue that within the interpretivism paradigm, the ontological perspective is that reality is based on an individual's interpretations and thus they make their own meaning which cannot be generalised. The epistemological stance from the interpretivism paradigm is that knowledge is therefore constructed individually or socially through individual experiences (Cuthbertson et al., 2020). In contrast, the assumptions underpinning quantitative research, of which the philosophical position is positivism, is that reality and knowledge are objective and separate from the researcher, theory generated from research is therefore able to be generalised across contexts (Bleiker et al., 2019; Cuthbertson et al., 2020).

The interpretivism paradigm aligns with the research questions of the current review, which aim to explore how clients and therapists make meaning from their experiences of non-response, and what could have improved the therapy experience. This philosophical underpinning also aligns with my personal position of how knowledge is created. I believe that individuals extract meaning from events according to their own attitudes and perspectives, rather than there being a single objective truth. This is a critical realism epistemological stance, which falls under the interpretivism paradigm and posits there can be multiple interpretations of the same phenomenon (Spencer et al., 2004) and that knowledge is understood through the interpretation of the data (i.e., not taken at face value but through interpretation of the underlying structures; Willig, 2013). I believe that individuals have the ability to articulate an experience which corresponds to their reality, thus has grounding in phenomenological thinking. Giacomini (2010) states that it is important to actively acknowledge the theoretical stance that researchers bring, as these influence chosen methodologies, and will shape interpretation of the data. Reflexivity is important in qualitative research, that is, the acknowledgement of the researcher's personal views, interests, biases, and assumptions, and how these affect the research process (Finlay & Ballinger, 2006). A reflexive statement is provided at the end of the methods chapter.

Process of study selection

A preliminary literature search was conducted on Google Scholar which found no existing qualitative systematic review looking at psychotherapy non-response. A systematic narrative synthesis exploring 'how does therapy harm?' was identified which produced a model of adverse psychotherapy process factors, including harm, from the client perspective (Curran et

al., 2019). The paper was discussed with research supervisors, and it was agreed that the focus of the current review was different and could be complimentary to the review exploring adverse therapy outcomes. Whilst, as discussed in the introduction, there may be overlap of harm and non-response in the literature, the current review aimed as much as possible to exclude therapy harm.

This preliminary search highlighted the overlap of outcomes covered by the 'negative therapy outcomes' literature and allowed for the development of initial inclusion and exclusion criteria using the PICo tool (Stern et al., 2014), see Table 1.

Inclusion and Exclusion Criteria

Inclusion and exclusion criteria were identified and used to inform the screening procedure (see Table 2). Initial key words based on three key concepts of the research aims were also identified to inform the search procedure (psychotherapy, non-response, and qualitative research). This search strategy was iteratively developed over time in conjunction with research supervisors, as whilst searching, problems with the definition of non-response became apparent. The aim was to be inclusive in order to avoid missing the experience of potential non-responding participants in the literature.

Table 1

PICo Tool Supporting Development of Inclusion Criteria

PICo Domain	Review Team Decision
Population	Lived experience of (either client or therapist) non-response from psychotherapy. Therapy focused on bringing about psychological change, no restriction on type of psychotherapy modality. No exclusions based on pre-therapy outcome measure score within the non-clinical range. No exclusions based on mental health diagnoses. Inclusive of studies that do not use outcome measures as well as those that do.
Phenomenon of Interest	How clients understand and make sense of non-response from psychotherapy, and also where there are therapist accounts, how they understand their client's non-response. Self-defined, statistically defined (using RCI; Jacobson & Traux, 1991), and outcome measure defined not using RCI criteria (i.e., a pre-specified change in pre-post such as on the Clinical Global Impressions-Improvement Scale; Guy, 1976) non-response included.
Context	Any psychotherapy context.

Table 2

Inclusion and Exclusion Criteria

Inclusion Criteria	Exclusion Criteria
Any qualitative research method which goes further than description or mixed-method research design which includes sufficient qualitative data for analysis.	Articles unavailable in English language.
The study explores negative outcome of psychotherapy.	Wrong study design: book chapters, review papers, conference abstracts, meta-analyses, randomised controlled trials (with no qualitative element).
Psychotherapy clients and/or therapist perspective of non-response from psychotherapy explored, either self or therapist-defined, defined using outcome measure pre-post, and/or statistically defined.	Quantitative research design.
A substantial dose of therapy must be completed (clients should have had an adequate number of sessions in order to have experienced psychotherapy non-response) Considered on a study-by-study basis using supervisory discussion.	Research solely exploring the harmful effects of psychotherapy using quantitative methods to define this (i.e., reliable deterioration) in all or the majority of the participants where there are no clear participant identifiers to extract relevant data from those not reporting deterioration.
	Inadequate qualitative data (including case study descriptive data).
	Early treatment drop-out clients not to be included (relative to the given therapy setting and model e.g., one or two sessions would not be an adequate therapy experience for the purpose of this review.
	Drop-out not to be included unless client experience states a lack of change as a reason for drop-out.
	Pure self-help being explored (i.e., no clinician involvement throughout the intervention).

Search Strategy

A comprehensive sampling method was chosen, where studies were purposefully selected that were in accordance with the inclusion criteria. Although, as this was an iterative process, the criterion was flexible to amendments with the purpose to be as inclusive as possible of all data that would be relevant for conceptual development on the topic area (Finfgeld-Connett, 2018). This was to ensure studies meeting final inclusion were representative of the aims and objectives of this review.

The search strategy aimed to find all available published studies on qualitative explorations of the experience (client or therapist) of psychotherapy non-response. The initial search and identification of key terms supported the development of the search strategy, which was supported by an information technology specialist with the University of Leeds. The databases that were included in the formal search were: Medline, PsycINFO, Embase, CINAHL, Web of Science, Scopus, and Social Work Abstracts (see Appendix B for an example of one of the search strategies developed). These databases were chosen to ensure a good reach. A grey

literature search was also conducted on Ethos to identify any relevant dissertations or theses, along with forwards and backwards citation searching of the relevant articles' reference lists, and the articles referenced in the retrieved papers. Index and reference terms stated in relevant papers were added to the search strategy to ensure relevant articles were identified.

The types of studies I aimed to include were qualitative or mixed-method study designs that collected sufficient qualitative data that was relevant and extractable. Purely quantitative studies were excluded such as: survey research, correlational research, quasi-experimental or experimental research. No exclusions were proposed based on quality criteria as the aim was to conduct a comprehensive review, and there was not an overabundance of papers expected to be retrieved.

Study Screening Methods

Title and Abstract Screening. Following the completion of searches in each database, all records were downloaded into the reference software EndNote, which is efficient for the de-duplication of research papers (Barroso et al., 2003). All de-duplicated records were transferred to Rayyan software, which aids in the initial screening of titles and abstracts (Ouzzani et al., 2016). This platform enabled two independent reviewers (also DClinPsy students conducting systematic reviews) to co-screen papers simultaneously. I was blinded to the independent reviewers' screening decisions. Twenty percent of abstracts (232) were independently reviewed in total, with each reviewer screening 10% (116) each (see Appendix C for the screening flowchart). Rayyan software enabled the independent reviewers to state whether they would include or exclude the paper and report reasons why based on the inclusion and exclusion criteria, discrepancies were resolved through discussion.

Full Text Screening. A data extraction form in Microsoft Excel supported the collation of data at full text screening. Papers were randomly allocated to the independent reviewers using a random number generator. The independent reviewers screened 10% (18 papers) each, resulting in 20% (36 papers) of full texts independently reviewed overall. Regarding consistency, this process identified 10 discrepancies overall that were resolved through discussion (see Appendix D for an example). Alongside this process, I brought papers for discussion to research supervision. Discussions were held regarding what we were conceptualising as non-response in our subjective views, thus what to consider regarding the inclusion or exclusion of queried papers. These discussions highlighted the complexity of the construct of non-response which was echoed in the literature. Specifically, there were discussions regarding whether papers that focused on the experience of dissatisfaction and drop-out fulfilled the definition of non-response, this is described in more detail below.

Consistent with the acknowledgement that qualitative research is inductive in nature (Dixon-Woods et al., 2006; Finfgeld-Connett, 2018), the inclusion and exclusion criteria were altered to fit with our developing understanding of how the non-response population may have been captured thus far in the literature. The adaptations agreed by the supervisory team were to expand the inclusion criteria, as there were limited studies explicitly stating the population were 'non-responders' however in various papers the method of recruitment and inclusion criteria fit with the understanding of non-response as being an unsuccessful outcome which was not the same as harm. See Table 3 for the final inclusion and exclusion criteria, and rationale for each decision.

Table 3

Justification for Inclusion and Exclusion Criterion

Inclusion/Exclusion Criteria	**Justification**
Any qualitative research method which goes further than description or mixed-method research design which includes sufficient qualitative element**.**	Adequate qualitative data was required for data analysis.
Psychotherapy clients and/or therapist perspective explored**.**	The review aimed to explore both experiences separately and to explore any cross-over to add to the conceptualisation of non-response.
The study explores negative outcome of psychotherapy**.**	Negative outcome literature could include participants who were non-responders, full text review would be required.
Experience of non-improvement from psychotherapy is explored, either self or therapist-defined. Identification of non-response in the client or therapist accounts of their therapy experience or using outcome measure (either using a cut off score or no reliable change). Terms may include: non-response/dissatisfied/poor outcome/remaining or unresolved difficulties (with no mention of worsening or deterioration as main therapy experience).	Inclusive criteria of non-response required in order to capture the experience of non-responders, as this is a relatively new research area it was decided that inclusivity was appropriate for concept exploration.
A substantial dose of therapy must be completed in the context of the therapy setting.	Clients should have had an adequate number of sessions in order to have experienced psychotherapy non-response (i.e., participant who attended one session would not qualify for inclusion for example).
Research solely exploring the harmful effects of psychotherapy using quantitative methods to define this (i.e., reliable deterioration) in all or the majority of the participants where there are no clear participant identifiers to extract relevant data from those not reporting deterioration.	Harm was considered a separate phenomenon with its own literature base; this review was interested in looking at a homogenous as possible experience of not responding from therapy rather than experiencing harm.

Early treatment drop-out clients not to be included.	Connected to substantial therapy dose needed for participant to have experienced adequate number of sessions.
Drop-out not to be included unless client experience states a lack of change as a reason for drop-out.	Drop-out was considered too wide a topic for general inclusion due to the large number of possible explanations for outcome other than non-response. Drop-out was only included where dissatisfaction with the outcome or not meeting therapy goals was reported.
Pure self-help being explored (i.e., no clinician involvement throughout the intervention).	This review concentrated on a therapeutic exchange between client and therapist, therefore self-help was not appropriate for inclusion.

Definition of Non-Response

Difficulties were experienced during screening regarding the definition of non-response, which was anticipated, as reported in the introduction chapter above. Non-response was conceptualised in various forms including poor outcome, non-improvement, treatment failure, not recovered, unchanged, dissatisfied, experiencing an unhelpful therapy, less improved, and unsuccessful. It was agreed that papers using reliable change and/or pre-post outcome measure scores to define non-response would be included as well as self-defined non-response, this was due to the variation of how non-response was conceptualised in the literature and the aim of this review to be inclusive of non-responding experiences. This led to discussions on the appropriateness of including papers where participants were defined as either 'dissatisfied' or 'drop-outs'. Client drop-out, which is also a term with many definitions, has been associated with both lack of improvement and treatment dissatisfaction (Goldenberg, 2002; Hoyer et al., 2006; Hunsley et al., 1999; Khazaie et al., 2016; Lampropoulos, 2010; Saatsi et al., 2007), thus it was deemed appropriate to consider this on a study-by-study basis. Where there were themes indicating a harmful experience, these participants were excluded, whereas where dissatisfaction was expressed with indication of participant defined non-response from therapy, these were deemed appropriate for inclusion. Some papers included non-response and reliable deterioration within the same sample, these studies remained in the review where non-response was the majority experience. Where there was ambiguity, every consideration was made to pick out non-response data from research papers (for example upon evaluating an intervention, participants either responded or did not respond, with qualitative interpretations of both experiences). For this review, non-response refers to either therapists and/or clients stating no overall meaningful change, not meeting therapeutic goals, and being dissatisfied with the outcome of treatment. This is congruent with the definition of non-response as a "lack of improvement in spite of treatment" (Linden, 2013, p. 288).

Risk to Rigour

Quality appraisal to assess methodological rigour of qualitative data has three stages which the current review followed. Booth and Noyes (2021) explained the first stage 'adequacy of reporting details' refers to a process which begins earlier in the method where the reviewer filters against a set criterion i.e., inclusion/exclusion criteria. This process began filtering out empirical studies that did not meet the minimum criterion of quality set for this review, for example descriptive case studies were excluded due to inadequate data. The second stage, referred to as the technical appraisal stage, is the use of an appraisal tool to assess the methodological rigor of included studies (Booth & Noyes, 2021). An adapted version of the Critical Appraisal Skills Programme (CASP; Long et al., 2020) tool was used to assess the methodological quality of the included papers. The third stage of quality appraisal refers to theoretical appraisal which considers the consistency of the theoretical underpinnings and methodology choice in primary studies and is often the least represented (Booth & Noyes, 2021). It is important to consider this stage because the researcher's position impacts upon the methodology chosen and how the data is interpreted (Hannes et al., 2010). The CASP (2018) has been criticised for not taking into as much consideration the underlying theoretical stances of studies (Hannes et al., 2010). Therefore, another tool was considered, the Joanna Briggs Institute (JBI) Critical Appraisal tool, due to its strengths in the appraisal of theoretical underpinnings of research (Lockwood et al., 2015). Despite this, the CASP was chosen as it is user-friendly and accessible, particularly for novice researchers (Majid & Vanstone, 2018; Sattar et al., 2021). Furthermore, the adapted version of the CASP by Long et al. (2020) met the shortcomings of the original version by adding a question exploring theoretical underpinnings therefore, satisfying the third quality appraisal stage.

Some researchers have noted that although quality appraisal for qualitative research is recommended, it is a contentious issue as to whether such quality appraisal should result in study exclusion (Finfgeld-Connett, 2018; Nye et al., 2016). Of relevance to this, Booth (2007) noted that no one appraiser is good enough, nor is any one appraisal tool good enough, reflecting the subjectivity of such a task. One view is that qualitative investigations should be considered in the context of each individual study due to varied qualitative methodologies rather than on a single set of guidelines (Rolfe, 2006). Therefore, critical appraisal in this review was not used as a basis to exclude studies, however this remained an important element as the methodological rigour of primary studies impacted the applicability of interpretations made. Two independent co-appraisers also critically appraised six papers each (54% of papers in total co-appraised). Disagreements were resolved through discussion with me, and research supervisors. A level of concern was appointed to the papers as per the Cochrane handbook guidance, as opposed to a rating or total score because this does not translate in qualitative evidence syntheses (Noyes et al., 2021).

Data Synthesis

This review aimed to explore the personal experiences of both clients and therapists across a range of settings and contexts, therefore it was important to choose a method which enables the comparison of different qualitative methods and methodological stances used within the literature. The method of analysis was not decided upon until screening and quality appraisal stages had been completed. Guidance produced by Booth et al. (2018) was referred to in supporting the appropriate choice of method, this guidance prompts researchers to consider the review question; epistemological stance; time and timeframe; resources; expertise; audience and purpose; and type of data (RETREAT). The chosen methodology for this review was Thematic Synthesis (Thomas & Harden, 2008).

Introducing Thematic Synthesis

Thematic synthesis is an interpretative method of synthesising qualitative data which is based on the primary research method thematic analysis (Thomas & Harden, 2008). This method supports an inductive approach to generating themes across studies: data is first coded line-by-line, then translated into descriptive themes, from which analytical themes are generated (Barnett-Page & Thomas, 2009). Thematic synthesis accommodates both (conceptually and contextually) thick and thin data (Flemming & Noyes, 2021). Such flexibility was considered important for the current review due to the mixture of studies that were identified for inclusion. Another justification for this method was that thematic synthesis can produce findings that directly inform practitioners (Booth, 2016). The production of recommendations would be useful for therapists to discuss risk of non-response with their clients. By adhering to the stages outlined by Thomas and Harden (2008) it was hoped that the interpretations would go beyond those identified in the primary research conclusions, whilst staying close to the original data to hold onto participants' lived experience.

Thematic synthesis has been critiqued as potentially lacking in interpretative power and if guidelines are too prescriptively relied on, there is risk of novice users oversimplifying methods (Flemming et al., 2019). Barnett-Page and Thomas (2009) also reported that thematic synthesis is less forthcoming than other QES methods (such as meta-ethnography) about its theoretical underpinnings, stating a "less problematised view of reality and a greater assumption that their synthetic products are reproducible and correspond to a shared reality" (Barnett-Page & Thomas, 2009, p. 6). Whilst acknowledging these critiques, this method is widely used and Flemming et al. (2019) report that this method is likely to be suitable for novice reviewers. How I underwent each stage of thematic synthesis is detailed below, however I will firstly describe an alternative method that was considered for this review.

Alternative Method for Consideration

Meta-ethnography (Nolbit & Hare, 1988) was also considered for this review. This method allows for an in-depth rich approach to the interpretation of themes and theory development (Britten et al., 2002). Meta-ethnography has been used in health research to explore the psychological experience of clients, which increasingly informs policy and practice (Lang et al., 2013; Sattar et al., 2021). Meta-ethnography aims to look at the relationships between concepts across studies to generate meaning beyond each original data set in the form of higher order themes (Campbell et al., 2011; Noblit & Hare, 1988; Thorne et al., 2004). Sattar et al. (2021) explain that a 'line of argument synthesis' is the following stage, where a new understanding is developed. This method appeared to fit with the current reviews' aims, however meta-ethnography requires rich, high quality primary qualitative data sets (Petticrew et al., 2013). As some of the studies identified for final inclusion were conceptually and contextually thinner, this method was not chosen. It was also taken into consideration that meta-ethnography is time intensive and requires a highly experienced team (Flemming et al, 2019), and as I was not experienced with QES methods this confirmed that meta-ethnography was not appropriate for the current review. The RETREAT guidance (Booth et al., 2018) supported this decision (please refer to Table 4).

Table 4

How RETREAT Guidance was Followed in Relation to the QES (Booth et al., 2018)

Domain	Definition
Review question	The review team considered this QES relatively fixed in what it wanted to explore when the review was first proposed, however as it developed the review questions became more 'emergent' as difficulties with defining 'non-response' arose (Eakin & Mykhalovskiy, 2003). The review aimed to understand the experience of psychotherapy non-response from the client and therapist perspective, through a systematic review of qualitative studies.
Epistemology	Critical realist epistemological stance. The supervisory team acknowledged that each included study has differing theoretical underpinnings and methodologies and I wanted to acknowledge any theoretical tensions that may exist between studies through transparent reporting and reflexivity. The review aimed to focus on the topic area rather than specific methodological approaches.
Time/timeframe	Due to this project being undertaken for a doctoral level qualification, I decided there was adequate time for the lead reviewer to aim to find as many studies as possible that met the eligibility criteria. Thematic synthesis was considered a good option to fit with the 'time' (intensity) and 'timeframe' (duration) for this review.
Resources	The QES is predominantly literature-based, however the supervisory team valued service-user involvement and so sought service-user feedback during the proposal stage and the final interpretation feedback. The use of EPPI Reviewer software was used to support the data analysis. These were factored into the research budget.
Expertise	The supervisory team had primary qualitative research experience, and one research supervisor had experience in a qualitative review. The primary reviewer was inexperienced in QES methods. The team accessed support from an information

	technology specialist for search strategy design and database searching. All researchers in the team had topic expertise to differing extents as two are qualified clinical psychologists and I am a psychologist in clinical training.
Audience and purpose	Primarily academic, specialist audience, with aims to publish and reach clinical practitioners. The review was not conducted in the context of an intervention review.
Type of data	Twenty-one studies were identified that used a sufficient qualitative method of data collection and analysis. There was a mix of rich data that had conceptual detail with studies which were conceptually and contextually thinner.
Choice of method	Thematic synthesis. This QES method was justified as this review sought to be flexible in providing descriptive and somewhat interpretative conceptual understanding of psychotherapy non-response. Due to the novice level of expertise in QES of myself and, the mixed type of data it was deemed inappropriate to conduct a more interpretative review such as meta-ethnography. Thematic synthesis was deemed the most appropriate choice of method.

Data Synthesis: Stages of Thematic Synthesis

The findings remain grounded in the original data, thus not losing the essence of the original participants' experiences. I primarily undertook the data analysis and continually discussed findings and interpretations in supervision meetings to confirm they were reflective of the original data set (Butler et al., 2016). Firstly, the included studies were read to support immersion with the data (Maher et al., 2018) and uploaded to the software EPPI-Reviewer which supports the analysis of data in systematic reviews (Thomas et al., 2010). The stages of thematic synthesis were then followed as recommended by Thomas and Harden (2008), this involved three key stages which were followed through an iterative process.

Stage one: Line-by-line coding
Stage two: Development of descriptive themes (remains grounded in the original data)
Stage three: Development of analytical themes (going beyond the data)

Line-by-line coding of the primary studies then took place in EPPI-Reviewer software, this process supported the identification of similarities and differences across studies (Lucas et al., 2007). Data from the findings/results section, and where applicable from the discussion sections of papers, were coded (see Appendix E for an example extract from the software). This was deemed applicable when there were new findings or interpretations introduced which were not covered in the results section as to avoid double coding without excluding all possible interpretation of the data by the primary authors. I kept a reflective diary throughout this process which helped me to keep grounded in the context of the original studies. Throughout this process, data was coded into pre-existing initial codes and new ones were developed when necessary, thus creating a bank of initial codes. This process was useful to stay close to the original data and

acknowledge my pre-existing assumptions and ideas as it was important to hold these in mind as to not favour ideas.

Each extract of data in the primary studies was given initial codes. It was common for extracts to have multiple codes assigned, for example "*we bottle it up for so long, and it gets to such a boiling point before we actually reach out for help*." was assigned to codes 'not the norm to show emotion/talk about issues' and 'bottle up emotions and problems.' In total there were 529 initial codes for the client perspective and 311 for the therapist perspective. The next step was to group similar initial codes. I did this by re-reading all the initial codes and assigned data and translated these across studies to see if similar codes/concepts could be grouped together. For example, codes 'hard to open-up in therapy for fear of being judged', and 'feeling judged stops client from asking for clarification' were included into a condensed code 'hard to open-up out of fear of being judged.' Coding was checked for consistency by my research supervisors, who agreed that it was clear how the initial descriptive themes were derived from the original data (see Appendix F for an example). The in-depth and immersive nature of this procedure allowed me to stay close to the original data.

The next stage was to further develop the codes by re-reading the data, grouping similar codes together in order to develop descriptive themes (Thomas & Harden, 2008). This process resulted in a total of 11 themes and 47 subthemes (client perspective) and 9 themes and 30 subthemes (therapist perspective). Alike Thomas and Harden (2008), up until this point in the synthesis I had stayed as close to the original findings of the included studies as possible by generating a set of themes and subthemes which described the experiences of psychotherapy from participants. However, the next stage aimed to go beyond the original data and generate analytic themes in order to produce a synthesised understanding of non-response.

I created a table on Microsoft Word with the initial codes, descriptive themes, subthemes, and raw data. This allowed me to observe the data at the descriptive level, and with support of supervisory discussion, to see if any overarching themes captured the understanding at a more interpretative level. Similar themes were grouped into an overarching understanding which appeared to capture the process of non-response at a third-order level (see Appendix G for an example of developing analytic themes). These discussions enabled me to develop additional understanding and concepts which related to the review questions and aims (Thomas & Harden, 2008; Britten et al., 2002). This process led to the generation of six analytical themes and 18 subthemes (client perspective) and four analytical themes and 10 subthemes (therapist perspective). See Appendix H and Appendix I showing the studies that contributed to each final theme. It is important to note that this process was not linear, reading the data throughout the

previous stages had an influence upon the analytical themes. A selection of client and therapist perspective analytical themes were also credibility checked through discussion with one of the independent reviewers to check that participant data fit with how the results have been represented. This discussion resulted in the further development of theme names which encapsulated experiences that I had not considered upon theme development. For example, a therapist subtheme previously named 'lack of understanding' was further developed to 'absence of a shared purpose' as this latter description was felt to encapsulate the lack of understanding and it captured the practical difficulties faced by therapists and clients in developing a shared understanding. Once the analytical themes had been developed I aimed to capture this into a process model which included the overlapping experiences of clients and therapists. This was developed after re-reading the results section with the aim to capture the experience of non-response as it may have occurred during the psychotherapy process. The model was discussed and modified with the support of supervisory discussion.

Confidence in the Findings

The GRADE CERQual (confidence in the evidence from reviews of qualitative research) approach was used to support the assessment of the confidence of the review findings (Lewin et al., 2018). The CERQual approach provides a helpful, transparent framework to assess confidence in the findings. Wainwright (2021) defined confidence as the extent that the findings are a reasonable representation of the phenomena, in this case the phenomenon of non-response. The GRADE CERQual Project Group reported that confidence is assessed by considering the: methodological limitations of primary studies; coherence (clarity and consistency between primary study and review finding); adequacy of data (richness and quantity of data from primary review supporting finding); and relevance regarding study context of the current review (Flemming & Noyes, 2021; Lewin et al., 2018). Lewin et al. proposed four confidence categories: high confidence (highly likely the finding is a reasonable representation of phenomenon); moderate confidence (likely that the finding is a reasonable representation); low confidence (it is possible that the finding is a reasonable representation); and very low confidence (unclear if the finding is a reasonable representation of the phenomenon of interest).

Self-Reflexivity

My experiences of providing therapy during the Clinical Psychology Doctorate and it not always going as successfully as planned, initially drew my interest to the area of psychotherapy non-response. Upon entering the research project, I held two key assumptions: clients may have been unmotivated to change, and a positive therapeutic relationship is a priority for successful therapy. Throughout my reading on the topic, what I understand as non-response has broadened considerably and I believe the phenomena to be much more complex than I realised. Upon starting

the project, I held an assumption that outcome categories may be fairly straightforward, akin to the outcome measures we use in clinical practice: successful outcome, non-response, deterioration, and in some cases harm. After reading the literature and reflecting on my own experiences I realise that this view was restricted and I am more open minded to what outcome may look like for clients (i.e., that there is a mix of success and lack of success across the outcome categories).

I find it interesting that although there is a sizeable proportion of therapy that results in non-response, this is not spoken about particularly openly within the profession. I wondered why that might be and relating to my own experiences as a Psychologist in Clinical Training, this subject is quite an emotive one, which may feel difficult to reflect on. I am drawn to psychodynamic schools of thinking, and from this perspective I held an assumption that therapists may be drawn into self-blame and feelings of inadequacy which may be too sensitive to open themselves up to exploring fully. I have certainly felt this way with my experiences with non-responding clients in clinical practice. I am also drawn to relational understandings of phenomena, such as attachment theory. These influences will also inevitably alter how I view and interpret the data, so I acknowledge that the resulting synthesis model is influenced by my understanding of what makes a secure therapeutic relationship. For example, conceptualising problems in the relationship as a lack of a secure base from which the client felt confident to explore (Ainsworth et al., 1978/2015).

These theoretical positions will have an impact upon how I read the original papers and the resulting synthesis model, as will my research position of critical realism. Due to this position, I will naturally look for underlying psychological and social processes that helps me to make sense of 'what is really going on' from the participant data (Willig, 2013). A key influence of the included papers appears to be phenomenology, this sits well with critical realism. Both are interpretative stances which hold commonalities in understanding the way in which knowledge is generated (Paterson, 2001; Willig, 2013). Possible tensions may arise between these perspectives and social constructivist stance, another key influence in the included studies. This is spoken about in more depth in the results section below. In summary, I acknowledge that my interpretation of the data is just one possible interpretation (Paterson, 2001).

CHAPTER THREE: RESULTS

Introduction to the Chapter

This chapter is separated into two parts. A summary of the search results is firstly presented, including study characteristics and quality assessment to support transparency of reporting. Part two narratively reports the synthesised understanding of psychotherapy non-response in the form of themes and sub-themes from the client and therapist perspectives. To support the proposed understanding of psychotherapy non-response, participant and author quotes from the original research papers are presented. Finally, I have constructed a visual diagram to support the understanding of the synthesis.

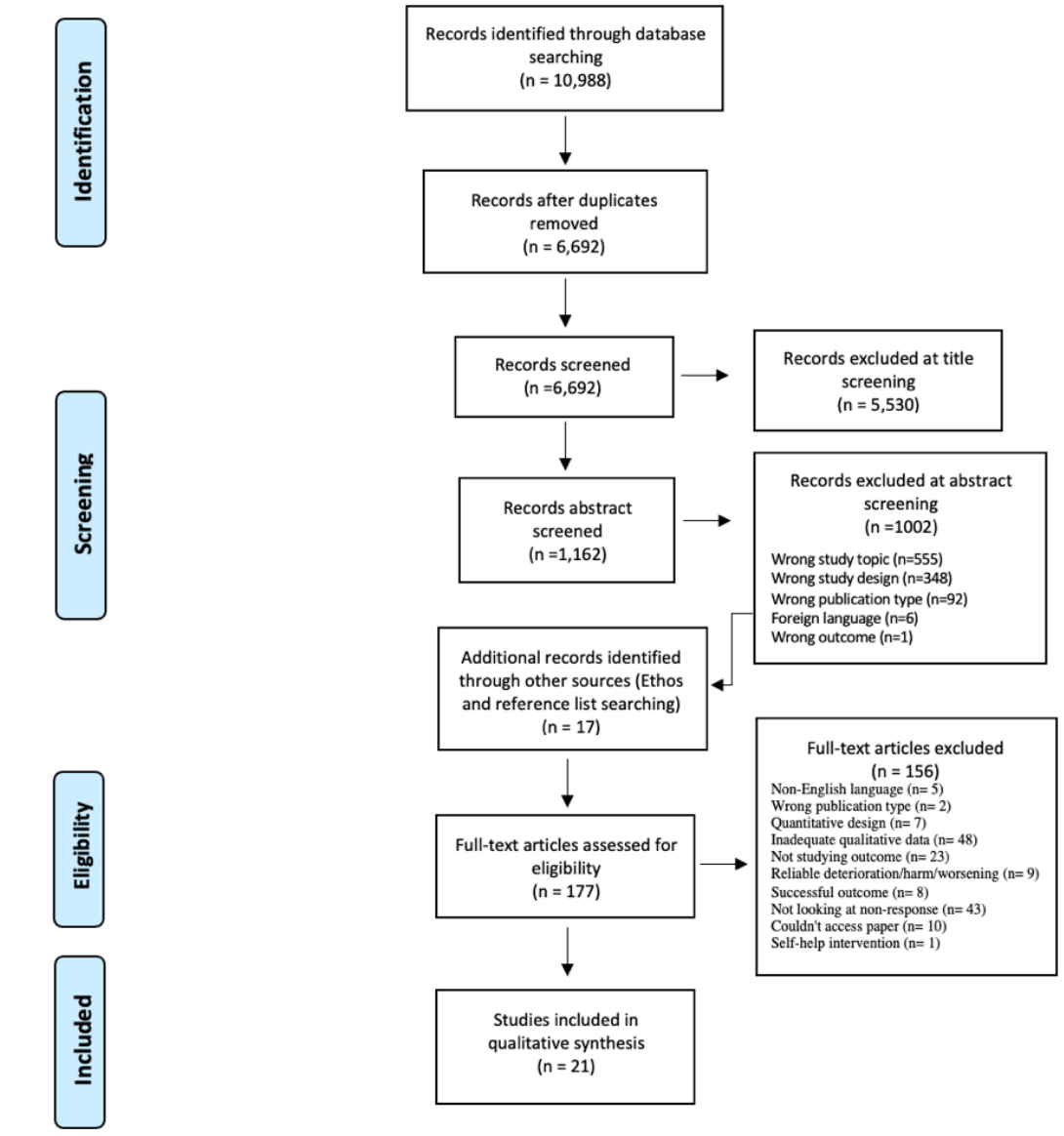
Part One: Literature Search Results

Included Study Contexts

In total, 21 qualitative studies were included in the QES. These included 155 client participants and 32 therapist participants who met the current definition of non-response (see Figure 1; Moher et al., 2009). There were *n*=16 studies in the context of individual therapy (Adler, 2013; Bellesi et al., 2020; Crowe et al., 2012; De Smet et al., 2019; Homan, 2019; Hopper, 2015; MacLeod, 2017; McGowan, 2000; Morton, 2019; Radcliffe et al., 2018; Stige et al., 2021; von Below & Werbart, 2012; Werbart et al., 2015; Werbart et al., 2019a; Werbart et al., 2019b; Westra et al., 2010), two in group therapy (Hjeltnes et al., 2018; Lundkvist-Houndoumadi & Thastum, 2017), and three with a mixture of group/family therapy and individual therapy (Archard, 2013; Laszloffy, 2000; Olofsson et al., 2020). The studies were conducted across seven countries: United Kingdom (*n*=9), Denmark (*n*=1), United States (*n*=2), Norway (*n*=3), Sweden (*n*=4), Belgium (*n*=1), and New Zealand (*n*=1). Some *(n*=9*)* of the included studies were conducted in the context of intervention trials, these are as follows: Lundkvist-Houndoumadi and Thastum (2017) was conducted in the context of a Randomised Controlled Trial (RCT) examining the effectiveness of the Cool Kids programme in Denmark; Hjeltnes et al.'s (2018) data were gathered from an open trial of Mindfulness Based Stress Reduction (MBSR) for young adults; four of the studies used data gathered from the longitudinal study the Young Adult Psychotherapy Project (YAPP) exploring psychoanalytic psychotherapy (Von Below & Werbart, 2012; Werbart et al., 2015; Werbart et al., 2019a; Werbart et al., 2019b); De Smet et al. (2019) gathered data in the context of the Ghent Psychotherapy Study (GPS), an RCT for depression; Crowe et al.'s (2012) data was from the RCT, the Christchurch Psychotherapy for Depression Study (CPDS); and the data used by Westra et al. (2010) were gathered in the context of an RCT comparing motivational interviewing prior to Cognitive Behaviour Therapy (CBT) or no prior treatment.

Figure 1

PRISMA Flow Diagram Showing the Study Selection Process (Adapted from Moher et al., 2009)



Included Study Characteristics

The included studies focused on a variety of outcomes: 10 studies set out to explore the experiences of psychotherapy non-response as a phenomenon (Bellesi et al., 2020; De Smet et al., 2019; Hopper, 2015; Lundkvist-Houndoumadi & Thastum, 2017; MacLeod 2017; Morton, 2019; Radcliffe et al., 2018; Werbart et al., 2015; Werbart et al., 2019a; Werbart et al., 2019b); four aimed to explore psychotherapy clients who had a dissatisfying psychotherapy experience (Adler, 2013; Archard, 2013; Laszloffy, 2000; Von Below & Werbart, 2012); five compared the differences between 'good' and 'poor' outcome groups in various settings (Crowe et al., 2012; Hjeltnes et al., 2018; McGowen, 2000; Olofsson et al., 2020; Westra et al., 2010); one study aimed

to develop an understanding of attrition (Homan, 2019); and one study explored the helpful and unhelpful therapy experiences of adolescents who came to therapy at the suggestion of other people (Stige et al., 2021).

The majority of studies (*n*=18) looked at the experience of adults with a range of ages from 18-69 years old (unable to provide average age due to the different styles of reporting and no reported ages in two studies). Three studies explored the experience of children and adolescents (average age 16 years old). Non-responding participant's gender data was not separated from the larger sample (of those that also included responders) in five studies, not reported in one study, but of the reported non-responding gender data 76% were female. The ethnicity of non-responding participants was reported in nine studies with varying detail (as reported in primary studies: *n*=4 Black Caribbean, *n*=13 White British, *n*=6 White, *n*=15 Danish ethnicity, *n*=7 Norwegian origin, *n*=8 Swedish origin, *n*=7 European American, *n*=1 Japanese, *n*=1 Eastern Indian). Ethnicity data were not reported in nine studies and not separated into non-responders from a larger sample in three studies.

There were a range of presenting problems that participants had sought therapy for and varied psychological approaches to talking therapy (including, Dialectical Behaviour Therapy, Cognitive Behaviour Therapy approaches, third wave approaches such as Compassion Focused Therapy, Acceptance and Commitment Therapy, integrative approaches, Cognitive Analytic Therapy, Eye Movement Desensitization and Reprocessing, Family Therapy, Systemic Therapy, and Psychoanalytic Psychotherapy). The reported professions who provided therapy in the original studies included: Clinical Psychologists, Psychotherapists (psychoanalysis and psychodynamic psychotherapy), Psychiatrists, Clinical Nurse Specialists, Social Workers, Counsellors, Cognitive Behaviour Therapists, and Family Therapists. See Table 5 for further study characteristics.

Table 5

Study Characteristics of Included Studies

Reference	Perspective	Time in Therapy	Data Collection Method	Methodology	Non-Response Criterion
Adler (2013)**	Client	Range from 6 months-6 years	Semi-structured interview	IPA	Self-reported non-response
Archard (2013)**	Client	Not reported	Semi-structured interview	Thematic Analysis	Self-reported no change and dissatisfaction
Bellesi et al. (2020)	Client	Average of 8 sessions	Focus group	Inductive Thematic Analysis	*Based on pre and post outcome measure scores
Crowe et al. (2012)	Client	Range 8-19 weekly sessions (average 13 sessions)	Transcripts of therapy sessions analysed	Thematic analysis	Based on pre and post outcome measure scores*
De Smet et al. (2019)	Client	Range 16–20 weekly sessions	Semi-structured interviews	Evolved Grounded Theory***	Statistically defined non-response
Hjeltnes et al. (2018)	Client	8 weekly sessions	Semi-structured interview	Thematic analysis	Statistically defined non-response
Homan (2019)**	Client	Not reported	Semi-structured interview	Constructivist Grounded Theory	Self-reported non-response
Hopper (2015)**	Therapist	Not reported	Semi-structured interview	IPA	Therapist-reported non-response
Laszloffy (2000)	Therapist and Client	Length varied from 1 to 44 sessions	Semi-structured interview	Inductive Content Analysis	Self-reported non-response
Lundkvist-Houndoumadi & Thastum (2017)	Client	10 weekly 2-hour group sessions and a 1-hour booster session 3 months later	Semi-structured interview	IPA	Based on pre and post outcome measure scores
MacLeod (2017)	Client	Range 6-12 sessions (average not reported)	Semi-structured interview	IPA	Statistically defined non-response
McGowan (2000)**	Therapist	Range from 5 months-1.5 years	Semi-structured interview	Evolved Grounded Theory***	Therapist-reported non-response
Morton (2019)**	Client and Therapist	10-16 therapy sessions (average 13 sessions)	Semi-structured interview	IPA	Statistically defined non-response

Reference	Perspective	Time in Therapy	Data Collection Method	Methodology	Non-Response Criterion
Olofsson et al. (2020)	Client	3 individual and 6 group weekly sessions (length not reported)	Semi-structured interview	IPA and Evolved Grounded Theory***	Based on outcome measure and population norm data
Radcliffe et al. (2018)**	Client	Range of 20-26 sessions (average approximately 22 sessions)	Semi-structured interview	IPA	Self-reported non-response
Stige et al. (2021)	Client	'Most participants received treatment for more than a year'	Semi-structured interview	Reflexive Thematic Analysis	Self-reported non-response
von Below & Werbart (2012)	Client	Range from 2-48 months (average 16.9 months)	Semi-structured interview	Evolved Grounded Theory***	Author reported dissatisfaction and non-response from participant transcripts
Werbart et al. (2015)	Client	Range 2-48 months (average 21.3 months)	Semi-structured interview	Constructivist Grounded Theory***	Statistically defined non-response
Werbart et al. (2019a)	Therapist	Range 7-48 months (average 19 months)	Semi-structured interview	Constructivist Grounded Theory***	Statistically defined non-response
Werbart et al (2019b)	Client and therapist	Not specified (less than 2 years)	Transcripts of participant and therapist interviews analysed	Inductive Thematic Analysis and Case Series methodology	Statistically defined non-response
Westra et al. (2010)	Client	8 weekly sessions (total 14 hours)	Transcripts of participant interviews analysed	Classic Grounded Theory analysis*** and consensual qualitative research methods (to extract meaning units to identify which group adhered more to each theme)	Statistically defined non-response

Note. IPA refers to the methodology Interpretative Phenomenological Analysis. *Based on pre and post outcome measure scores differs from statistically defined as these do not rely on statistical significance to determine outcome, but rather certain scores on outcome measures.** indicates a thesis, the Radcliffe et al. (2018) paper is a published research paper, however quotes from the original thesis project were also used. ***Not explicitly stated in papers but authors have referenced: Corbin and Strauss (1990; 2015), Strauss and Corbin (1998), Charmaz (2014), and Glaser and Strauss (1967).

Quality Assessment of Included Studies

Table 6 shows the full methodological quality checks for included studies using the amended CASP criteria (Long et al., 2020). All studies satisfied the CASP criterion of having clear research aims and that a qualitative approach was justifiable. The majority of studies (*n*=12) reported ethical approval. There were seven studies who did not report ethical approval however this was in the context of secondary research, as the researchers were using pre-collected data from intervention trials (Crowe et al., 2012; De Smet et al., 2019; Laszloffy, 2000; Westra et al., 2010; Werbart et al., 2015; Werbart et al., 2019a; Werbart et al., 2019b). In one primary research study ethical considerations were unclear and ethical approval was not clearly reported (MacLeod, 2017). The use of secondary data was appropriate, however for these studies the use of a fixed interview template (e.g., The Client Change Interview; Elliott et al., 2001) impacted upon the depth of data gained from participants around their non-responding experience.

In total, eight of the included studies either did not report or reported limited information regarding the philosophical or epistemological perspectives underpinning the research. A total of 13 studies reported the underlying epistemological positioning of their chosen methodology (Archard, 2013; De Smet et al., 2019; Homan, 2019; Hopper, 2015; Lundkvist-Houndoumadi & Thastum, 2017; McGowan, 2000; Morton, 2019; Radcliffe et al., 2018; Stige et al., 2021; von Below & Werbart, 2012; Werbart et al, 2015; Werbart et al., 2019a; Werbart et al., 2019b). Only eight of these explicitly acknowledged their own personal epistemological and/or theoretical positioning that had an impact upon how they interpreted the data (Archard, 2013; De Smet et al., 2019; Homan, 2019; Morton, 2019; Radcliffe et al., 2018; Stige et al., 2021; von Below & Werbart, 2012; Werbart et al., 2019a). For example, Werbart and colleagues reported a group of their studies with psychodynamic theoretical underpinnings were interpreted through this lens, as the studies were part of a larger trial exploring the effectiveness of psychoanalytic psychotherapy. As this is a group of studies, this will likely impact the resulting synthesis in the current review. As not all epistemological underpinnings are clearly reported, there may be unknown influences on the interpretation of the data by the original authors that are not able to be taken into consideration.

All studies reported the methodology used, these ranged from more descriptive methods (inductive content analysis) to more interpretative methodologies (IPA). The focus of the included studies appeared congruent with theoretical underpinnings, for example the exploration of the lived experience of psychotherapy non-response fit with the reported phenomenological perspective taken by Hopper (2015). There was an apparent incongruence between methodology and underpinning epistemology in one study (Olofsson et al., 2020), as the researchers reported the use of aspects of IPA and Evolved Grounded Theory (GT), which originate from different

theoretical and philosophical origins. Olofsson et al. (2020) also stated that both methodologies involve symbolic interactionalism which is an important theoretical consideration in constructivist GT rather than IPA. Further, they stated the use of Evolved GT due to the reference of Corbin and Strauss (2015), not Constructivist GT. This provides an unclear stance on the perspective from which they interpreted the data.

There were tensions apparent between certain methodologies and data collection methods in three studies. The methodological inconsistencies for a group of studies (from one group of authors) using GT methodology were due to the use of secondary interview data which was collected as part of larger studies (Von Below & Werbart, 2012; Werbart et al., 2015; Werbart et al., 2019a). It may have been more methodologically consistent to explore participants' experience through in-depth interviews in which the interviewer could have built upon participant experiences and answers, consistent with this methodology (Rennie, 2006; Strauss & Corbin, 1998). Further, 11 (52%) of the studies were methodologically flawed due to a lack of consideration of researcher reflexivity (Adler, 2013; Bellesi et al., 2020; Crowe et al., 2012; Laszloffy, 2000; Lundkvist-Houndoumadi & Thastum, 2017; MacLeod, 2017; McGowan, 2000; Olofsson et al., 2020; von Below & Werbart, 2012; Werbart et al., 2019b; Westra et al., 2010). Therefore, in these studies the researchers' position in relation to the research design and the interpretation of results was unclear. This is an important consideration as biases and assumptions will inevitably influence the research we are involved in, and the conclusions made from such research.

Overall Quality

Overall, there are three papers which are of high concern (Crowe et al., 2012; Laszloffy, 2000; MacLeod, 2017), six papers of moderate concern (Adler, 2013; Bellesi et al., 2020; Lundkvist-Houndoumadi & Thastum, 2017; McGowan, 2000; Olofsson et al., 2020; Westra et al., 2010), and 12 papers of low overall concern (Archard, 2013; De Smet et al., 2019; Hjeltnes et al., 2018; Homan, 2019; Hopper, 2015; Morton, 2019; Radcliffe et al., 2018; Stige et al., 2021; von Below & Werbart, 2012; Werbart et al., 2015; Werbart et al., 2019a; Werbart et al., 2019b). One of the main issues with quality overall is limited researcher reflexivity, which may affect the current synthesis due to data potentially being impacted by researcher bias (Willig, 2013). The conclusions from the included studies appeared to be adequately based upon the data collected and chosen methodologies. Despite some tensions between theoretical perspectives within a QES it remains important to synthesise the available evidence to further the research in a developing area (Bearman & Dawson, 2013). Acknowledging this, and as this is an emerging area of research, each paper adds value to the evidence base and thus no papers were excluded.

Included Studies Theoretical Underpinnings

A challenge facing the synthesis of qualitative data in general is the difference in the epistemological underpinnings and methodologies of individual studies, as reported in Table 6. By considering the principles of meta-theory by Paterson et al. (2001), this helped to me to acknowledge what impact the theoretical stance may have had on the interpretations from the primary researchers in the included studies. Principles which I considered included, reading primary studies thoroughly and noting the underpinning theoretical influences to the chosen methodologies which may have had a significant influence on the research, as theoretical frameworks will inevitably shape the way the data are analysed and understood (Paterson et al., 2001). This helped me to consider the main influences upon the current synthesis.

The same data set can be approached and interpreted in multiple ways according to the position from which you approach the data and what questions you may have about it (Willig, 2013). Therefore, the theoretical underpinnings of included studies needed to be considered in order to understand how this may impact the final synthesised understanding of non-response. There are varied methodologies, as described, in the original studies. A prominent influence in the included studies appeared to be phenomenology, that is, research which aims to generate knowledge about subjective, lived experiences from research participants, using IPA (Willig, 2013). Willig continues that phenomenological researchers seek to understand 'what it is like' to experience the phenomena of interest, rather than from a critical realist stance (my positioning) which seeks to explore what may be underlying these descriptions of experience. The studies of this epistemological approach included in the current review (Adler, 2013; Hopper, 2015; Lundkvist-Houndoumadi & Thastum, 2017; MacLeod, 2017; Morton, 2019; Radcliffe et al., 2018) aimed to look at the world through their participants' eyes, without questioning the validity of the experience (Willig, 2013). This will influence the resulting synthesis by producing rich descriptive lived experiences from participants. However, as the intention of primary researchers was not to explore causal explanation of the experience, this may limit the ability to infer casual processes for the current synthesis.

Another influence from the included studies appears to be Grounded Theory (moderate constructivist stance). It was not explicitly stated by the researchers that this was the stance taken, however this was inferred through author references such as Charmaz (2014). This epistemological position considers multiple realities and acknowledges that there are many possible realities, the findings of which are not necessarily transferable to other contexts and individuals (Willig, 2013). This causes some tension in the current review as the aim of the review is to synthesise numerous original studies to generate a wider conceptual understanding of a phenomenon. There are also studies included in the current review underpinned by evolved

Grounded Theory, again not explicitly reported by original authors, thus inferred through author references such as Corbin and Strauss (1990/ 2015). Willig (2013) stated that socially constructed approaches focus less on the quality of the experience (as phenomenology focuses on) and focuses on the way in which participants speak about their experiences within the world (or social contexts). An aim in such approaches is to generate theory, thus developing meaning from the explanations of experience, which is in contrast to that of phenomenological researchers (Willig, 2013; Giacomini, 2010).

Despite the influences from social constructionism and phenomenology in the current review, both approaches are interpretative in nature and so there may not be problematic tensions in the data that would have a significant impact on the resulting synthesis, providing that these considerations are acknowledged during stages of data synthesis. Giacomini (2010) posited that both phenomenology and grounded theory methodologies focus on the interpretation of meaning, however it is what influences meaning making where they differ. Phenomenology has an individual focus, whereas grounded theory focuses on socially constructed meanings (Giacomini, 2010).

It should be noted that the group of studies using GT by Werbart and colleagues, appear to have prioritised the voice of the researcher and their interpretations in the primary studies, thus it is more removed from the data. This is compared to the studies using IPA which prioritised the voice of the participant with rich lived experiential quotes, over researcher interpretation. As there are four theses using IPA in the current review, it is acknowledged that there are more original quotes from these papers. These considerations were managed through reflective processes such as using a reflective diary, adhering to credibility checks with supervisors and independent reviewers, and having supervisory discussions.

Table 6

*Methodological Quality of Included Studies using the Adapted CASP Tool (*Long et al., 2020*)*

Reference	Research design appropriate to address aims?	Theoretically clear, consistent, conceptually coherent?	Was the role of the researcher/ reflexivity described?	Was the data analysis sufficiently rigorous?	Overall concern
Adler (2013)	Yes	Can't tell – limited information reported	No - not reported	Yes	Moderate
Archard (2013)	Yes	Yes (realist position)	Yes	Yes	Low
Bellesi et al. (2020)	Can't tell – limited justification	Can't tell – not reported	No – not reported	Can't tell – no description provided of data analysis stages	Moderate
Crowe et al. (2012)	Yes	Can't tell – not reported	No - not reported.	Can't tell – limited description of analysis process	High
De Smet et al. (2019)	Yes	Yes (acknowledged deviates away from underpinnings of GT* due to design)	Yes	Yes	Low
Hjeltnes et al. (2018)	Yes	Can't tell – not reported	Yes	Yes	Low
Homan (2019)	Yes	Yes (constructivist position)	Yes	Yes	Low
Hopper (2015)	Yes	Yes (explains their phenomenological position)	Yes	Yes	Low
Laszloffy (2000)	Can't tell – methodology used was not explained or justified	Can't tell – not reported	No – not reported.	Can't tell – limited detail reported	High
Lundkvist-Houndoumadi & Thastum (2017)	Yes	Yes (considers theoretical concepts phenomenology, hermeneutics, and idiography)	No – not reported	Can't tell	Moderate
MacLeod (2017)	Can't tell – limited justification	Can't tell – not reported	No - not reported	Can't tell – no description provided of data analysis stages	High
McGowan (2000)	Can't tell – unclear if clients would self-report poor outcome	Yes (explain their constructivism position)	Can't tell – limited information reported	Yes	Moderate
Morton (2019)	Yes	Yes (explains their interpretative position)	Yes	Yes	Low

Reference	Research design appropriate to address aims?	Theoretically clear, consistent, conceptually coherent?	Was the role of the researcher/ reflexivity described?	Was the data analysis sufficiently rigorous?	Overall concern
Olofsson et al. (2020)	Yes	Can't tell – IPA and GT appear incongruent	Can't tell –unclear what considerations were made	Yes	Moderate
Radcliffe et al. (2018)	Yes	Yes (explains their interpretative position)	Yes	Yes	Low
Stige et al. (2021)	Yes	Yes (phenomenological tradition)	Yes	Yes	Low
von Below & Werbart (2012)	Yes	Yes (acknowledged deviates away from underpinnings of GT* due to design)	No – not reported	Yes	Low
Werbart et al. (2015)	Yes	Yes (acknowledged deviates away from underpinnings of GT* due to design)	Yes	Yes	Low
Werbart et al. (2019a)	Yes	Yes – acknowledged theoretical underpinnings	Yes	Yes	Low
Werbart et al. (2019b)	Yes	Yes (congruent methodology)	Can't tell – limited acknowledgement of this	Yes	Low
Westra et al. (2010)	Yes	Can't tell – not reported	Can't tell – limited explanation of this	Yes	Moderate

Note. *Grounded theory (GT).

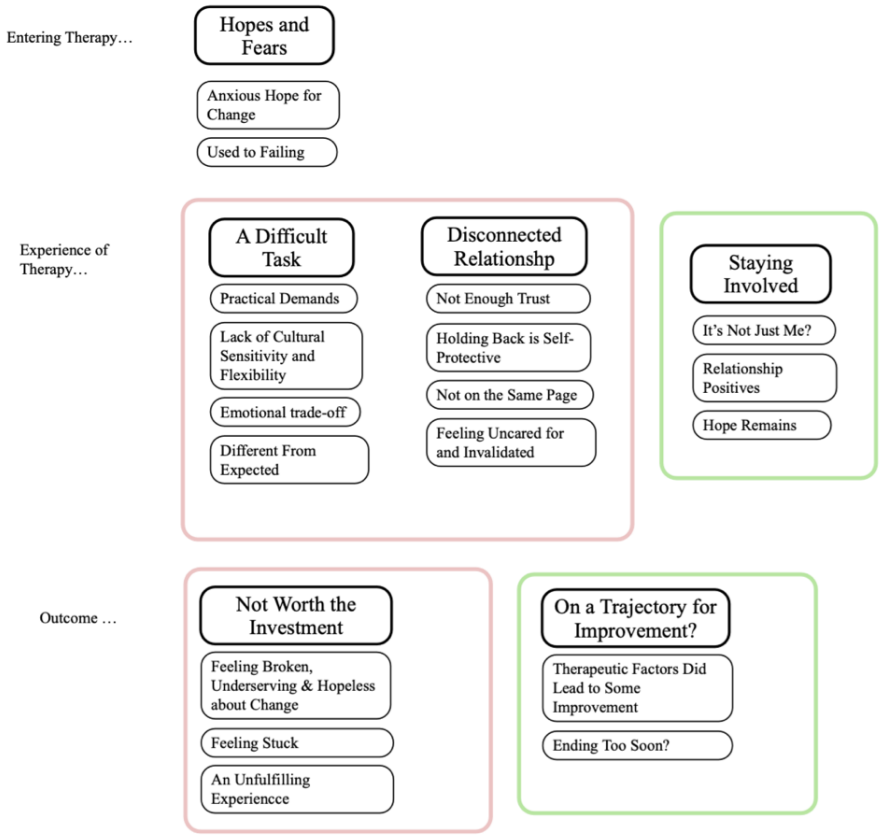
Part Two: Synthesis Results

Client Perspective

A total of six analytical themes and 18 subthemes were identified by generating an analytical understanding of the phenomena of psychotherapy non-response from the client perspective. Client perspective themes were derived from 18 papers focusing on the experience of clients and are broadly organised chronologically (starting therapy, during therapy, and outcome of therapy). The confidence ratings in the themes are presented alongside the analysis to allow the reader to consider the contribution of each theme to the resulting synthesis. Confidence ratings are based on the methodological quality, coherence, adequacy, and relevance of the contributing studies to the findings (see Appendix J for full description). Themes are presented with illustrative quotes from the original studies. See Figure 2 for a thematic map of client experiences of non-response.

Figure 2

Thematic Map Showing Client Perspective Themes and Subthemes



Note. Text within bold border are themes with subthemes presented beneath. The green outlined borders show positive elements, and red borders show negative experiences during and as a result of therapy.

Theme One: Hopes and Fears

There was a dichotomy of hope for therapy to bring about positive change and feelings of apprehension towards starting therapy. This apprehensiveness also encapsulated a want for the therapist to be able to provide certainty in the form of a 'cure' of participants' difficulties. Some clients held negative self-beliefs which may be understood as clients' feeling they may be setting themselves up for failure. This theme included two subthemes. Overall, there is moderate confidence in this theme.

Anxious Hope for Change

Some clients described dissatisfaction with their lives pre-therapy, with some referring to adverse experiences in their environment, and others describing difficult relationships which had contributed to their present difficulties that they were seeking support for. Clients often experienced a deterioration in their mental health and felt this was intolerable, thus sought support through therapy:

Client: "We bottle it up for so long, and it gets to such a boiling point before we actually reach out for help." (Bellesi et al., 2020)

Fifteen studies contributed to this finding, providing moderate confidence that clients held a hope for therapy to produce a positive change in their lives, this could arise from a place of desperation and as one client described this was their 'last chance':

Client: "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." (Morton, 2019)

A fewer number of clients held onto somewhat idealised expectations of therapy and expected therapy to be a 'cure', with their therapist seen as an expert who could 'fix' their difficulties, however these were described in rich depth from a phenomenological perspective:

Client: "I suppose it would be good if she could have waved a magic wand and that feeling had gone, you know?" (Morton, 2019)

Client: "I was very depressed when therapy started and probably also a bit negative, so already at the second session I got more sad, because I didn't feel it was helping…I don't know exactly

what I was expecting. I guess I expected a bit miraculously that the anxiety would disappear forever." (Lundkvist-Houndoumadi & Thastum, 2017)

Author and Client: "One participant also spoke about viewing the therapist as an expert, having the answers and being able to sort things out. [client name] describes her perception of the therapist as "this big, old wise owl" and goes on to say; "Surely if you are a psychologist/psychiatrist, whatever, you should be in that position. You've studied this thing. You've seen these scenarios, you know statistically in thousands of people, surely that you should be able to say. 'Oh, yes, you fall into this category and this is what we need to do for ya." (Radcliffe et al., 2018)

Used to Failing

Clients across 12 primary studies expressed doubt and apprehension towards therapy and towards their self-abilities, which ultimately impacted engagement. Starting therapy with negative pre-conceptions and insecurity seemed to be associated with a fear of failure. This was consistently described across and within studies, therefore therapy felt like a risk, and some may have expected therapy to fail:

Author: "The participants who reported little or no improvement in their symptoms after treatment, however, had much stronger doubts, describing fears of failure and disappointment at the start of the course." (Hjeltnes et al., 2018)

Client: "I was afraid to fail in therapy… I typically start things but can't manage to continue them. Maybe because… when it hasn't gone well one day, I can't let that go. It is all or nothing often, so I was afraid I would not do very well [in therapy]." (De Smet & Werbart, 2019)

There was a typical experience described of scepticism towards therapy and their therapist which could result in a resistance to fully engage in the process or to 'jump in with both feet'. This was understood as potentially self-protective for clients because if they were to attend but not fully commit they are protecting themselves from the failure, judgement, and shame of which they feared. The opportunity of closeness posed a threat for clients and so a distance remained:

Author: "Resistance or ambivalence in therapy may therefore be regarded as self-protective and anxiety-reducing." (Crowe et al., 2012)

Author: "Most patients described feeling a certain resistance toward therapy (n = 16). For instance, they did not take therapy very seriously, had difficulties with opening up or were reluctant to do certain exercises." (De Smet et al., 2019)

Theme Two: A Difficult Task

This theme has four subthemes and describes a feeling that therapy was overall, a difficult task. One way in which therapy was difficult, as described by a relatively small sample of participants, was in terms of the practical demands such as learning techniques. The second aspect that participants described was regarding therapy being emotionally demanding. Overall, there is low to moderate confidence in this theme.

Practical Demands

A minority of clients from six contributing studies described some practical aspects of therapy as difficult, such as learning and maintaining skills. Despite limited contributing data, it seems important that these clients described finding it challenging at times to link therapy skills to everyday life and not all techniques were found to be useful. This was possibly related to therapy not being appropriately scaffolded, mis-paced, or a misunderstanding of rationale may not have provided clients with the trust they needed to commit to therapeutic tasks:

Author: "[Client] 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" (Morton, 2019)

Client: "DBT for me the good bit I got out of it was making friends.. yeah, rather than the skills because I think it was very complicated some of the stuff." (Archard, 2013)

Author: "The less-improved participants struggled to understand the rationale for the MSBR program, which made it difficult for them to see how what they learned during the course could be used in the difficult situations of their everyday life." (Hjeltnes et al., 2018)

Author: "Patients stated that they were unable to use the techniques when feeling really bad, or they did not find the time to do so." (De Smet et al., 2019)

Lack of Cultural Sensitivity and Flexibility

This subtheme explores an experience described by a minority of clients, likely due to the limited number of clients from an ethnic minority background in this QES. This subtheme

predominately arose from the analysis of an included study looking at the experiences of Black Caribbean women who were therapy non-responders (Bellesi et al., 2020). Another study which included a client who experienced a language barrier during their therapy experience also participated to this subtheme (Laszloffy, 2000). Past experiences of racism and discrimination led clients to carry a fear of being treated unfairly in services. Clients emphasised the importance cultural sensitivity training for professionals, and a well-paced therapeutic relationship to support with gaining trust:

Author and client: "Participants recommended that BME service users were given the opportunity to spend more time in the initial sessions familiarising with their therapists. They suggested that therapists may find it useful at the beginning of treatment to be more curious and enquire clients more extensively about their cultural background, concerns and beliefs about mental health, and family attitudes towards discussing emotional issues. This may increase shared understanding between clients and their therapists, and promote collaboration and alliance." (Bellesi et al., 2020)

Emotional Trade-Off

With moderate confidence, it was found that clients from fourteen studies described therapy as emotionally demanding and there was a sense that they felt unprepared for this aspect of the process. Although there was consistency regarding coherence of this finding across the included studies, the majority of the data originated from phenomenological theses. Through these reports, clients appeared to learn through the process that it takes a lot of emotional energy to commit to therapy and some questioned whether what they had gained was worth it:

Client: "It does make you look at it a bit more depth maybe than you're prepared to, you know you sort of think 'that's a sore point...and do I really want to open that can of worms?' Because we don't have enough sessions to get through it, so trying to talk to someone about what's bothering you and to get to the bottom of that without getting those feelings too far in front, because when you come to the end of the session, you've got to bottle it all back up, take it back with you on the bus or in the car. It's like unfinished business." (Radcliffe et al., 2018)

Clients described therapy as taking a lot of energy to try something new and learn to respond differently. In addition to this, some clients noted that if they were struggling with depression, it could make it even more effortful for them to engage with the emotional demands of therapy:

Client: "At the time I was so depressed that it was as if I was closed up inside a bubble of total negativity. I wanted to, but I couldn't do anything and I was very frustrated." (Lundkvist-Houndoumadi & Thastum, 2017)

Client: "But not everything is you know, like I say, it just em… it's like airing your dirty washing and you can just do without looking at it, and I just sometimes think it's so … It's just so tiring thinking of all that and dealing with all that – but I was dealing with it anyway, it's just that I could [pause] I could just shut off a bit more, which sounds ridiculous." (MacLeod, 2017)

Some clients described that gaining insight into their difficulties was not always experienced as helpful, in fact this could be challenging. There was a sense of uncomfortableness with becoming self-focussed, which related to a new self-awareness resulting from the therapy:

Client: "So I've got to go away on my own and sort out the problems that I've been trying to…deal with for my whole life and in the last four years have been brought to a position of…complete…separation of all the different problems and my ways of coping with them and being told categorically that I am wrong about those things and that my ways of dealing with it are…damaging to me and non-beneficial to anyone around me." (Radcliffe et al., 2018)

Author: "Insight into the patient's problems or feelings could lead to sadness, loss of hope, or difficulties in sharing feelings and thoughts with others." (Von Below & Werbart, 2012)

Different From Expected

Clients across fourteen studies described a desire for a different therapy modality or approach from their therapist. Some clients wanted a less directive therapy, whereas a theme across a greater number of participants was seeking more activity from their therapists such as guidance, advice, and challenge:

Client: "I don't know whether sitting down and talking about having so many problems helps me much. I don't know. Maybe I should have had group therapy with similar people, or art therapy, since I like to paint." (Von Below & Werbart, 2012)

Author: "The experiential and discovery-oriented format of the course became frustrating for some of the less-improved participants, who wanted more explicit guidance and practical advice on how they could solve their problems." (Hjeltnes et al., 2018)

Despite the individual differences in preference, for a considerable proportion of client participants therapy did not seem to match what they expected, thus providing moderate confidence that this is an important aspect of non-response:

Client: I expected her [the therapist] to give me good advice on how to deal with my problems. How I can worry less, how I can improve my breathing, just some tips. I must have imagined therapy the wrong way, she did not give me any tips. I'm kind of disappointed... I still don't understand the purpose of talking about all these things, I often felt worse after the session. (De Smet et al., 2019)

Clients could blame their therapists for the lack of overall meaningful improvement thus far. Some clients expressed that if the structure of therapy was different (which they perceived as in control of their therapist) then their experiences may have been different. Clients spoke of desires for their therapist to be more active in the process and provide more guidance for them:

Client: "If we discussed the subject that happened in my past in the beginning rather than waiting until week seven, the effect would have been more." (Westra et al., 2010)

Client: "Like I've said about structure, like I said about checking in for reviews…it's something that would have been useful every session." (Radcliffe et al., 2018)

Author: "A typical aspect of dissatisfaction was the patient wanting the therapist to actively structure the sessions, lead the dialogue, ask challenging questions, and urge her forward. When the patient talked about mundane matters, she actually wanted the therapist to stop her and lead the conversation into important matters. Had the therapist only done that, it would have been easier to trust her and express difficult feelings openly, thereby benefiting more from therapy." (Von Below & Werbart, 2012)

Theme Three: Disconnected Relationship

This theme consists of four subthemes and describes a disconnection in the therapeutic relationship. Clients described a lack of trust in the relationship which could make it harder to be open, there was also a fear of opening-up being overwhelming; perhaps therapy did not feel safe enough for this. The therapeutic relationship appeared to be missing a sense of mutual collaboration. This occurred even when clients had described a relatively positive bond with their therapist, therefore they could experience the therapist as kind but there was a misalignment of goals and direction. Some clients described a sense of feeling uncared for, with some reiterating the fact that this is "just a job" for therapists, reflecting that an empathetic connection may have

been lacking. Clients also alluded to their dissatisfaction with therapy being unacknowledged and there was potentially not enough space provided for rupture and repair. Overall, there is low to high confidence in this theme.

Not Enough Trust

There appeared to be a lack of trust towards the process of therapy and towards therapists as reported by participants in 14 studies, this indicated moderate confidence in the following subtheme. This was understood as a disconnect in the therapeutic relationship and added to participants 'holding back'. Clients described there being a poor match with the therapist which may have been indicative of a lack of unconditional positive regard within the relationship:

Client: "There was, like, no closeness... I have no idea what she thought about me and what she, she actually thought. She said, of course, that she liked me and all, but maybe she just said that because she thought I wanted to hear it." (Von Below & Werbart, 2012)

Author: "Three informants who failed to maintain their changes depicted their relationship with their therapist as either very distanced, or characterized by mistrust and insecurity, or both." (Olofsson et al., 2020)

Clients described a fear that being open and honest with their therapist about their difficulties would be overwhelming for them and that doing this could make their problems worse or become overwhelming for them to manage. There was a fear of losing control:

Author: "Although on the one hand, [client] 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." (Morton, 2019)

Client: "I've thought about this afterwards …I didn't completely open up, nor allow him in completely; I was probably afraid; that is, I think the fear took over, fear of losing control. Maybe it was linked to trust somehow, you do not have one hundred percent confidence, either in yourself or him." (Werbart et al., 2015)

Some clients described a fear of being judged by their therapist, which prevented them truthfully opening-up. This fear of judgement was understood as an intolerance of feelings of shame and feeling exposed and vulnerable. This was also reflected in the studies of group therapy, with the task of speaking openly in a group so daunting that clients did not want to engage:

Author: "[Client] felt that an aspect of her analyst's authoritative stance included being judgmental. Her sense of being judged led to feeling "more inhibited" as her treatment continued. It became more difficult for [client] to talk to her analyst." (Adler, 2013)

Holding Back is Self-Protective

Closely related to the subtheme above, clients across 14 studies described in detail an experience of holding themselves back from therapy, thus there is relatively high confidence in this aspect of non-response. There was a sense that holding themselves back (not necessarily consciously) from connecting to the therapeutic relationship, and thus engaging with the process of therapy, was self-protective. Avoidance through emotional distance/disconnect kept clients safe. It felt difficult for some clients to 'let another person in' and this contributed to the limited effectiveness of therapy for some:

Client: "There are nuances in me that I find hard to express because they feel ridiculous and I am very uncomfortable with them, and I did not succeed, could not even manage to talk about them in therapy. Sometimes I think I did not reach out because I did not convey the whole feeling." (Werbart et al., 2019b)

Client: "I can only imagine how hard it was for anyone that came into contact with me and felt like they weren't getting anywhere. But that's because I was not willing or capable to be honest, um, and I think for me it's like a weird, it's like some super cheesy, it's not you, it's me, type of thing. I don't think that think there is anything they could have done until I was prepared to be honest with my drinking. And I don't think that there is any therapist in the world that I would have been willing to be honest with my drinking." (Homan, 2019)

Client: "Masking myself over the real issues and just talking about stuff that I wasn't passionate about, I'd only ever skirt what I wanted to talk about but then go into more safe stuff." (Radcliffe et al., 2018)

Some clients had difficulties being honest with their therapists about the issues they were experiencing with the therapy itself:

Client: "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." (Morton, 2019)

Author: "A patient's criticism, frankly expressed in the interviews, was never brought up directly in psychotherapy." (Werbart et al., 2015)

Not on the Same Page

It was found with moderate confidence that clients and therapists did not appear to 'be on the same page' during therapy. This was described across 16 of the primary studies and was characterised by a lack of agreement on therapy direction. Clients described therapists not letting them talk about what they wanted to bring, therefore there was a lack of agreement on the focus of therapy, therapy goals, and ultimately a lack of collaboration:

Client: "I thought we had really hit it off. She was warm and I thought she really understood why I came to therapy. I was feeling very hopeful, but as time went on I realized she was never letting me talk about what I wanted to. She didn't want to focus on what I wanted to." (Laszloffy, 2000)

Author: "Several of the participants experienced that their therapists had their own agenda and seemed afraid to explore or misunderstood what was important treatment foci for the adolescents, thus increasing the feeling of not being seen." (Stige et al., 2021)

The failure of therapists to understand clients' problems left clients feeling misunderstood, unheard, and ultimately as an unequal partner in the therapeutic collaboration. When therapists did not do what clients had expected them to do, this could leave clients feeling increasingly reluctant to engage with the process:

Client: "She [the therapist] could get stuck, I mean really locked into trivial points that I knew meant absolutely nothing, and despite that kept looking for some sort of thesis that I knew was untrue, and I could not get her to realize it was wrong. She was pretty bad about listening at times." (Von Below & Werbart, 2012)

Client: "I expected her [the therapist] to give me good advice on how to deal with my problems. How I can worry less, how I can improve my breathing, just some tips. I must have imagined therapy the wrong way, she did not give me any tips. I'm kind of disappointed… I still don't understand the purpose of talking about all these things, I often felt worse after the session." (De Smet et al., 2019)

Some clients spoke of a lack of discussion about why therapy felt inadequate, perhaps indicating a lack of transparency or discussion about the therapeutic process:

Author: "Participants also wanted to hear from their therapists that they acknowledged there were problems occurring in therapy, or problems with the relationship. The participants did not expect perfection from their therapists. Having the problems with treatment or the relationship addressed would have been preferable to the therapist trying to tough it out and ignore the issues." (Homan, 2019)

Author: "A number of ruptures in the therapeutic alliance went unresolved" (Morton, 2019)

Client: "The job of an analyst is to bear that your feelings get hurt, and also try to pay attention to what's being enacted, what's going on for the patient. But instead, it felt like he took it as a slight, if I complained or attacked, and was not able to remain in the analytic mode of also paying attention to, okay, what's happening here, and what are you feeling, what's going on inside of you. It just felt like that stopped." (Adler, 2013)

Feeling Uncared for and Invalidated

A limited number of clients described therapists as seemingly disinterested in understanding their presenting problems, thus a sense of feeling uncared for and unseen emerged. Due to this finding lacking adequacy of data, there is low confidence in this experience. Nevertheless, those that described this feeling reported that it made it difficult for clients to share difficult experiences with their therapist:

Client: "You have that thing that when you sit there talking to a psychologist, many of them tend to just sit there and write. And like, and then, it is better that they kind of pay attention to those who sit there and talk and show that actually you care what that person has to say." (Stige et al., 2021)

Client: "I wish, that those clinicians had been able to say what was going on so I didn't have to guess. I might have still left, but at least I would have been like, at least this person really has my best interest, or this person really wants me to get the support I need…" (Homan, 2019)

On the more harmful end of this experience were feelings of invalidation and anger. Understandably, this caused ruptures in the relationship:

Client: "I hated it. I didn't like [DBT therapist]. Just I don't know, I got a funny vibe off her and she called me a 'drama queen' a lot and the actual word she used was 'drama queen' and that upset me." (Archard, 2013)

Client: "They should at least respect the fact that you're a person, individual and different enough from their scripted model of the person…their non-existent average patient." (Radcliffe, 2018)

The anger felt towards the therapist could be caused by incorrect interpretations. It was felt that when anger arose in the relationship this was not adequately explored by their therapists which left the feelings unresolved and in one example a client blamed themselves:

Author and client: "[Client] acknowledged that her anger had been difficult for her analyst to tolerate, and that maybe it had been too much or she had gone overboard. [Client] described her anger in the following way: It wasn't like a direct or mature anger – it was like immature biting nastiness, you know? It was a very primitive part of me that I'm sure was unpleasant and didn't… it wasn't like I was an adult treating him like an adult. I'm sure it was pretty awful – I can be awful sometimes." (Adler, 2013)

Theme Four: Staying Involved

This theme consists of three subthemes which present an understanding of why clients may have remained in therapy despite limited therapeutic gains. Overall, there is low to moderate confidence for this theme and 15 included studies contributed positive engaging aspects of their therapy experience despite the resulting non-response outcome.

It's Not Just Me?

Although this subtheme was found to have low confidence, this subtheme encapsulates the positive feeling of validating and normalising mental health difficulties which may have kept clients engaged in therapy. This was seen across individual and group therapies, however, was more prevalent in the research from group therapy settings:

Authors: "Positive aspects were highlighted, since for some youths, it had been a good opportunity to socialize and find out there were others with similar difficulties." (Lundkvist-Houndoumadi & Thastum, 2017)

Client: "It was nice to see that there are others. Who maybe struggle with … [and] have some of the same feelings. But you do not have much contact with them … [They] live separate lives, so it does not have that much impact, really. It is good to see that there are others, but … you are still alone." (Hjeltnes et al., 2018)

Client: "I realised that mental health can be good at one stage, and then at another stage, it can be where you are unwell… And we all go through that spectrum, it's the same with your physical body." (Bellesi et al. 2020)

Relationship Positives

With moderate confidence, this subtheme shows that some clients experienced positive therapeutic relationships or positive *elements* of the relationship. This reflects that a supportive relational experience may not be enough to produce meaningful change, but it was an engagement factor. Having a therapeutic relationship that was experienced as safe felt validating for clients:

Author: "Even a patient with negative experiences described the therapist mostly in positive terms, and the positive relationship made the patient stay in therapy." (Werbart et al., 2015)

Client: "My therapist pushed a few buttons and saw me and heard me for the first time in my life… She had a way of being as a person that made me feel safe." (Olofsson et al., 2020)

Hope Remains

For some clients, therapy helped to adjust their initial expectations of there being a 'quick fix'. This finding has low confidence due to a minimal amount of contributing data, however where this was reported by clients, hope appeared to provide motivation to continue with therapy:

Client: "I think there's no such thing as an ideal world. And I've got to the now, the fact that yes I have talked about it but there's no quick fix, and there's, the benefits must be just being able to talk." (Radcliffe et al.. 2018)

Client: "I might have expected therapy to be a bit more practical, but I noticed quite fast that this wasn't the goal of the sessions and I accepted that, I didn't see the talking as a waste of time." (De Smet et al., 2019)

Despite dissatisfying therapeutic experiences, clients held onto hope that change would occur by remaining involved in the therapeutic process:

Client: ""… I guess kept going and hoping that something would change. But I just didn't feel like anything was changing… I would walk out of the sessions, a lot of the sessions, towards the end like what just happened, or why am I doing this? But I guess I just kept going back 'cause I

thought something's going to happen, something's going to click, but nothing ever did." (Homan, 2019)

Theme Five: Therapy Was Not Worth the Investment

This theme describes clients' feelings that their experience of non-response was ultimately not worth the investment they had put in. As well as the emotional and time investment, for some clients this also meant monetary investment. This theme consists of three subthemes. Overall, there is moderate confidence in this theme.

An Unfulfilling Experience

There was a sense that therapy was helpful up until a point, but disappointingly not enough to produce meaningful change for clients across 12 included studies. There were clear descriptions of clients finding some benefit but therapy not quite 'hitting the mark' with what they wanted change with. This emphasises the complexity of non-response as there was some gain, but not enough, this was found to have moderate confidence:

Client: "And it [sigh] it sort of helped to go and talk, I suppose, but it didn't help me problem…you know it were like a sounding board and I could get things off me chest but it didn't solve anything." (Radcliffe et al., 2018)

Author: "Typically, the patient expected more from therapy, but was disappointed when expectations were not met. There was some progress, but not all the way, possibly due to lack of time or because therapy in itself was not enough." (Werbart et al., 2015)

For a minority of clients, they struggled to see the point of therapy and they felt it was a waste of their efforts:

Client: "So, I think 'okay, therapy has ended now and once again I'm nowhere, it did not help, and it only cost me money, a lot of time and energy, and why? For nothing." (De Smet et al., 2019)

Client: "I didn't think it was actually doing anything…because I didn't really see the point in just how does just talking about stuff was gonna…change anything." (Radcliffe et al., 2018)

Feeling Stuck

This subtheme captures, with moderate confidence, the experience of clients wanting to move forward however something was holding them back from making changes. Nine studies

contributed rich detail to this theme. Fear and an unreadiness for change may help to explain this feeling. When looking back on their therapy, clients explained their non-response as a sense of being stuck and unable to move forwards:

Author and client: "In general, patients wanted to move forward but felt unable to: [Client] Rationally I know what my problems are or what I should do, but there is just nothing changing." (De Smet et al., 2019)

Client: "If I could have challenged myself more to speak in front of the others, it probably might have been helpful, but I was not ready for that. I do not think it would have helped [if the teachers had encouraged him to enter social situations]. I have to do it completely at my own pace when I am ready. And I do not think that I am ready." (Hjeltnes et al., 2018)

Feeling Broken, Undeserving, and Hopeless About Change

Clients across 13 primary studies described negative self-conscious emotions when reflecting upon the outcome. They could look inward when trying to understand why change had not occurred in the way they had wanted it to; this finding was found to have moderate confidence. Such attributions could perpetuate negative self-beliefs that some clients described entering therapy with. Fewer clients questioned if they even deserved therapy, thus minimising their needs, and indicating a belief that others were more important than they were:

Client: "…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?" (Morton, 2019)

Some clients were self-critical and turned the blame towards themselves for therapy failing. They could feel that there must have been a 'right way' and they were responsible for therapy not going as planned. There was a sense of hopelessness regarding some clients' perceived ability to change:

Client: "And it [not making progress in therapy, and the therapist's reactions] made me feel kind of stupid too. Like am I making too big of a deal of this? Or am I imagining all of this? I just started to feel a little crazy." (Homan, 2019)

Client: "…And maybe, they can't do anything, does that mean I'm beyond help? It's just the fact that, I've taken this risky set of steps in trying to fix something, and I really feel, I've only been convinced that it's very definitely broken." (Radcliffe et al., 2018)

Some clients described feeling worse at times throughout and after therapy. This may indicate that non-response sits in the centre of a continuum that ranges from improvement to worsening, which may reflect that therapy can evoke difficult emotions and experiences which holds the potential for clients to feel worse after therapy:

Client: "Through no fault, it's made it worse, because like I said it's kind of buried it more. So it's a lot harder to access, so then when it does happen, it happens with a vengeance, it's awful. And it's almost relearning how to cope again." (Radcliffe et al., 2018)

Client: "Now I feel all shut up inside myself… It feels much worse, not at all... I now feel less motivated than I was last time... despite – if not feeling actually worse – feeling about the same." (Von Below & Werbart, 2012)

Theme Six: On a Trajectory for Improvement?

This final theme consists of two subthemes and describes that although clients were non-responders, benefits and positive therapeutic experiences were still gained by some. There was a sense that therapy could be seen by some clients as the starting point for change, and that perhaps therapy prevented worsening. As clients were still able to get something positive from therapy, a thread of hope remained for change to occur after their non-response experience. Overall, there was moderate to high confidence in this theme.

Therapeutic Factors Did Lead to Some Improvement

As described, clients across 13 studies reported positive experiences and some therapeutic gain from therapy. Despite being classified as non-responders, some clients were still able to hold onto hope for change to occur in the future which may reflect a continued motivation for change. There was large variation within this theme regarding the emphasis on the positive experiences, as some described this as their majority experience whilst others focused on reporting positive elements from a largely negative experience, thus there was moderate confidence in this finding:

Client: "Improved? Yeah. I think I can express myself much better, and I noticed it during the course of therapy. She understood me more and more than in the beginning, when I was

incredibly muddled. I couldn't fit the pieces together, and now I can; most likely the therapy helped with that." (Werbart et al., 2015)

Client: "So, so life's definitely getting better as I say, my mood's still low but I feel as long as I'm hoping then…that's an improvement. Because if you'd seen me [laughs] what I was like two and a half years ago, you know." (MacLeod, 2017)

Having a space to express themselves and for therapists to offer new understandings was felt to be normalising and cathartic for some clients. This may be interpreted as clients valuing the experience of being alongside someone who could share in their feelings and experiences:

Client: "In general, I feel much stronger, mentally. I have gained many insights in therapy… It gave me peace of mind and recognition that okay, my thoughts, experience and things I long for are not that strange." (De Smet et al., 2019)

Author: "Weekly therapy sessions were considered important for being able to talk, express feelings and thoughts." (De Smet et al., 2019)

Ending Too Soon?

Clients across 10 studies gave rich descriptions of therapy as ending too soon or indicated that the pace of therapy offered may not have been quite right for them. A minority of these clients described that they anticipated that change may come but were aware of wider systemic issues in healthcare such as time limited interventions which impacted upon their experience of non-response. This was particularly in relation to more flexibility with the number and pace of sessions, some clients felt as though they were on their way to recovery, but were unable to reach this destination due to lack of time:

Author: "Families thought that a long process is required for change to occur, and therapy was not long enough for this." (Lundkvist-Houndoumadi & Thastum, 2017)

Therapist: "I don't remember the techniques the therapist gave me well enough to implement them but it's a lot to cover in a short time." (Westra et al., 2010)

Client: "I think what hurts worse is the fact that, just the little bit of light in the dark is, is enough to give you hope and then, when time runs out, and you're crashing and burning." (Radcliffe et al., 2018)

Therapist Perspective

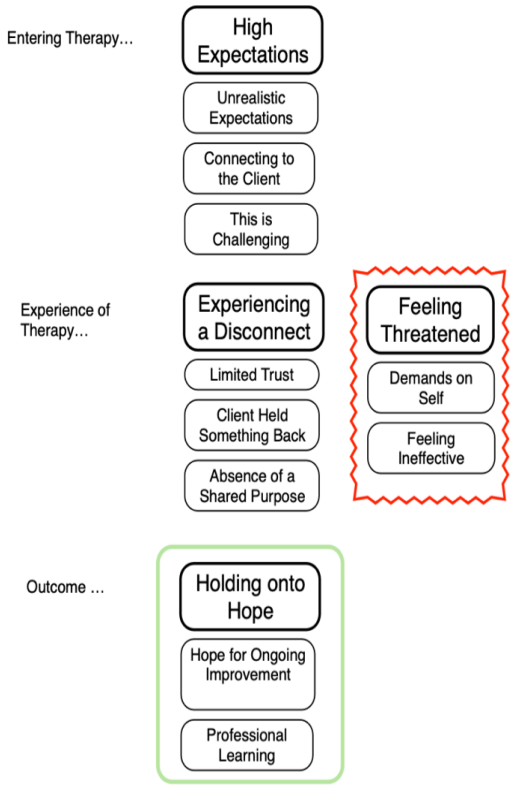
A total of four themes and 10 subthemes were identified by generating an analytical understanding of the phenomena of psychotherapy non-response from the therapist perspective. The themes were derived from six papers focusing on the experience of therapists. Like the client perspective, the confidence ratings in the themes are presented alongside the analysis to allow the reader to consider the contribution of each theme to the resulting synthesis (see Appendix J for description of the rating process). See Figure 3 for a thematic map depicting the themes and subthemes. I will now outline the themes with illustrative quotes from the original studies.

Theme One: High Expectations

This theme consists of three subthemes and describes the therapists' expectation of therapy and what they perceived their clients' expectations of change to be. Therapists could be hopeful upon entering the therapeutic endeavour and some expressed a self-belief that they could help to bring about positive change for clients. Therapists from one study (Hopper, 2015) described external pressures to achieve successful outcomes, which may be perpetuated by

Figure 3

Thematic Map Showing Therapist Perspective Themes and Subthemes



Note. Text within bold borders are themes with subthemes presented beneath. The green outlined border shows positive elements, and the red jagged border highlights feelings of threat.

services/organisations who seek evidence of effectiveness. This at times differed from therapists' conceptualisation of meaningful change. For some, once therapy began, there was a bond that developed with the client, as therapists described liking them and being interested in the work. However, for some there was a sense of this therapy being a difficult task. Overall, there is low to moderate confidence for this theme.

Unrealistic Expectations

This is a moderate confidence finding. Some therapists perceived clients to have expectations of therapy and change that were perhaps too great to achieve through therapy. This could lead to therapists feeling a pressure to achieve:

Author: "[Therapist] perceived [client] as well motivated but having unrealistic ideas of therapy. They had talked a lot about this, including how much support she needed and how fast it would work."(Werbart et al., 2019b)

Therapist: "I felt like she wanted me to wave a magic wand." (Hopper, 2015)

Therapist: "I think she was hoping that I would somehow unlock a key and she'd never have to feel those feelings again." (Morton, 2019)

Therapists in one study (Hopper, 2015) held a strong positive self-belief that they could help to bring about change for clients, thus potentially indicating a high expectation that they held for themselves. There is less confidence in this aspect of the finding however it is important to acknowledge:

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

Therapist: "I was saying well you've had loads of the wrong therapy and this is the first time you will have the right therapy."

The participants in Hopper's (2015) study also referred to service pressures, therefore a minority of therapists expressed a sense of having something to prove. As one therapist stated a need to 'earn your stripes' to show efficacy to colleagues:

Therapist: "I arrived as a newly qualified in October and immediately just started the work with this chap, I thought you know I need to affect some change with people, I need to demonstrate that I can actually do this job." (Hopper, 2015)

Some therapists also described that service conceptualisation of success does not always fit with their conceptualisations of meaningful change for clients:

Therapist: "Mental health services that are based on the medical model, where the idea of symptom reduction is the goal. Sometimes it might not be about actual reduction in symptoms, it might be making them feel at ease about the symptoms that could be a meaningful shift for someone." (Hopper, 2015)

Therapist: "It has been successful in the sense that he's engaged and he's talked about it and that he carries on coming which is a good thing." (McGowan, 2000)

Connecting to the Client

This is a low confidence finding as although two of the contributing papers offered rich detailed data, there were a limited number of participants who contributed to this understanding. Nevertheless, for some therapists, there was an initial bond with the client described, they were interested in the work at the start of therapy and described the client in positive terms, this affective bond could stay throughout the process of therapy:

"The therapist early could feel being unusually creative and free, liking the patient or being exceptionally moved by this particular patient's predicament." (Werbart et al., 2019a)

Therapist: "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." (Morton, 2019)

Therapist: "I feel really fond of that patient and I really hope he can move on" (Hopper, 2015)

As acknowledged, this theme does not have a strong grounding in the data as only some therapists in three of the studies spoke of this, however there is a potential parallel with the clients who felt they had a caring therapist but that this was not enough to produce change.

This is Challenging

This finding is of low confidence due to data adequacy, as the majority of rich supporting data was contributed by one study. Once therapy had commenced, some therapists sensed some

challenges with the therapeutic process. This may be related to the perceived complexity of clients' difficulties:

Therapist: "I certainly had a sense that he would be very difficult to make significant progress with, I think partly aside from everything the length of time he'd been suffering with these difficulties you know for thirty two years and the severity of the emotional neglect. I suppose my experience told me that it wasn't going to be easy." (Hopper, 2015)

Author and therapist: "The therapist conceived the patient's problems as unusually severe and felt perplexed, contaminated by the patient's problems, confused, and unable to think: 'It is so massive, both her blues and resistance, so I don't really know what to do, I feel myself perplexed.'" (Werbart et al., 2019a)

In some cases, therapists described feeling that clients were not improving even from early on, but despite these doubts, therapists continued the work. For some, there was a sense of underestimating or minimising clients' complex difficulties from the start:

Therapist: "Repeatedly I felt that I shouldn't be working with her, that I wasn't doing her any good and yet I carried on." (Hopper, 2015)

Author: "The therapists of nonimproved patients seem to have overestimated the patients' functioning and underestimated the scope of their problems." (Werbart et al., 2019a)

Theme Two: Experiencing a Disconnect

Therapists described finding it difficult to understand clients' problems and collaboratively formulate a direction for therapy. There was a mismatch of expectations of therapy resulting in therapists and clients often not being on the same page. Therapists could express a disconnect in the therapeutic relationship which may reflect a lack of trust in the alliance as therapists expressed that their clients were holding something back. This theme consists of three subthemes. Overall, there is moderate to high confidence for this theme.

Limited Trust

There is moderate confidence in this subtheme. Due to the interpretative nature of this understanding, it is possible that there was another underlying process other than limited trust that could have been interpreted from the data. However, moderate confidence remains due to the description of this phenomenon from some participants. There was a distance and uncomfortableness described by therapists in the therapeutic relationship and a sense that this

may have been due to a lack of trust from clients. Some therapists commented on struggling to deepen the connection with clients, possibly indicating that clients were keeping therapists at arm's length:

Therapist: "From the start I just didn't feel comfortable with them, and I sensed that they didn't trust me." (Laszloffy, 2000)

Therapist: "I just thought there's no relationship developing here, there's not really a trusting open relationship developing here and that was immediately a bad sign." (Hopper, 2015)

Therapists described clients keeping an emotional distance, and some described once the therapeutic relationship was developing, that some clients may have felt threatened by this emerging closeness and so therapists experienced disconnection:

Therapist: "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." (Morton, 2019)

Author: "Typically, the therapist described that the patient reacted with growing aversion to the therapeutic progress and to increased attachment to the therapist in the course of therapy." (Werbart et al., 2019a)

Another way clients were perceived by therapists as maintaining a self-protecting emotional distance was through compliance:

Therapist: "I think [client] 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." (Morton, 2019)

Author: "[Therapist] wondered if she [the client] idealized and tried to please him." (Werbart et al., 2019b)

Therapist: "I think she did things because she felt they were the polite thing to do." (McGowen, 2000)

Cultural differences were also described as impacting the relationship in one included study (Laszloffy, 2000). Due to there being only one study who specifically recruited participants from minority backgrounds, it is important to report due to potential consequences of cultural/racial bias upon the therapeutic relationship. The contributing therapist described cultural differences between themselves and the client as impacting upon the relationship which ultimately maintained distance:

Therapist: "It also is important to acknowledge that cultural/racia1 biases may have contributed to the difficulties in joining." (Laszloffy, 2000)

Therapist: "I felt self-conscious and uncomfortable with them about my English. They looked at me like they didn't understand me. I felt like I confused them." (Laszloffy, 2000)

Client Held Something Back

There is moderate confidence in this finding as there were detailed descriptions across the five studies of therapists perceiving clients holding something back from the relationship. Therapists sensed that clients did not fully engage with the therapeutic process which impacted upon the effectiveness of therapy:

Therapist: "I don't think I really was able to engage him.. in the way I might have liked to have worked i.e. in a kind of CBT way." (McGowen, 2000)

Author: "From the start of therapy, participants either experienced barriers to therapeutic progress or a sense that it was not progressing well (e.g. resistance from the client or a sense that the client did not want to be in therapy)." (Hopper, 2015)

Therapists may have been, perhaps unknowingly, viewing their clients through a lens of fragility, as some therapists spoke of the awareness of difficulty in the relationship but were unable to discuss this in therapy. A tentative suggestion may be on one hand, therapists offered reflections or interpretations too soon which resulted in clients holding back due to fear of criticism, judgement, or rejection. On the other hand, therapists may be predicting they will not be well received, and so do not share them. This aligns with some clients seeking a more active therapist. This potential self-protective action by clients may have left therapists feeling invalidated in their approach. As this aspect of the finding is more interpretative it is less grounded within the data, thus reducing the confidence in coherence. However, there were indications of this in the data:

Author: "[Therapist] sensed that [client] 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." (Morton, 2019)

Therapist: "Reflecting on your experiences for cognitive therapy requires some capacity to kind of think through things at kind of semi-logical level anyway. Or at least to follow someone else doing that. And I just really didn't think [client] could do that. It was almost like the more we focused on his psychotic experiences the harder it was for him to think about them." (McGowen, 2000)

Therapist: "I'd find it very difficult to talk about those kinds of relational issues with him because he would see it as a real threat or insult." (Hopper, 2015)

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

Therapists from one study (Hopper, 2015) additionally report an interesting potential parallel in that supervision could feel threatening for therapists, so the distance in the therapeutic relationship was mirrored by distance in the supervisory relationship:

Therapist: "While I did find it validating that we were kind of having a laugh at how hopeless our jobs felt maybe while we were doing that we could have been talking in a bit more real way about it….sitting with those feelings of hopelessness and despair and feeling deskilled and like you're letting the patient down in some way, maybe that's what we should have been talking instead of sitting around and laughing." (Hopper, 2015)

It was understood that for participants in this study, fear of criticism and imposter syndrome was a motivating factor to hold back from their clinical supervisors:

Therapist: "I think there's always some sort of self-surveillance that goes on in modern healthcare where you're always trying to compare yourself to some complicit norm, whether you're seen as efficient or good at your job, probably get enough of that from my own kind of self-critique but there is always that level of self-surveillance, self-monitoring and justifying to myself whether to keep seeing this person or not." (Hopper, 2015)

Absence of a Shared Purpose

There is high confidence in the following finding as all six of the contributing studies reported that the non-response therapies lacked a sense of collaboration with a mutually agreed direction for therapy. Therapists described not being able to fully understand clients' difficulties:

Therapist: "'It reflects pretty much how her life is like. On the surface everything looks very competent and good. But you still have a sense that there is something going on under the surface. And I can't get the hang of what's going on there." (Werbart et al. 2019a)

Therapist: "I'm sure that one reason we never really connected was because I never quite got what they wanted from me. I felt inadequate because I couldn't figure out the problem." (Laszloffy, 2000)

This lack of understanding of the client could subsequently lead to a lack of mutually agreed direction and focus for the therapy. Therapy was not felt to be an equally collaborative effort:

Author: "Those from the [dissatisfied] cases routinely raised this issue, citing their difficulties in developing a clear focus for therapy and mutually agreed upon goals." (Laszloffy, 2000*)*

Author: "Although [client] and [therapist] 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." (Morton, 2019)

A key task reported by therapists, mostly in the phenomenological papers, appeared to be validating and normalising mental health difficulties. Therapists described encouraging different perspectives and understandings of client's difficulties, in order to introduce the idea of acceptance, thus dispelling the high expectations that clients held for therapy being a solution that could alleviate all their problems. Some therapists appeared to hold on to the fact that therapy may not always result in positive change due to complex factors and that small changes can still be meaningful, however this was incongruent with client expectations, adding to feelings of misunderstanding:

Therapist: "It's not so much that I hope to solve people's problems in therapy or help them to solve their problems, it's more that I hope people come to believe that consulting others, being with others and asking for support can help in whatever way." (Hopper, 2015)

Therapist: "I think we did sort of talk about, you know, 'you'd like these things to go away, but…', to try and help [client] see that we're all kind of living with those feelings and it's about how we live with them…I think it was better when we were talking about it." (Morton, 2019)

It was also inferred from some of the therapists' descriptions that clients may have wanted a different type of therapy or approach such as one that was more directive, however this appeared to not always result in a change of approach:

Author: "[Therapist] knew that [client] wanted more advice and feedback, but she did not reflect in her interview on confronting [client] with their incompatible views or adjusting her approach." (Werbart, 2019b)

Theme Three: Feeling Threatened

There was a sense from the papers that therapists could experience feelings of threat, particularly when therapy was not going as planned. Therapists described emotional demands that they may not have been expecting, such as feeling strong emotions and that their boundaries were beginning to blur, possibly reflecting fighting for success. When therapists accepted this as a non-response outcome there were feelings of inadequacy and ineffectiveness. This theme has two subthemes. Overall, there is moderate confidence for this theme.

Demands on Self

There is moderate confidence in this finding as all but one of the contributing studies contributed to the finding that alike clients' experiences of therapy, some therapists also described therapy being emotionally demanding. However, two of the study contributions (Laszloffy, 2000; Werbart et al., 2019b), were less grounded in the data. They described a taxing experience of trying to connect with the client in the context of clients holding back and not being on the same page, with one therapist describing this therapy experience as 'less rewarding'. Therapists could feel anger and frustration towards this process:

Therapist: "I found it really wearing. It was the hardest thing I did in the week. I was really tired when I came out of those sessions." (Hopper, 2015)

Author: "[Therapist] 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." (Morton, 2019)

Therapist: "It was calm on the surface of her speech, but [my] countertransference was so powerful, I was confused, I felt I was drawn into some damned depth and sometimes had to work my way up in order to be able to get her something back, so there was a mighty force under the surface." (Werbart et al., 2019a)

As some therapists described frustration with a sense of being 'stuck', their boundaries could begin to be held less rigidly as they experienced a desperation to try everything they could:

Therapist: "I was a bit pissed off and frustrated because the amount of effort I put in, I thought right you're going to get it both barrels, you're going to get the A grade, I'm going to get this sorted now, come on I can do this, we can do this, I can do this, we can do this." (Hopper, 2015)

Author: "The therapist felt losing control of the process, unable to balance between closeness and distance." (Werbart et al., 2019a)

Therapist: "I then felt the need to do therapeutic things outside of the therapy which is really out of the ordinary for me. I'm normally really quite boundaried with patients." (Hopper, 2015)

Therapists could unknowingly take a rejecting or critical position (possibly indicating emotional disconnection from the side of therapists), therefore potentially being pulled into enactments rather than holding a meta-cognitive position which, alike clients, could be seen as self-protective against feelings of failure. As this aspect of the finding is more interpretative, there may be other interpretations of this response, however some therapists described their frustration turning to feelings of powerlessness and defeat:

Therapist: "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…" (Morton, 2019)

Therapist: "I was reactive. He pushed my buttons because he was so sarcastic and angry." (Laszloffy, 2000)

Therapist: "It could feel like being dragged into a black hole or fighting to stay above the surface, being lost and powerless." (Werbart et al., 2019a)

Feeling Ineffective

There is moderate confidence in the finding that some therapists spoke critically of their ability and could offer statements in interviews that alluded to them holding the responsibility of therapy failing such as "*I didn't get anywhere really with [client]*" (McGowan, 2000). Data from theses and a study which was of high methodological concern underpin this finding. From these participants, a self-critical voice emerged for some and there were descriptions of therapists feeling guilty and inadequate:

Therapist: "I felt inadequacy as a therapist and that I wasn't getting it right, that I'm not very good at engaging people. That I just wasn't getting my technique right somehow" (Hopper, 2015)

Therapist: "I just didn't know how to address his difficulties. I felt helpless and ineffective." (Laszloffy, 2000)

Therapists had not achieved the success that they held out for in the beginning. As alluded to by a minority of therapist participants, this may be related to the expectations felt from colleagues and services as well as their internal expectations of their ability as therapists:

Therapist: "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?" (Morton, 2019)

Therapist: "I suppose my most prevalent thought was, why can't I manage like all the other therapists can?" (Hopper, 2015)

Upon therapy termination, some therapists described a reluctance to let go, this was not always explicitly stated as seen from the following author quote from Werbart et al. (2019b) "*[Therapist] said they prolonged the therapy by one year and he thought she [the client] still needed more therapy*." While others described relief, as can be seen in this therapist quote in Hopper (2015) "*There was an element of relief that I was no longer working with someone that complex*."

Theme Four: Holding onto Hope

This final theme describes the experience and consequences of a non-response outcome for therapists. Despite a difficult therapeutic experience, therapists described a determination to continue sessions with the hope of change occurring. Hope was also maintained as therapists recalled meaningful change that clients were still able to get from the experience, such as validating new perspectives and awareness to help to reconceptualise clients' difficulties. Hope continued to be held upon therapy termination, in that therapists hoped clients would continue to improve post-therapy through the skills they had gained. Finally, hope was regenerated upon reflection of what therapists felt that *they* had gained from the experience of non-response. This theme consists of two subthemes. Overall, there is very low to moderate confidence for this theme.

Hope for Ongoing Improvement

Four studies contributed in detail, with one study adding minimal data, on the positive changes that therapists described clients were still able gain despite core problems remaining. Therapists placed importance on the development of and validating new perspectives for clients and maintained that this was something positive that clients got from therapy:

Therapist: "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." (Morton, 2019)

Therapist: "She is much freer than before therapy, she has a better eye on herself, she knows a lot more about her problems…previously she was somehow pseudo-aware, but now she's actually much more aware of her problems and she has the opportunity to work on them, if she dares and if she wants." (Werbart et al. 2019a)

It was interpreted by the current review that therapy was hoped to be a catalyst for continued change post-therapy, possibly suggesting therapy was a starting point for change. There is moderate confidence regarding this finding, as hope may be one interpretation from the data:

Author: "Even if the symptoms were not really relieved or the problems were not solved, the therapist believed that the patient started a development she would continue on her own after termination." (Werbart et al., 2019a)

Professional Learning

Reflecting upon the non-response experience, some therapists described being able to take learning away that they have held in mind during their clinical practice. This also included an adjustment of their expectations of how much pressure and responsibility they place on themselves to produce change:

Therapist: "It was great because I learned so much about working with couples. I made mistakes, but it helped me to become a better therapist." (Laszloffy, 2000)

Author: "[Therapist] 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." (Morton, 2019)

Therapist: "I think they will or won't get better with or without my help and this reminds me that I am no longer responsible for another person's wellbeing." (Hopper, 2015)

Most contributions for this finding were grounded in the phenomenological data from Hopper (2015). Therefore, although it is important to reflect on what therapists from Hopper's study took from the non-response experience, there is very low confidence in in this finding overall.

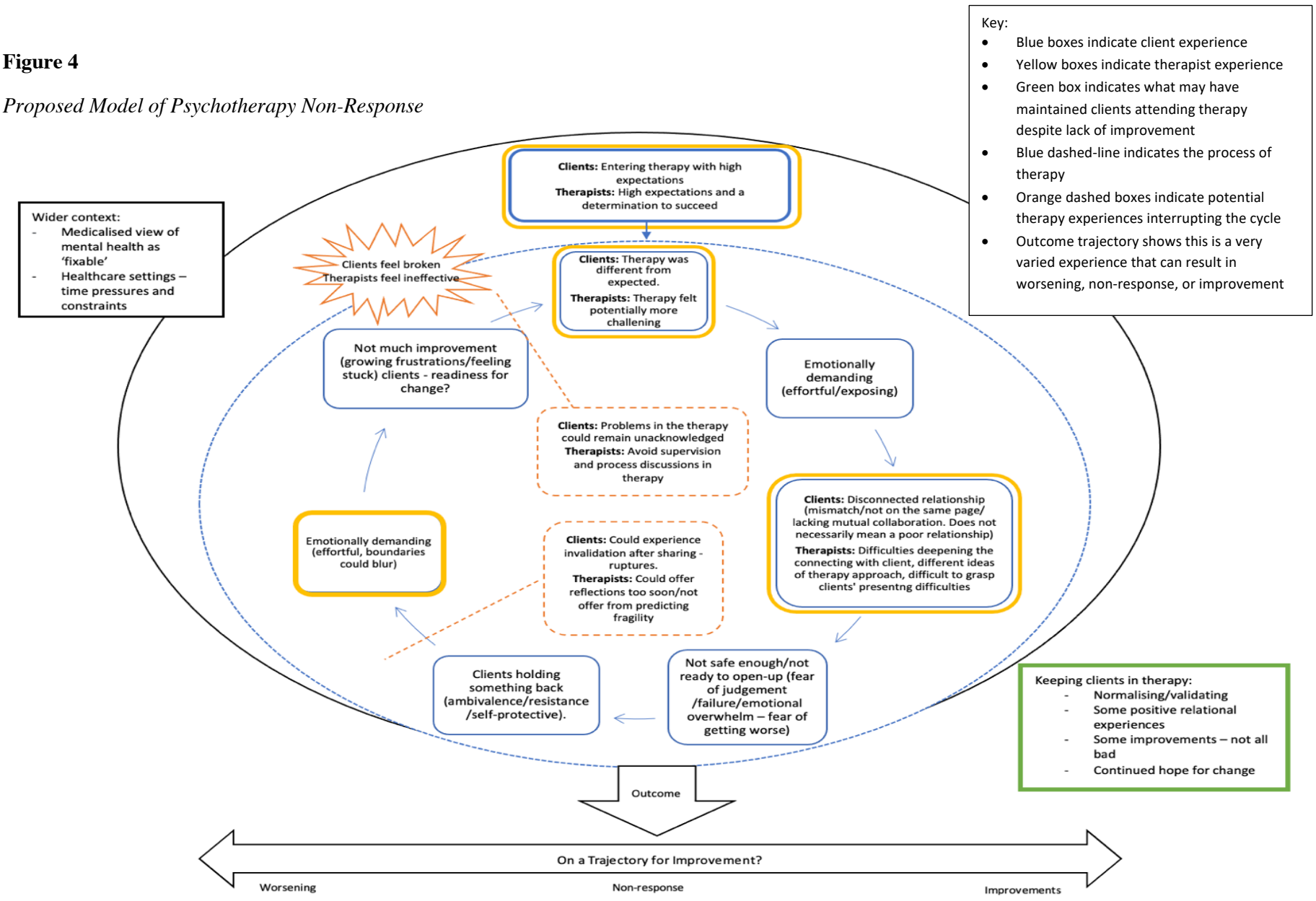
Narrative Synthesis

See Figure 4 for a visual representation of the narrative synthesis. There were shared themes of high expectations for the therapy, this was fuelled for client participants by a need for their lives to be different and thinking therapy is the answer. For therapists, this was potentially fuelled by a determination to help and be successful which arose from both internal and external pressures to achieve. There were also similarities with a sense of uncertainty about the therapy for clients and the process perhaps seeming different to what they had expected. Similarities in therapist narrative were seen as they described this therapy as a challenging experience where they felt like things were not going the way they had hoped for from early on and could feel confused about the client's difficulties.

Across both perspectives, there was a sense of disconnect in the therapeutic relationship. Not all participants described a negative relationship, therefore a negative relationship did not appear to be a pre-requisite for non-response, however, there did appear to be something missing

Figure 4

Proposed Model of Psychotherapy Non-Response



from the alliance. From both client and therapist perspectives, there appeared to be a lack of trust described in the relationship which could act as a barrier to genuine connection and closeness. There were descriptions of some clients feeling undervalued, uncared for and invalidated as their therapists did not seem to understand what was going on for them. In contrast, the therapists appeared to be trying hard to understand their clients' presenting difficulties and trying their best to offer appropriate help. They experienced feeling as though clients were reluctant to fully trust them and the process, which led some to offer reflections too early or propose interventions that were not congruent with clients' ideas of therapy and go down a route in therapy that was not collaborative. Alternatively, some therapists may have felt a need to hold back on discussing problems in the relationship or themes which they predicted clients may not be in a place to receive. Interestingly, in the negative relational experiences, it may have felt for clients as though the therapist was not seeing or hearing them as individuals which may indicate a lack of positive regard and congruence (genuineness) which in turn is perhaps a key factor in not opening-up or connecting with the therapist. When these characteristics were shown, it appeared to keep clients in therapy however did not seem enough to produce change.

There appeared to be a general theme across both perspectives around a lack of understanding and collaboration. Clients and therapists both described different perspectives on how therapy would look, and there seemed to be a lack of mutually agreed focus for therapy which could be frustrating for both sides. Clients described an ambivalence and reluctance to fully engage in the process and would often hold back from therapists, sometimes only sharing what felt like surface level topics to avoid the meaningful issues, which could feel too threatening to approach. Particularly in the context of a disconnected relationship, clients may have feared judgement, which perpetuated them 'holding back' i.e., shame may have been a powerful motivator for passivity. Therapists sensed client's ambivalence to fully engage in the process, however there was not much mention in the papers of therapists approaching this directly with clients. Therefore, holding back appeared to be a parallel process that may have been self-protective.

Therapy was emotionally challenging for both clients and therapists. Clients did not necessarily expect therapy to be this way. Therapists seemed to experience this particular therapy as tiring and they were fighting to stay aware of countertransference but could feel pulled into the process which could lead to anger, frustration, and criticism of the client. There was a sense of both clients and therapists feeling under threat. Therapists could describe their professional boundaries beginning to blur as they tried everything they could think of to bring about change for clients, with some extending therapy or trying many different interventions. There appeared

to be a point for both clients and therapists where the non-response and disappointment was accepted which was accompanied by shared disappointment.

This brought about strong self-blaming explanations for both clients, who felt broken and hopeless, and therapists who felt ineffective and incompetent. Therapists at first could become critical and blaming of clients, then move to self-blame which may also be a parallel process. Both sides could feel a responsibility for the failed therapy and turned inwards for explanations. Some therapists acknowledged system insufficiencies which perpetuate clients' problems, thus taking a wider view and acknowledging therapy limits in this context. For therapists, this self-criticism and fear of criticism from others may have also been instrumental in holding back from talking about these cases openly in supervision. Some therapists described a comparison towards other therapists and imposter syndrome, which could contribute to feeling as though they let their clients down, as other therapists may have been able to 'solve' their problems. For clients, therapy could feel like a risk that did not pay off.

However, therapy was not without its successes. Clients described some improvements and positives that they experienced, such as learning new techniques and/or cathartic experiences of having a place to be able to talk and express their emotions. A key outcome for clients was the normalisation of difficult mental health experiences, which is interesting as some therapists named this process in descriptions of therapy aims. Therapists described the aim of being able to help clients to live with these difficult experiences rather than be able to take suffering away completely. Clients and therapists both held onto some hope for a positive change in the future, however there were some clients who described a loss of hope moving forward, therefore there may be a difference in these client's experiences.

Confidence in the Findings

The GRADE CERQual approach was used to support the assessment of the confidence of the review findings (Lewin et al., 2018). The method was described in detail in the methods chapter above. This approach supported the assessment of the extent to which findings are a reasonable representation of the phenomena non-response (Wainwright, 2021). Overall, there were three high confidence findings, 17 with moderate confidence, seven with low confidence, and one very low confidence finding (see Appendix J for the full CERQual evidence profile table).

In order to contextualise the narrative synthesis some important considerations need to be taken by the reader. Firstly, this synthesis has not separated the analysis by the therapist modality, therefore there may be influences at play between professions (clinical psychology, psychiatry, and social work for example) and therapy models. It should be noted that the collection

of papers by Werbart et al. are underpinned by psychoanalytic perspectives which have contributed to the understanding of some of the therapeutic processes underpinning experiences in this synthesis. These papers were analysed from the perspective of the author, and it may be relevant to note that they did not interview the participants directly as this was pre-collected data. This is also true for the other papers that analysed secondary data (Crowe et al., 2012; De Smet et al., 2019; Laszloffy, 2000; von Below & Werbart, 2012; Westra et al., 2010; Werbart et al., 2015; Werbart et al., 2019a; Werbart et al., 2019b). Another consideration to hold in mind is the differences in questions (and therefore type of knowledge gained) asked during interviews, as studies from intervention trials may have used standardised interview guides such as the Client Change Interview (Elliott, 2001), whereas theses may have detailed, specific guides on the phenomenon of non-response as the primary focus. This is also important for the general effectiveness studies exploring poor outcome included in the current review, as this data may be in relation to a specific therapy rather than their non-response experience as the key focus. This outcome and change information is important for developing the understanding of non-response, however it is a consideration to hold in mind that for some studies non-response was a key focus, and for others it was not.

Of note, there are theses that have contributed to the proposed model of non-response, some of which were not primarily exploring the experience of non-response (Adler, 2013; Archard, 2013; Homan, 2019; McGowan, 2000), and some that were (Hopper, 2015; Morton, 2019). Radcliffe et al. (2018) is a publication from a Doctoral thesis, therefore the thesis (Radcliffe, 2014) was also used for quotes. As theses are in-depth documents, the richness and quantity of data will have inevitably influenced my interpretations of the data. I was drawn to the phenomenological conceptualisations of non-response from the rich participant quotes. Key theories which were also referred to in the original studies were attachment theory (Bowlby, 1969/1982), and the model of corrective experiences (Hill et al., 2012) which will have influenced the context of which I view change in therapy and subsequently, non-response.

Acknowledging these influences on the resulting synthesis, the proposed model of non-response provides a first attempt at synthesising the experiences of non-response from both client and therapist perspective. This is an emerging research area, and it is hoped that this synthesis will provide rationale for further research to explore the experience of non-response to develop this understanding.

Reflexivity

The experience of conducting a secondary research project has been interesting and equally challenging in parts. I have reflected upon the value of a research team when interpreting

a large amount of data, such as that from this review. Discussions with supervisors was an important aspect of this project as it allowed me to take a step back from the data and to try to gather an interpretative stance. I have reflected on the importance of working in a review team where possible, this may have felt exacerbated at times during this project as it was conducted during the COVID-19 pandemic.

I also recognised a pull during the analysis of data to see the experiences from the perspective of a therapist, due to my role as a Psychologist in Clinical Training. This was important to acknowledge as it will have had an impact upon how I viewed, understood, analysed, and ultimately presented the data in the synthesised understanding. I found a reflective diary helpful for this process and also bringing this to my attention as I was analysing. This occurred throughout the analysis of both client and therapist data, as I found myself putting myself in the shoes of the therapist and wondering what may have been occurring to result in the responses that I was reading. From the analysis, I also found myself intrigued by the presence of positive affective relational experiences between clients and therapists in some cases. I reflected on a previously held assumption that a non-responsive therapy would include a poor bond between client and therapist. I have found it valuable to hold in mind the different aspects that make up a therapeutic relationship as well as the affective bond. I have noticed that this has had a positive impact upon my clinical practice during the completion of this project. For example, I have noticed the emphasis I have placed in my recent thinking on the client theory of change and if these align with the agreed therapy goals. The following section will now discuss the review findings in relation to the wider literature.

CHAPTER FOUR: DISCUSSION

Introduction to the Chapter

The discussion chapter will present the two aims of this QES that were outlined in the introduction chapter and demonstrate how each research aim was considered. I will present a summary of the findings and discuss how these relate to existing wider literature around the topic. The strengths and limitations of the review will be presented, followed by clinical and further research implications.

Summary of the Research

This QES set out to produce an understanding of psychotherapy non-response by systematically reviewing the 21 papers that met inclusion criteria. Non-response was defined using Linden's (2013) definition: "a lack of improvement in spite of treatment" (p.288). Despite the apparent clarity of this definition, my supervisors and I had to carefully consider the descriptions of non-response as reported in the studies, in order to determine inclusion in the review. As this is an emerging area for research, it was decided to be inclusive to ensure non-responder experiences were captured across studies not necessarily exploring this phenomenon directly (for example effectiveness and drop-out studies). Additionally, reliable deterioration and harm data was excluded wherever possible. These considerations were thoroughly outlined in the method chapter. The aim of these considerations were to capture a homogenous enough sample that ensured confidence in the phenomena that was explored was non-response, but also heterogenous enough to broaden the transferability of interpretations (Finfgeld-Connett, 2018).

Thematic synthesis was identified using the RETREAT guidance as most appropriate for this QES (Booth et al., 2018). To fulfil the review aims, initial codes through line-by-line coding from the client perspective (529) and therapist perspective (311) were translated into descriptive themes (11 themes, 47 subthemes client perspective; nine themes, 30 subthemes therapist perspective). The next stage involved 'going beyond the data' which generated six analytical themes and 18 subthemes from the client perspective and, four analytical themes with 10 subthemes from the therapist perspective. The analytical themes resulted in a proposed conceptual model of non-response (Figure 4). In this chapter, the findings will be contextualised in relation to the psychotherapy and change, and wider literature.

To briefly summarise the review findings, the thematic findings allowed an elaboration of a process that started with high expectations and an experience of therapy feeling emotionally demanding. This was often accompanied by a feeling of disconnect in the therapeutic relationship

as neither clients nor therapists felt as though they were working in mutual collaboration toward an agreed therapeutic direction. This contributed to disappointment for both clients and therapists, where blame could turn inwards as responsibility was self-attributed for the disappointing outcome. Although, hope tended to remain at the end of therapy, particularly for the therapists who took learning from the experience into their future clinical practice. Findings will be reported in order of the research aims, beginning with how psychotherapy clients and therapists understand and make sense of their experience of non-response. This will be followed by the second research aim seeking to explore how psychotherapy may have been improved.

How do Psychotherapy Clients and Therapists Understand Their Experiences of Psychotherapy Non-Response?

The findings relating to the first research question can be extrapolated from Figure 4 which shows the key aspects of the experience of non-response from both the client and therapist perspective. The proposed model of non-response highlights how some of the proposed common factors, as mentioned in the introduction chapter, were implicated in the non-response therapy experience.

Client Expectations

Considering client expectations are estimated to make up 15% of outcome variance and have been suggested to partially account for treatment outcome, client expectations are important to acknowledge (Dew & Bickman, 2005; Greenberg et al., 2006; Lambert, 1992; Watsford et al., 2013). Expectations can be broken down into role expectancies, and outcome expectancies (Dew & Bickman, 2005). For the non-responders in the current review, both expectations appeared to have some violations. Westra et al. (2010) explored expectancy violations in good and poor outcome cases and found that poor outcome clients were more likely to report violations of initial positive expectations and these clients were left disappointed with the therapy, which is in keeping with this review's findings.

As well as high expectations for change, other elements of therapy seemed not as clients had expected. Thus, the client theory of change, which is the belief held by clients regarding how change may come about for them, may not have been adequately explored at the start of therapy (Duncan & Miller, 2000). Therefore, it appears as though both parties formulate an image of how they think therapy will progress and how change may occur, and when these expectations are unmet, this can cause a stunt in therapeutic progress. There were descriptions of the therapy not aligning with how clients imagined it would be, and some clients spoke of their therapists not acting in the way that had expected, thus reflecting a violation of the expectancies of their therapist's role (Arnkoff et al., 2002). This may be also indicative of a lack of therapist

responsiveness to client needs (i.e., adjusting their approach) which has shown to be present in effective therapy, where an "ebb and flow of clinical interaction" exists (Norcross & Wampold, 2011, p. 100). Some clients spoke of an expectation that they thought they/their therapists would be more/less active (there was a trend towards clients wanting a more active therapist, perhaps suggesting a need for structure and guidance) and so, there was a conflict between expectations and reality which has been shown to negatively impact outcome (Elkin et al., 1999). Dew and Bickman (2005) tentatively suggest that if clients are not informed about the collaborative nature of therapist and client roles in therapy, then this discordance may persist through the therapeutic process and lead to a fractured therapeutic relationship and a lack of improvement.

Therapist Expectations

It also appeared as though some therapists entered therapy with high expectations of what therapy (or themselves) could achieve. This may have been linked to wider organisational pressures that a minority of therapists described, and in turn could have an impact upon how open therapists may feel able to be when these expectations are unmet i.e., in the case of non-response due to fear of blame (O'Connor et al., 2011), however this is a tentative hypothesis. Bear et al. (2022) explored the management of endings in unsuccessful therapy with adolescents and concurred that there was an impact of wider system pressures upon the therapy experience. Bear et al. reported that endings were difficult for both clients and therapists and this difficulty was compounded by excessively high public expectations about what therapy can achieve. The therapists spoke of a difficult experience of trying to maintain hope and manage expectations during therapy, which was challenging in the context of inflexible structures and constrained resources. Wolpert (2016) adds that it is assumed within healthcare that failure is a rarity, which can add to unhelpful expectations for both clients and therapists. Considering these potential external pressures may develop our understanding of why some therapists in this review felt unable to bring non-responding clients for supervisory discussion.

Related to this are potential internal pressures, which is theoretically comprehendible if there is an unspoken belief that success is the norm, thus potentially inducing feelings of threat or shame. Research has supported that therapist perfectionism (i.e., unrealistically high standards) may be related to poorer client outcomes (Presley et al., 2017). Presley et al. reported that 31% of therapists scored in the above average range for the 'concerns over mistakes' subscale of a perfectionism measure, which may parallel the findings in this review relating to avoidance of seeking supervision for cases of non-response that therapists may have interpretated as failure. Although as the authors note, this study relied on correlational data and therefore causation cannot be determined, it is an interesting area for consideration. Wittenberg and Norcross (2001) noted that perfectionism is common amongst psychological practitioners and is associated with low

tolerance of ambiguity. This might explain the finding in the current synthesis that therapists appeared to become critical and frustrated when they could not understand the problem presented to them by clients. When psychotherapists were asked to identify their most distressing thoughts related to their practice in a study by Deutsch (1984), the responses included internal expectations that they should be able to help every client, and that when clients do not progress, thinking this was their fault. Research has indicated a negative association between some dimensions of therapist perfectionism (high concerns about perceived mistakes, and doubts in approach/actions dimensions), with emotional reactions to clients including feelings of inadequacy, overwhelm, criticism, and over-involvement (Ganske et al., 2015; Pozza et al., 2022; Zuroff et al., 2010). Such traits were implicated in the proposed conceptual understanding of non-response from the current synthesis.

Disconnected Therapeutic Relationship

Part of the experience of non-response that was similar for clients and therapists was a disconnected therapeutic relationship and a sense of holding something back, which was felt to be self-protective. In the current review, there was an overall lack of trust in the process which prevented clients from opening-up and fully engaging with the process. For some this seems likely to result in a lack of corrective experiences around their emotional expression (this may have been too difficult to bring to therapy in the first place, or they may have not received enough benefit from expressing and so 'held back'). Meta-analytic evidence has reported a medium-to-large effect (d=.85) between client's emotional expression and outcome, and a medium effect (d=.56) of therapist emotional expression and outcome, thus this may be an important aspect of understanding non-response (Peluso & Freund, 2018). Furthermore, therapists sensed a resistance (and could be resistant to engage themselves) which in turn could lead them to follow an agenda that was not necessarily mutually shared with clients.

The affective bond that was missing from some of the therapeutic experiences in the current review may be related to what is referred to as 'the real relationship' which is marked by the extent to which therapist and client find each other genuine (Gelso, 2014). Gelso et al. (2018) reported meta-analytic findings of a moderate association between the real relationship and outcome, which has implications for the common factors of empathy and congruence/genuineness. Bordin (1979) spoke of this type of bond as one connected to trust, respect, affective attachment, and liking one another. This is in line with the first of three pathways of the contextual model (Wampold, 2015). The first pathway proposes that successful therapy provides a human connection which involves a trusting relationship with a caring and empathetic therapist (the real relationship), which for some in this review was missing.

Interestingly, not all clients described a poor therapeutic relationship, with some describing an overall positive relationship experience. For these clients, it appears that the relationship was being experienced as safe enough to open-up and talk, as described by the majority of participants in De Smet's et al. (2019) study of non-responding clients with depression. However, there were also clients who described an overall poor match, and clients who described a good bond that was felt to be trusting, however there was a disconnect in other aspects of the relationship. Research has shown that a positive therapeutic relationship (a bond between client and therapist, agreement about therapy goals, and agreed therapy tasks; Bordin, 1979) is related to successful therapy outcomes with a moderate effect (Baier et al., 2020; Horvath et al., 2011; Weck et al., 2015).

The second aspect of the therapeutic bond that Bordin (1979) suggested supports the tasks and goals of therapy to take place. When lacking, this alone may not necessarily be a pre-requisite for non-response but may contribute to a non-response outcome, as clients and therapists suggested not 'being on the same page' and a lack of mutual understanding of the direction for therapy. Making sense of the finding that the relationship can be experienced as positive, i.e., a bond has formed, but that the overall impact of therapy is non-response, it may be that one of the other components of the therapeutic relationship are inadequate. Taken with the findings on expectancies, it seems likely that this is either the goal or the tasks could be misaligned. This supports the second 'expectations' pathway of Wampold's (2015) contextual model which proposes that successful therapy relies upon clients believing the proposed therapeutic goals and tasks will be helpful in alleviating their difficulties. The third pathway of the contextual model posits that for successful therapy, clients must also enact healthy actions i.e., specific therapeutic actions/techniques which the client and therapist expect will bring about positive change. Again, this review found that the type of therapeutic action did not always meet clients' agreement. The contextual model may help to understand the experiences of non-response, as Wampold proposed that a strong alliance is necessary for the second and third pathways, as without mutual collaboration it is unlikely clients will enact 'healthy actions' to support and maintain positive change.

Although both client and therapist are involved in the successful development of the therapeutic relationship, research indicates that it is the therapists' contribution to the alliance, which is predictive of outcome over the client's contributions (Baldwin et al., 2007; Del Re et al., 2021). It is the clients *experience* of the relationship that is important, however this research indicates that more effective therapists can form stronger therapeutic relationships which is associated with better outcomes. This suggests that therapists may hold greater responsibility for the therapeutic relationship in relation to the direction of outcome, the clinical implication being

that therapists may be able to influence the alliance development deliberately (Del Re, 2021). Although, therapist factors are not the sole consideration in the therapeutic relationship, as previously discussed client characteristics including social support, readiness for change, and attachment style are also predictive of outcome (Bohart & Wade, 2013; Sprenkle & Blow, 2004). Nevertheless, this suggests that there may be scope that strengthening the alliance may result in better outcomes.

Overlap with Adverse Effects

A key finding of the current review was the overlap observed between the proposed factors implicated with the non-response model and those proposed in understanding of deteriorated and harmful experiences. Non-response therefore does not appear to be an absence of effects, but a range of experiences which when negative, can be similar to those who have deteriorated or were harmed. As noted in the introduction chapter, Curran et al. (2019) produced a model of process factors, from the client perspective, that may lead to negative therapy effects (including harm). Some of the client and therapist current findings that overlap with Curran et al.'s model include: unmet goals and expectations; therapist boundary violations; lack of therapist flexibility (and possible lack of responsivity); lack of understanding of what therapy will be like (client perspective); fear; sense of desperation for therapy to 'work'; and anxiety of 'getting therapy wrong'. Curran et al. note negative relational patterns which also had a cross-over with the current understanding of non-response, such as alliance ruptures, relational distance (either too close or too far), and lack of trust. There was also a sense of this being the 'wrong therapy' which was also noted in the current review, and a lack of client involvement in the therapy. Perhaps unsurprisingly, the differences between the current review's proposed non-response model and Curran's et al. model of adverse factors primarily concern the use of therapist power and boundary violations related to malpractice. Additionally, non-responders also had the potential to have a more successful therapy, which means there is also overlap with models of successful outcome (e.g., Ladmanová et al., 2021).

Hardy et al. (2019) proposed a model of risk factors for negative and/or harmful therapy, which included the risk of therapist power and unethical behaviour. This model also proposes factors that overlap with the current one, such as a lack of client involvement in the process and a lack of consideration of taking on board client feedback when therapy felt misaligned with client expectations. Hardy et al. also importantly note the context of inflexible service structures which could lead to clients undertaking treatment that they deemed was inappropriate for their need, and some clients reported having no choice upon what treatment they received, this is echoed in the current review findings. From therapists' perspective in this study, some described working beyond their competence and that a lack of sufficient supervision compounded the issues. Despite

many similarities, a noted difference in this study and the current review of non-response, may be that non-responders are more able to hold onto hope and positives of their therapeutic experiences, whereas these experiences are not described in the understanding of deteriorated/harmed clients. However, one study by Hart et al. (2021) exploring the experience of eight clients who were reliably deteriorated, and their therapists showed comparable experiences to non-responders which included that of positive experiences and outcomes. Taken with the findings of this review, this evokes curiosity regarding the meaningfulness of outcome measure categories. This argues for a qualitative element to outcome measurement as standard for clients to explain positive and negative nuance in their change, if any occurred (Hill et al., 2013; McLeod, 2011). It appears, as De Smet et al. (2019) reported, that the statistical indications using the Jacobson and Traux (1991) method of clinically and reliable change, may not be as clear cut as therapy outcome language suggests. Furthermore, it may be useful to incorporate the clients' initial expectations and theory of change into the understanding of such varying experiences being captured by outcome categories.

What Could Have Improved the Psychotherapy Experience for Clients and Therapists?

Further exploration and contextualisation of the findings is now presented with regards to ways in which the non-response experience could have been improved.

Responsivity to Client Need

Considering the findings related to client expectations described above, it is sensible to suggest that a check-in regarding these be conducted at the start of therapy, and continual check-ins throughout the therapy process to aid with collaborative goal formation and review. It may be interpreted that therapists who had a non-responding client in this review did not fully explore client's idea of cure/theory of change at the commencement of therapy. Dew and Bickman (2005) suggest that clients remaining uninformed about the collaborative nature of therapy could lead to lack of improvement if this discord in expectation remains. Therefore, a conversation with clients regarding the expectations of therapy could help to dispel unrealistic expectations and potentially lessen the power imbalance in the relationship if clients are given permission early on to give feedback if therapy is not meeting their expectations. This is imperative as research has shown that client-feedback about therapy is more predictive of outcome than therapist evaluation (Hannan et al., 2005; Walfish et al., 2012). It is also vital that therapists establish expectations of possible outcomes from the start of therapy, to ensure clients are giving their informed consent to a process which does not necessarily result in success (Bear et al., 2022).

Clients in this review reported that a different type of therapy or therapeutic approach would have made a positive difference for them. There were difficulties with the therapeutic

technique itself for some clients, thus there may be scope to consider whether clients would have had a better experience if they were matched to a therapy that better suited them. Interestingly, clients often stated that more time in therapy may have produced results for them, a key finding in a Doctoral thesis by Radcliffe (2014). However, as there were varied lengths of time spent in therapy in the current review, this suggests that more therapy does not necessarily mean better outcomes. Nevertheless, client choice about therapist and therapy modality is an area of consideration when a client is not responding to current treatment. Research on therapy has reported that some therapies appear to be more effective for some clients, therefore individual tailoring may be preventative of non-response at referral stage (Nilsson et al., 2007; Sugg et al., 2020).

Considering Readiness to Change

The findings demonstrate a striking parallel finding in that from each perspective there were reflections of clients holding something back from therapy and/or their therapist. There were descriptions of potential ambivalence and a reluctance to fully engage in the process, as was a key finding in Werbart's et al. (2019a) study 'it was like having half the patient in therapy'. As discussed, this holding back could have been related to the disconnected therapeutic relationship not feeling safe or trusting enough to share distressing themes which may have evoked shame and fear of judgement. Some clients described a sense of the therapy feeling stuck, they had gained some insights, but it felt difficult to accept or put the new perspectives into action, as was presented by the core category 'stuck between knowing versus doing' found in the study of no change by De Smet et al. (2019). However, it is also important to consider theories of change as client factors are strong predictors of outcome (Bohart & Wade, 2013).

Change models such as the Transtheoretical Model (TTM) of change (Prochaska & DiClemente, 1982) may help to support this understanding. The model suggests that clients enter therapy with certain levels of motivations and readiness to change. Prochaska and DiClemente proposed five stages of change: the first 'pre-contemplation' stage reflects no current consideration of change; the second 'contemplation' stage is where serious consideration to change develops; the third 'preparation' stage is where planning to make the change takes place; the fourth 'action' stage is where visible change occurs; and the fifth stage 'maintenance' is the stage at which change is maintained. The stages are not linear, and clients can enter therapy at various levels and change throughout the course of therapy. From this understanding it may be proposed that therapists in the current review did not accurately consider how ready the client was for change to occur, resulting in mis-paced sessions and a lack of consideration of the client's theory of change. If therapists can identify what stage a client is in this would enable tailored intervention to meet client need (Freeman & Dolan, 2001). Motivational interviewing

may also be a valuable clinical method to enhance motivation for change (Miller & Rollnick, 2009). Considering the current review found a lack of mutual collaboration, the TTM may have been useful for therapists to reflect upon and talk to clients about.

It should however be considered that the TTM places motivation within the individual, and as clients live within much wider and complex contexts, the sole use of this model as an understanding of client motivation may be problematic. The wider context which impacts client outcomes is reflected by the large proportion of outcome associated with extratherapeutic factors (Lambert, 1992). Therefore, it may be useful to consider a model of therapeutic engagement which views engagement through interpersonal process that provides guidance on establishing a therapeutic relationship at each stage, rather than intrapersonal processes of motivation and readiness (Levy, 1998). As Bohart and Tallman (2010) wrote, there is no unmotivated client, however the motivations may not align with their therapist's, so it is important for therapists to understand client motivations in order to provide client-centred therapy. Again, motivational interviewing prior to or at the start of therapy may provide valuable discussion with clients which can consider wider contexts relating to level of engagement (Miller & Rollnick, 2013).

Acting When Therapists Feel Threatened

This review indicated that therapists may experience internal pressures and are possibly fearful of the consequences of a 'failed' therapy, alike a key finding from Hopper (2015). Therefore, it appears necessary to introduce teaching on the prevalence and factors associated with negative outcomes during therapy training programmes, such as the Doctorate in Clinical Psychology (DClinPsy). This could help to dispel some assumptions such as failure is a rarity, as acknowledged by Wolpert (2016). This may help therapists to adjust the pressure and responsibility they may feel to produce change for clients. As noted above, therapists may experience perfectionist traits, this is no surprise if we consider the competitive route to training courses such as the DClinPsy. However, this may increase feelings of threat and shame when therapy does not go as planned. When therapists feel threatened, this review showed a potential route for therapists is to become less boundaried (over or under-involved), and at times critical of clients, which has been echoed in the literature previously (Ganske et al., 2015; Pozza et al., 2022; Zuroff et al., 2010). There was also a concerning finding for some therapists who did not bring non-response cases to clinical supervision. This finding links with a key finding from Morton (2019) who described "therapy as a threatening experience" (p.117) for both clients and therapists.

In these instances, a model which may be useful for therapists to refer to is Compassion Focused Therapy (Gilbert, 2009). The model draws upon the neuro-behavioural model of three

affect regulation systems: the drive, incentive, and resource seeking system; the soothing, safeness, and contentment system; and the threat-focused/ protection system (Depue & Morrone-Strupinsky, 2005). Gilbert (2013) proposed that it is when the systems become unbalanced, that psychological problems can occur. It could be formulated that therapists' threat/protection systems become activated during therapy with clients who are not responding, as they may feel inadequate or criticised (as some therapists referred to in the current review). This aligns with the proposition that guilt and shame of therapy failure may propel therapists to not disclose their non-response case to clinical supervisors (Kluft, 1992). Therefore, there may be some utility in advising therapists to recognise this threat and encourage accessing their soothing system during these difficult therapies. In practice, this could include bringing non-response cases to clinical supervision to explore the emotional impact and to dispel bringing this frustration into the therapy room. This is an anecdotal suggestion and there will be many other ways to conceptualise the threat that is induced for therapists in response to non-response, however this model has shown to be useful in working with self-criticism (Gilbert, 2009). Furthermore, self-compassion exercises have shown beneficial effects when used in supervision for Doctoral trainee clinical and counselling psychologists with perfectionist traits and negative emotional responses towards clients (Richardson et al., 2020).

Reflecting on a model to formulate their emotional responses may be a useful task for clinical supervision to support the recognition of therapy cases that are at risk of non-response. Supervisor training could include consideration of the therapist factors associated with negative outcomes to introduce these conversations during supervision. It is important to note the critique that Rousmaniere (2016) reported, that supervisory discussion is fraught with bias because we draw upon memory and notes of cases to discuss, however the author notes that memory has biases in self-appraisal. Rousmaniere continues that our memory is filled with our blind spots and biases which are driven by shame, past experiences, and many other factors such as these. This can make it difficult for supervisors to give corrective feedback, therefore Rousmaniere recommended that recorded sessions may be a useful asset in supervision, thus may be helpful with non-responding cases. Additionally, with the knowledge that clinical supervision shows significant positive effects for supervisee development but limited direct impact upon client clinical outcome (Watkins, 2011), it is important for therapists to work on improving their effectiveness outside of supervision, for example through deliberate practice.

Deliberate practice has been proposed to increase clinical effectiveness (Chow et al., 2015; Rousmaniere, 2016; Rousmaniere et al., 2017). Rousmaniere (2016) summarised the principles of deliberate practice to include observing own clinical practice via recording; gaining expert feedback; setting small incremental goals just beyond therapist ability; repetitive

behavioural practice of specific skills; continuously assessing practice through client feedback; and addressing therapist avoidance by developing emotional self-awareness and non-reactivity. Bennett-Levy (2019) reported that effective therapists engage in both personal practice and self-reflection. Further, it has been found that therapist reflective skills and attachment style are predictive of outcome (Cologon et al., 2017; Heinonen & Nissen-Lie, 2020). Therefore, it is argued that deliberate and personal practice (which include self-reflection/awareness of intrapersonal factors such as attachment patterns) are key in developing therapist effectiveness in cases of therapy non-response. It is postulated that self-reflection was lacking, or harder to access, in the context of non-response which reflects the emotional demands described by therapists in the current review.

Clinical Implications

There are numerous clinical implications to take forward from the developed conceptualisation of non-response. Therapy training programmes should teach trainees about the different outcome categories and how to have meaningful conversations regarding different outcomes with their clients. This is important to ensure informed consent is gained upon starting therapeutic work, and to dispel the myth of therapy being a 'magic bullet' that clients can hold. This is important as high expectations may perpetuate therapist's unrealistic expectations which, as we have seen from the current review, may have an impact upon the therapeutic relationship and upon therapist self-efficacy. It is furthermore recommended that therapists gain a full understanding of their client's expectations of therapy, their roles, and the outcome. This would be helpful at the beginning of therapy to readjust expectations to a more realistic view of what therapy may be able to provide support for (Dew & Bickman, 2005).

Another key implication from the current review is the promotion of therapist honesty at the start of therapy about the outcome possibilities following therapy. Wolpert (2016) helpfully shared examples of how therapists can have the conversation with clients about the possibility of non-response and therapeutic failure. In the current review, clients and therapists rarely felt able to discuss dissatisfactory experiences which may have come from a place of defence or unawareness of this experience from either side. Nevertheless, therapists hold a power in the therapeutic relationship which enables them to hold these conversations and offer a change in approach if necessary. If therapists learn that the therapeutic approach is not the right fit for clients during therapy, they should remain open to cross modality referrals. For example, there should be service pathways which allow a client to be referred to another professional who uses a therapeutic model that the client and therapists have decided would be a better fit for them. This should be approached with caution to ensure this is the reason for ineffective therapy, rather than it relating

to problems in the therapeutic relationship for example, as research indicates that therapists are poor predictors of poor outcome (Hannan et al., 2005; Hatfield et al., 2010).

From the findings of this QES, it appears that deterioration/harm and non-response have considerable overlap. This is a key clinical implication as non-response should not be viewed as an absence of any effect. Therapists should monitor their client's progress and gain regular feedback on the effectiveness of therapy from their perspective. This is imperative as clients who terminate therapy within the category of non-response may have had an experience similar to deterioration and/or harm, therefore there is an ethical duty to explore this experience. Therefore, a mix of quantitative and qualitative measures should be used to assess therapy effectiveness, as this review has shown that there are a range of experiences which are encompassed under the non-response classification. Ideally, there should be a qualitative element to outcome measurement as standard for clients to explain nuance in their change, if any occurred (Hill et al., 2013; McLeod, 2011).

Additionally, Norcross and Lambert (2018) recommended the routine monitoring of client satisfaction with the therapeutic relationship and comfort with therapists' responsiveness, as well as response to the treatment, this is proposed as a further clinical implication. They argued that this monitoring increases opportunity to repair collaboration and the therapeutic relationship, along with exploring external factors that may be impacting outcome. Norcross and Lambert also outlined the importance of measuring the alliance using standardised outcome measures throughout treatment, again opening opportunities for adjusting approaches if necessary and in line with the clients' needs. When opportunities are not provided to discuss dissatisfaction, problems may remain unadjusted for and dissatisfaction is likely to continue, as was captured by the experience of non-responders who described feeling stuck in the current review. A minority of participants in the current review spoke of what I have interpreted as, a lack of rupture and repair, or where rupture occurred there was not sufficient repair. Research indicates that ruptures are common in therapy, and it is the repair of such ruptures that have been linked to successful outcomes (Safran et al., 2011). Therefore, therapists need to note and actively engage with ruptures, as it appears that this (active engagement with and repair of ruptures) was possibly lacking from the current review.

A further implication from the review is that therapists should discuss difference and diversity with clients during therapy and the impact of this upon the therapeutic experience. Models such as the Social GGRRAAACCEEESSS (Burnham, 2008/ 2012) can support therapists to remain mindful about aspects of social difference. Cultural sensitivity and/or humility training

is also recommended for therapists. Lastly, therapists are encouraged to follow the guidelines of deliberate practice in order to improve their clinical practice.

Strengths and Limitations

The following section will critically discuss the design and completion of the study. Both strengths and limitations associated with the study will be outlined.

Research Design

This qualitative evidence synthesis (QES) provided a conceptual understanding of psychotherapy non-response which goes beyond the findings of the original studies. The current review went further than a previous synthesis by von Below (2020) which explored no change from psychoanalytic psychotherapy with young adults in the context of the Young Adults Psychotherapy Project. The current review is also complimentary to the model of factors associated with adverse outcomes including harm by Curran et al. (2019). The findings of the current review add to the literature in this topic area and adds valuable insight from both client and therapist perspective. The review has presented useful clinical implications which will be helpful for therapists to improve clinical effectiveness. I also acknowledge that due to the interpretive nature of synthesising qualitative evidence, the proposed model of non-response is one possible interpretation of the data and there may be alternative conclusions.

Rigour was established through a systematic approach to this QES. A comprehensive search strategy was developed with the support of an IT specialist with the University of Leeds. Expert guidance increased likelihood of identifying studies with characteristics relevant to the phenomena of interest (non-response). It is acknowledged that it is possible that relevant studies may not have been identified, however as the aim of a QES is not to identify all possible literature on the topic area, this was felt to be acceptable (Booth, 2001). It should be noted that this review was limited to studies in the English language, there may have been studies published in different languages that present alternative views of psychotherapy non-response. The included studies were a mix of published research articles and Doctoral theses which would have otherwise been unretrievable without approaching the authors directly and requesting access. The non-disseminated findings appeared congruent with the published literature therefore, dissemination bias was hopefully reduced (Booth et al., 2018; Toews et al., 2017). Further, the widely used CASP (2018) quality appraisal tool was used to assess methodological quality, results of which were transparently reported earlier in the report (Long et al., 2020). A proportion of the included studies were additionally co-rated by independent reviewers; however, a noted limitation is that not all the studies were able to be co-rated. Most studies (n=12) were of low concern, however

six studies presented moderate concerns and three posed high concerns to the trustworthiness of results.

Conducting a QES enabled the comparison of non-responding experiences across varying contexts, for example NHS statutory services and private services of varying therapy lengths, which is a strength of this research methodology (Tong et al., 2012). Data was synthesised following the guidance for conducting thematic syntheses presented by Thomas and Harden (2008) which was felt to be appropriate using the RETREAT guidance (Booth et al., 2018) as a decision tool. To support credibility, codes and theme development were checked during research supervision and with an independent reviewer. It was also intended to credibility check with a service-user consultant, however due to circumstances unrelated to the research project this was unable to go ahead. Service-user involvement was utilised at the research panel stage to confer about research questions and added value of the research project.

Data Synthesis

Acknowledgment is needed of the difficulty with synthesising data in general from multiple sources whilst staying close to the participants' experiences. I attempted to stay close to the data during theme development stage where I condensed similar codes and their accompanying raw quotes next to one another, thus encouraging the continuous re-reading of raw data. I also kept a reflective journal during the coding stage to help me to hold in mind the context of included studies. Helpfully, Duden (2021) has explored this topic in a recent research article. Duden describes the tension of merging studies without losing meaning and recommends transparency both where themes may be clearly derived from the data, and where themes are developed from indirect or implicit statements and so are more inferred. I have attempted to do this throughout the results as I have made it clear where only some participants have referred to an experience. Duden also highlights the use of GRADE CERQual (Lewin et al., 2018) to provide support in assessing the confidence in findings without the positivist interpretation of confidence due to frequency. I have made clear where there is less confidence underpinning themes and so increased caution should be taken in line with this. As reported in the 'confidence in findings' subsection earlier in the report, there were underpinning theoretical frameworks and epistemology which I may have been more drawn to during the development of this synthesis. One of the difficulties with the method of QES is the synthesising of differing underpinning perspectives of the original studies. This was carefully considered during the systematic stages of the research and through credibility checks which is hoped to have mitigated some of these difficulties.

Another limitation is the lack of exploration on the extra therapeutic factors that impact on outcome. There are estimates of client and their environmental factors accounting for between

33.3-40% of improvement (Cuijpers et al., 2012; Lambert, 1992). Part of this estimate does include client factors, some of which have been discussed in this report, however there is a remaining proportion of variance that is attributable to external therapy factors which have not been given focus in this review and is lacking from the proposed model of non-response. It is also curious that the current review found therapists and clients self-attributed blame of non-response (or at times blamed one another), however the estimates from the literature inform us that it is likely that a large proportion of therapeutic outcome is external to the therapy.

Participant Sample

Some of the reviewed studies included non-response and deterioration in their participant samples. Within the review it is possible to identify approximately six reliably deteriorated participants in the current sample of participants. However, there may have been an overlap of participants who took part in the studies within the context of the YAPP project (Werbart et al., 2015; Werbart et al., 2019a). This also prompts another potential limitation of the current synthesis which is a broad definition of non-response. The current review aimed to include participants who were either statistically defined as non-responders, and self-defined non-response. Within self-defined non-response, it was accepted to include dissatisfaction, as it was rationalised in discussion during research supervision that those who are dissatisfied with the outcome but did not speak of being harmed may be describing the phenomena of non-response. This was considered to be acceptable as this is an emerging research area. Nevertheless, great consideration was taken upon screening of original studies to include non-response experience whilst excluding deterioration and harm where possible. It is acknowledged that this approach may have resulted in a sample of participants who may not have experienced non-response and perhaps dissatisfaction is a separate phenomenon which should be explored.

It is also an important acknowledgement that the therapists included in the current review were from different professional backgrounds, as stated earlier in part one of the results section, the reported professions who provided therapy in the original studies included: Clinical Psychologists, Psychotherapists, Psychiatrists, Clinical Nurse Specialists, Social Workers, Counsellors, Cognitive Behaviour Therapists, Family Therapists. It would have been valuable to have compared the different professional backgrounds in line with theme development to see if theoretical underpinnings contributed to understandings. It may be a possible fruitful venture to explore whether experiences of non-response are markedly different in comparison of therapy modality. From the current review, it does appear that experiences of non-response may be transtheoretical as similar themes were generated across studies, however as this was not explicitly explored within this review, it cannot be concluded with certainty.

As reported in the method section, there were a range of methodologies used in the primary papers. Possible tensions were acknowledged between the psychoanalytically orientated grounded theory studies which prioritised researcher interpretation, and the phenomenologically orientated studies which prioritised participant quotes in their result sections. Additionally, there were six theses included in the current review (Adler, 2013; Archard, 2013; Homan, 2019; Hopper, 2015; McGowan, 2000; Morton, 2019), which provided rich lived experiential data of what non-response may have *felt* like, however these are not peer reviewed. To note, Radcliffe et al. (2018) is a published thesis, thus I also had access to in-depth quotes from this report. There is also a discrepancy in the word limit of theses and published reports. The latter are restricted to word count and therefore contain fewer participant quotes. These factors were taken into consideration both through reflexivity, and through credibility checks and supervisory discussion.

There was a lack of exploration into the impact and importance of culturally adapted practice in the current review. This was reflective of the cultural and ethnic homogeneity of the participants included in the original studies. It is a strength that the findings are drawn from different healthcare systems in different countries, however the therapies offered in these settings seemed to be Western and individualised. Wampold (2015) emphasised the importance of the cultural adaptation of evidence-based treatments, as the explanation of the client's difficulties must be acceptable to clients otherwise treatment is not culturally sensitive or person-centred. In addition, Crawford et al. (2016) highlighted that clients who are from minority groups including ethnic and sexuality, are more likely to experience harmful therapy. Within the current review, one study (Bellesi et al., 2020) explored the experience of Black Caribbean women who did not respond to psychotherapy in a primary care mental health service within the NHS. Bellesi et al. reported important themes related to how participants' previous experiences of racism and discrimination had an impact upon their current therapeutic relationship, making it difficult to build trust in a time limited therapy. A study from the wider literature (Cardemil & Battle, 2003) reported that clients from ethnically diverse backgrounds described more positive experiences in cases where therapists showed an awareness of the impact of difference in the therapeutic relationship. Further, Owen et al. (2011) reported that client's perception of their therapist's cultural sensitivity was positively correlated with the therapeutic relationship.

Future Research

As previously reported, there were a diverse range of outcome experiences despite aligning with the definition "a lack of improvement in spite of treatment" (Linden, 2013, p.288). Therefore, it may be useful for future research to aim for a more homogenous sample where the non-response experience is statistically defined and the client and/or therapist agree that this

captured their therapy experience. Transferability of the model of non-response proposed in the current review may be compared to such studies to seek any disparities.

As this review relied on retrospective accounts of therapy, it would be valuable to capture the process of non-response as it occurs in the therapy process. One problem with synthesising the studies in the current review is that the length of time after therapy ended varied. This means that the impact of reflection over time is not clear. This may in part help to explain the varying views of the same outcome category. For example, it may be possible that participants were able to reflect on helpful aspects of therapy after a certain amount of time. This is of course a hypothesis, which there is value in exploring perhaps in a study which collects data at specific time points after therapy. Furthermore, as a key aspect of non-response appeared to be clients holding something back from the process, with a retrospective study it is impossible to identify whether clients entered therapy with the view of not fully engaging, or this may have occurred through therapy. This cannot be fully understood through retrospective research design, it would be helpful to explore the mechanisms of this phenomenon by identifying if withholding is an indicator of therapeutic problems or a mediator of problems.

It would be useful for further research to implement case tracking to identify trajectories and implementing strategies to explore change in outcome. This review has postulated that a change in therapy is needed once therapy failure is identified, therefore exploration in this topic area may help to develop effective strategies to change the trajectory of therapy.

Conclusion

To the best of my knowledge, this QES was the first to attempt to synthesise the client and therapist experience of non-response, where deterioration and harm were avoided where possible to isolate non-response phenomena. This synthesis resulted in a proposed model of non-response which was characterised by difficult emotional experiences from both client and therapist perspectives and a tendency for both to hold something back from the relationship and the process. There were themes of mistrust and misunderstanding in the therapeutic relationship and a sense of misalignment in the therapeutic approach to therapy which was not what clients or therapists were expecting. A key finding was the overlap between the non-response literature and the deterioration and harm research. This suggests that non-response is in fact not an experience of no change, but that non-response experiences are painful for clients who were left feeling as though therapy was not worth their investment, which has clear clinical implications for both clients and therapists. There was however a subset of clients who experienced a positive therapy. This may indicate flaws in the way therapeutic outcome is measured, however there were also important experiences of hope which was interpreted as important in the continuation of therapy.

Final Reflections

Embarking on this topic has been a challenging but rewarding experience. I feel privileged to have read the words of so many clients and therapists who have shared their experiences on a difficult topic. I hope I have brought justice to the experiences of the participants. Throughout the stages of analysis, I have felt a pull to step into my therapist shoes rather than view the data from a researcher perspective. For example, I found myself trying to understand what may have been occurring for therapists as clients were describing their experiences. It took a conscious effort to note what I may have been experiencing and return to the position of researcher, although I acknowledge that this will have inevitably impacted my interpretations of the data and my researcher and therapist selves are not separate. I have begun to notice how this research has had an impact upon my clinical practice, as it has helped me to hold in mind the words of clients who have had a non-responding experience, which ultimately left them impacted after the therapy had ceased. I hope that this thesis will also provide further acknowledgement of the negative outcomes of therapy and that this should not be shied away from but embraced in order to improve clinical practice, so ultimately we can provide the best care we can for clients.

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List of Abbreviations

QES	Qualitative Evidence Synthesis
RCT	Randomised Controlled Trial
NHS	National Health Service
CORE-OM	Clinical Outcomes in Routine Evaluation Outcome Measure
CCI	Client Change Interview
YAPP	Young Adults Psychotherapy Project
PICo	Population, Phenomenon of Interest, and Context tool
PRISMA	Preferred Reporting Items for Systematic Reviews and Meta-Analyses
ENTREQ	Enhancing Transparency in Reporting the Synthesis of Qualitative Research
PROSPERO	International Prospective Register of Systematic Reviews
Medline	Medical Literature Analysis and Retrieval System Online
PsycINFO	Psychological Information Database
Embase	Excerpta Medica Database
CINAHL	Cumulative Index to Nursing and Allied Health Literature
Ethos	E-Theses Online Service
DClinPsy	Doctorate in Clinical Psychology
CASP	Critical Appraisal Skills Programme
JBI	Joanna Briggs Institute Critical Appraisal
RETREAT	Review Question, Epistemology, Time/Time Scale, Resources, Expertise, Audience and Purpose, and Type of Data
EPPI-Reviewer	Evidence for Policy and Practice Information and Co-ordinating Reviewer software
MBSR	Mindfulness Based Stress Reduction
GPS	Ghent Psychotherapy Study
CPDS	Christchurch Psychotherapy for Depression Study
CBT	Cognitive Behaviour Therapy
IPA	Interpretative Phenomenological Analysis
GT	Grounded Theory
CAMHS	Child and Adolescent Mental Health Service
DBT	Dialectical Behaviour Therapy
BME	Black and Minority Ethnic
GP	General Practitioner
GRADE CERQual	Grading of Recommendations Assessment, Development and Evaluation - Confidence in the Evidence from Reviews of Qualitative Research
SoQF	Summary of Qualitative Findings
CFT	Compassion Focused Therapy
TTM	Transtheoretical Model of change

APPENDICIES

Appendix A: ENTREQ Items

Table A1

ENTREQ Items Used to Support Transparent Review Reporting (Tong et al., 2012)

No.	Item	Considerations
1	Aim	Report the research question the review is seeking to address.
2	Synthesis methodology	Identify the synthesis methodology or theoretical framework which underpins the synthesis, and describe the rationale for choice of methodology.
3	Approach to searching	State whether the search was pre-planned or iterative.
4	Inclusion criteria	Specify the inclusion/exclusion criteria.
5	Data sources	Describe the information sources used and when the searches were conducted; provide the rationale for using the data sources.
6	Electronic Search Strategy	Describe the literature search.
7	Study screening methods	Describe the process of study screening.
8	Study characteristics	Present the characteristics of the included studies.
9	Study selection results	Identify the number of studies screened and provide reasons for study exclusion.
10	Rationale for appraisal	Describe the rationale and approach used to appraise the included studies or selected findings.
11	Appraisal items	State the tools, frameworks and criteria used to appraise the studies or selected findings.
12	Appraisal process	Indicate whether the appraisal was conducted independently by more than one reviewer and if consensus was required.
13	Appraisal results	Present results of the quality assessment and indicate which articles, if any, were weighted/excluded based on the assessment and give the rationale.
14	Data extraction	Indicate which sections of the primary studies were analysed and how were the data extracted from the primary studies?
15	Software	State the computer software used.
16	Number of reviewers	Identify who was involved in coding and analysis.
17	Coding	Describe the process for coding of data.
18	Study comparison	Describe how were comparisons made within and across studies.
19	Derivation of themes	Explain whether the process of deriving the themes or constructs was inductive or deductive.
20	Quotations	Provide quotations from the primary studies to illustrate themes/constructs, and identify whether the quotations were participant quotations the author's interpretation.
21	Synthesis output	Present rich, compelling, and useful results that go beyond a summary of the primary studies.

Appendix B: Search Strategy Example for Database Searching

Table B1

Search Strategy for OVID Medline(R) All 1946 to 2021 Database Search

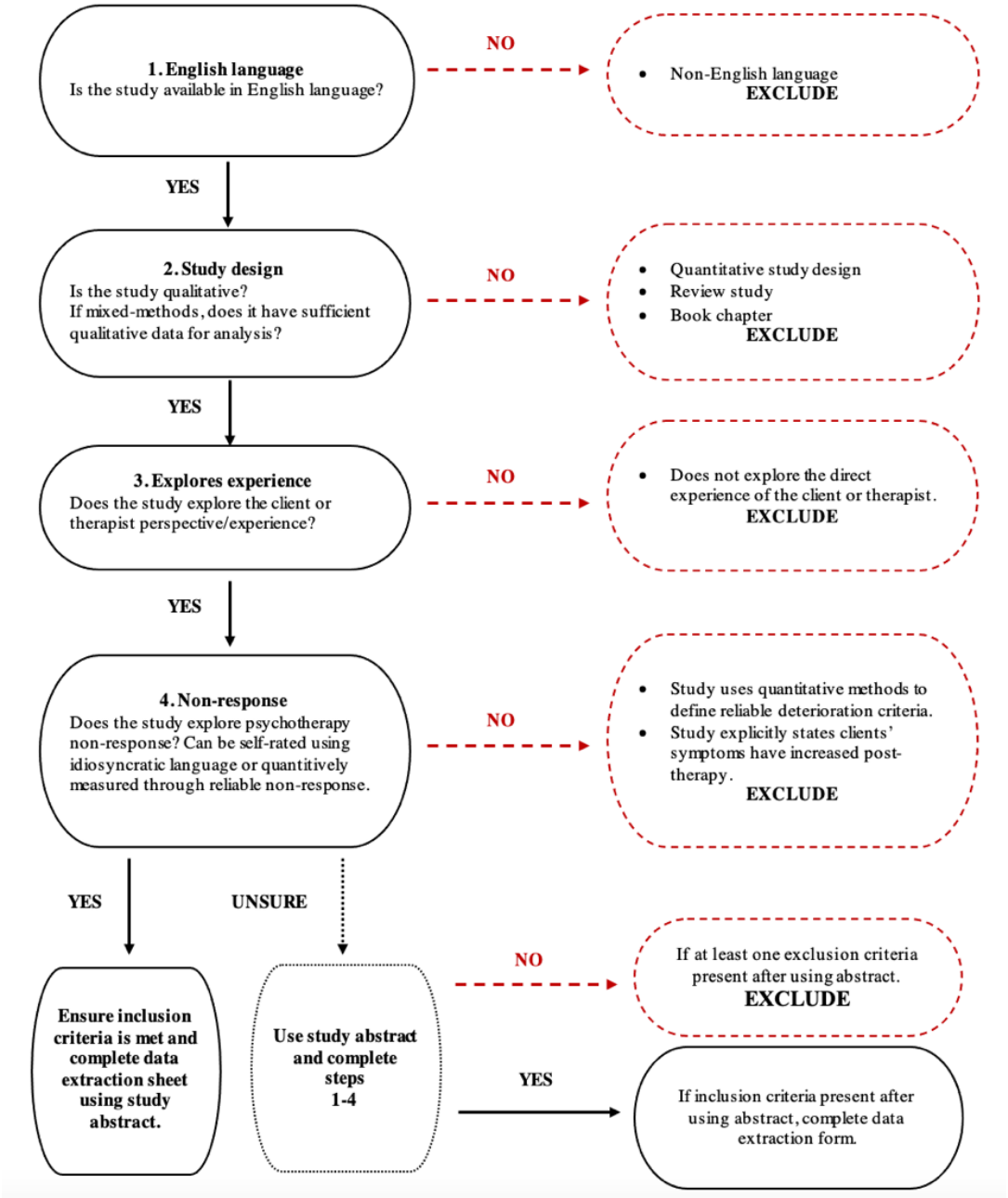
	Searches	Results
1	((talking OR psychol* OR counsel*) ADJ3 (therap* OR treatment* OR intervention*)).tw.	28,333
2	((cognitive or dialectical or compassion or "solution focused" or schema) ADJ3 (therap*)).tw.	25,464
3	(CBT or ISTDP or psychotherap* or counsel*).tw.	167,245
4	exp Psychotherapy/	201,626
5	1 or 2 or 3 or 4	346,799
6	("negative processes" or non-improv* or nonimprov* or "no improv*" or dissatisf* or non-respond* or "non respons*" or nonrespons* or "no response" or unchang* or "treatment fail*" or "fail* in treatment*" or "no change" or "no effect").tw.	535,651
7	((no OR non OR lack OR poor OR negative OR absence) ADJ3 (improv* OR respons* OR outcome* OR change OR effect)).tw.	755,036
8	((unchang* OR dissatisf* OR unsatisf* OR unsuccess* OR negative OR unhelpful OR disappoint*) ADJ5 (treatment* OR therap* OR psychotherap* OR outcome*)).tw.	67,168
9	Treatment failure/	35,956
10	("drop* out" OR drop-out* OR "prematur* terminat*" OR "hindering event*").tw.	18,138
11	((terminat* OR withdr*) ADJ3 (therap* OR psychotherap* or counsel*)).tw.	5,593
12	6 or 7 or 8 or 9 or 10 or 11	1,051,328
13	((semi-structured or semistructured or unstructured or informal or in-depth or indepth or face-to-face or structured or guide*) ADJ3 (interview* or discussion* or questionnaire*)).tw.	140,826
14	((therapist* or patient* or client* or service user*) ADJ3 (perspective* or view*)).tw.	30,438
15	(patient* and therapist* perspective*).tw.	119
16	("focus group*" or qualitative or "key informant").tw.	276,821
17	interviews as topic/ or focus groups/ or narration/ or qualitative research/	139,188
18	("thematic analysis" or narrative or "interpretive phenomenological analysis" or "case series" or "case stud*" or "discourse analysis").tw.	248,327
19	Grounded theory/ or hermeneutics/	2,312
20	("mixed model*" or "mixed design*" or "multiple method*" or multimethod* or triangulat* or "mixed method*" or mixed-method).tw.	63,815
21	13 or 14 or 15 or 16 or 17 or 18 or 19 or 20	685,785
22	5 and 12 and 21	1,613

Qualitative filter used for this search strategy by Wagner et al. (2020).

Appendix C: Title and Abstract Screening Flowchart

Figure C1

Screening Flow Chart



Appendix D: Co-Rating Discrepancy Screening Examples

Table D1

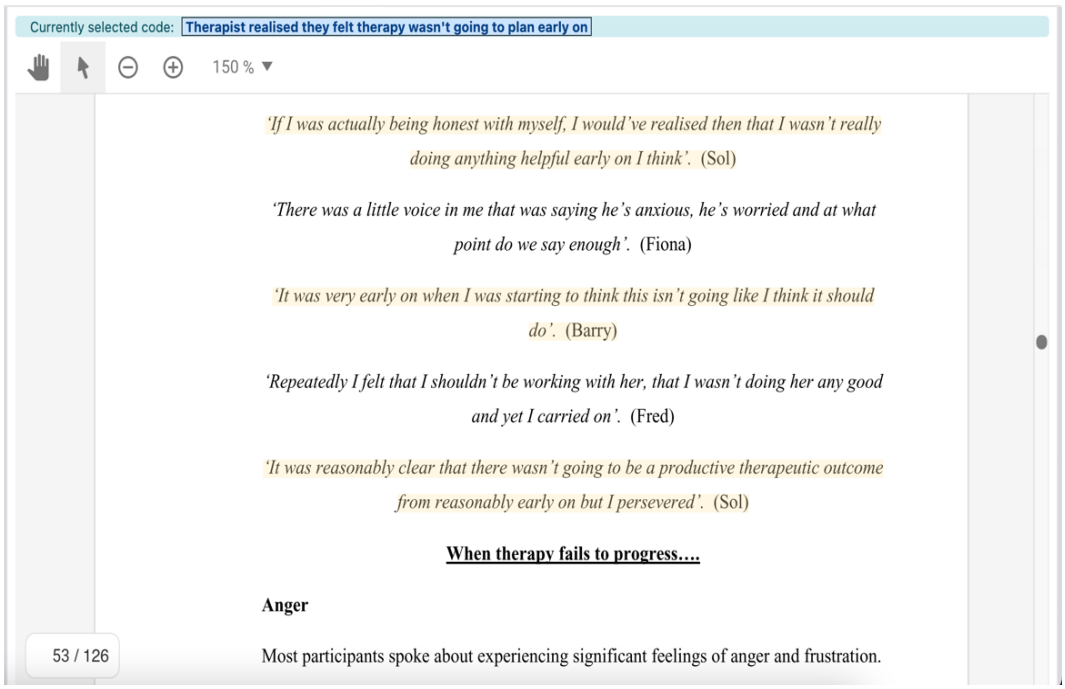
Examples of Co-Reviewer Discrepancies at Abstract and Full Text Screening Stage

	Paper Title and Author	Reviewer 1 (author) Decision	Reviewer 2 Decision	Reviewer 3 Decision	Decision After Discussion with Screener 1
Abstract screening	Attachment-based family therapy and individual emotion-focused therapy for unresolved anger: Qualitative analysis of treatment outcomes and change processes (Steinmann et al., 2017).	Include	N/A	Exclude; wrong topic: Successful outcome	Include – although the focus was on successful outcome there was mention of unstained positive change and negative outcomes, therefore this needs to be reviewed at full text.
Full text screening	An exploratory study of premature termination in child analysis (Midgley & Navridi, 2006)	Exclude: Not looking at nonresponse	Include	N/A	Exclude: Thematic analysis of data from assessment session - not exploring their therapy experiences.

Appendix E: Example Line-by-Line Coding

Figure E1

Line-by-Line Coding Using EPPI-Reviewer Software



Note. The initial code the data is being assigned to in this example is 'therapist realised they felt therapy wasn't going to plan early on.'

Appendix F: Example of Line-by-Line Coding and Data

Table F1

Example of Line-by-Line Coding with Assigned Initial Data

Initial Line-By-Line Code	Participant Data
Therapy increased self-analysing/self-focus which was not good (code 41)	**Crowe et al. (2012):** "I'm getting in to too much self-analysing; it's not good for me. It just stirs things up." **Lundkvist-Houndoumadi and Thastum (2017):** "Youths' attention appeared to become self-focused." **Radcliffe (2014):** "So I've got to go away on my own and sort out the problems that I've been trying to…deal with for my whole life and in the last four years have been brought to a position of…complete…separation of all the different problems and my ways of coping with them and being told categorically that I am wrong about those things and that my ways of dealing with it are…damaging to me and non-beneficial to anyone around me." **von Below and Werbart (2012):** "Insight into the patient's problems or feelings could lead to sadness, loss of hope, or difficulties in sharing feelings and thoughts with others." **Werbart et al. (2015):** "It's much easier if you have high standards and live up to them in practice and not have to think so much, but now I'm sort of processing it all, and that makes me try to lower my ambitions. On the other hand, I think I accomplish too little, so I feel a bit bad about that. So I think I've got some kind of performance anxiety that I never had before." **Werbart et al. (2019b):** "Sometimes she felt that the therapy was disturbing rather than helpful, and she became more self-focused than she wanted."

Appendix G: Examples of Descriptive and Analytical Themes and Subthemes

Table G1

Development from Initial Coding to Analytical Themes

Initial Codes	Descriptive Theme	Subtheme	Analytical Theme	Subtheme
39. Clients found therapy too difficult/emotionally effortful-takes a lot of energy to try something new/respond differently/dig deep	Psychotherapy is difficult to engage with	Therapy is emotionally difficult (codes 39, 72, 58)	A Difficult Task	Practical demands (66)
58. Low self-efficacy made it harder to engage with therapy and therapist		Therapy techniques are hard to learn and maintain – practically difficult (code 66)		Lack of cultural sensitivity and flexibility (codes 82, 83, 84)
41. Increased insight was unhelpful as clients became self-focused and aware of difficulties		Cultural sensitivity needs to be considered (codes 82 & 84)		Emotional Trade-off (39, 41, 58, 72)
72. Fear of losing self-control (being overwhelmed with intolerable emotions)		Flexibility with language barrier needs to be considered (code 83)		Therapy was different than expected (42, 62, 54, 71)
66. Hard to link therapy techniques to everyday life		Clients disappointed with the reality of therapy (codes 62 & 54)		
82. Therapists cultural assumptions could limit the amount that clients got from therapy		Having your eyes opened was not always helpful (41)		
83. Language barrier interfered with the therapeutic relationship				
84. Past experiences of discrimination induced fears of unfair treatment				
42. Mismatch of therapy modality and client preference				
62. Therapy was different to what clients had expected				
71. Therapist didn't do what they said they would do/what client expected				
54. Nothing new learnt through therapy- sense of being stuck (therapist not active enough, no continuity, structure, direction)				

Appendix H: Study Contributions to Client Perspective Themes

Table H1

Contributing Studies for Theme and Subtheme for Client Perspective

Client Perspective																			
Theme	**Subtheme**	**Reference**																	
Starting Therapy		**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**
Hopes and Fears	Anxious hope for change		X	X	X	X	X	X		X	X	X		X	X	X	X	X	X
	Used to failing		X		X	X	X	X		X		X	X	X	X			X	X
During Therapy																			
A Difficult Task	Practical demands		X		X	X	X			X		X							
	Lack of cultural sensitivity and flexibility			X					X										
	Emotional trade-off	X	X		X	X	X	X		X	X	X	X	X		X	X	X	
	Different from expected	X	X			X	X	X	X	X		X	X	X		X	X	X	X
Disconnected Relationship	Not enough trust	X	X	X			X	X	X	X		X	X	X	X	X	X	X	
	Holding back is self-protective	X	X			X	X	X		X	X	X	X	X	X	X	X	X	
	Not on the same page	X	X	X		X	X	X	X	X		X	X	X	X	X	X	X	X
	Feeling uncared for and invalidated	X	X					X				X		X	X	X	X		
Staying Involved	It's not just me?		X	X			X			X	X	X	X						
	Relationship positives		X	X		X			X			X	X	X			X		X
	Hope Remains							X				X		X	X	X			
Outcome																			
Not Worth the Investment	An unfulfilling experience	X	X			X	X	X			X	X		X	X	X	X		X
	Feeling stuck				X	X	X	X	X	X		X		X			X		

	Feeling Broken, Undeserving and Hopeless about Change	X			X	X	X	X		X		X	X	X	X	X	X		X
On a Trajectory for Improvement?	Therapeutic factors did lead to some improvement	X	X	X		X	X		X		X	X	X	X		X	X	X	
	Ending too soon?			X		X				X	X	X		X	X	X	X		X

Note. 1. Adler (2013), 2. Archard (2013), 3. Bellesi et al. (2020), 4. Crowe et al. (2012), 5. De Smet et al. (2019), 6. Hjeltnes et al. (2018), 7. Homan (2019), 8. Laszloffy (2000), 9. Lundkvist-Houndoumadi & Thastum (2017), 10. MacLeod (2017), 11. Morton (2019), 12. Olofsson et al. (2020), 13. Radcliffe et al. (2018), 14. Stige et al. (2021), 15. Von Below & Werbart (2012), 16. Werbart et al. (2015), 17. Werbart et al. (2019b), 18. Westra et al. (2010)

Appendix I: Study Contributions to Therapist Perspective Themes

Table I1

Contributing Studies for Theme and Subtheme for Therapist Perspective

Therapist Perspective							
Theme	**Subtheme**	**Reference**					
Starting Therapy		**1**	**2**	**3**	**4**	**5**	**6**
High Expectations	Unrealistic expectations	X		X	X	X	
	Connecting to the client	X			X		X
	This is challenging	X			X		X
During Therapy							
Experiencing a Disconnect	Limited trust	X	X	X	X	X	X
	Client held something back	X		X	X	X	X
	Absence of a shared purpose	X	X	X	X	X	X
Feeling Threatened	Demands of self	X	X		X	X	X
	Feeling ineffective	X	X	X	X	X	
Outcome							
Holding onto Hope	Hope for Ongoing Improvement	X		X	X	X	X
	Professional Learning	X	X		X		

Note. 1. Hopper (2015), 2. Laszloffy (2000), 3. McGowan (2000), 4. Morton (2019), 5. Werbart et al. (2019b), 6. Werbart et al. (2019a)

Appendix J: Confidence in the Evidence for Reviews of Qualitative Research (CERQual) Evidence Profile

Table J1

Confidence in the Evidence for Reviews of Qualitative Research (CERQual) Evidence Profile

Review Finding		Contributing Studies	Explanation of Confidence in the Evidence Assessment	Confidence in the Evidence
Client Perspective*				
Hopes and Fears • High expectations of therapy to be a cure or fix, to alleviate clients' problems. • Therapy felt like a risk for clients as they held low self-belief and uncertain of what therapy might entail, clients were resistant and sceptical.	Anxious Hope for Change	2, 3, 4, 5, 6, 7, 9, 10, 11, 13, 14, 15, 16, 17, 18	**Methodological limitations (moderate concerns):** Ten low concern studies, three moderate concern studies, and two high concern studies contributed. Main limitations: unclear theoretical underpinnings and researcher reflexivity not reported. Limited justification of research design and stages of analysis were also problems in the lower quality studies. **Coherence (moderate concerns):** Data are consistent within and across studies. The clients across the studies described seeking support in the context of wanting to make positive changes to their lives, however there was anxiety reported about what therapy entails. The anxiety and desperation to change is a more interpretative understanding of the data therefore there may be another way of conceptualising this feeling from participants. **Adequacy (moderate concerns):** Most studies contributed data reflecting a want for change in their lives and a sense of desperation for this, this was consistent across the data and a sufficient number of participants contributed. However, there were some studies which failed to capture the experience of unrealistic expectations, the phenomenological studies contributed most to this aspect. **Relevance (minor concerns):** Eleven studies were directly, four were partially relevant (mostly attributed to the potential of another phenomenon under exploration due to the original studies conceptualisations of self-defined dissatisfaction).	Moderate confidence
	Used to failing	2, 4, 5, 6, 7, 9, 11, 12, 13, 14, 17, 18	**Methodological limitations (moderate concerns):** Eight low concern studies, three moderate concern studies, and one high concern contributed. Main limitations: unclear position of the researcher in relation to the phenomena explored, unclear research design and stages of analysis. **Coherence (moderate concerns):** Most of the contributing studies described in sufficient detail experiences of fear, resistance, scepticism, and apprehension. There were also consistent descriptions of a fear of failure across and within studies alongside author interpretations in the data for this resistance as self-protective. However, the conceptualisation in this review of therapy feeling like a risk due to this is interpretative and so may have other explanations.	Moderate confidence

			Adequacy (minor concerns): Most of the contributing studies described in adequate detail experiences of fear, resistance, scepticism, and apprehension. This was seen in rich detail across seven studies, whilst the other studies contributed thinner data. **Relevance (minor concerns):** Eight studies were directly relevant, four were partially relevant (attributed to the potential of another phenomenon under exploration due to the original studies conceptualisations of self-defined dissatisfaction).	
<u>A Difficult Task</u> • Therapy lacked cultural sensitivity and flexibility • Therapy was emotionally taxing for clients. It took a lot of energy to engage in therapy which made clients question if therapy was worth it the emotional investment. • Therapy was different to what clients had expected, this caused clients to hold back on their engagement.	Practical demands	2, 4, 5, 6, 9, 11	**Methodological limitations (moderate concerns):** Four low concern studies, one moderate concern, and one high concern contributed. Methodological limitations concerned a lack of consideration of researcher reflexivity, and limited data analysis description so it is unclear how interpretations were developed. **Coherence (moderate concerns):** Finding is grounded in the data, participants across studies describe practical challenges to using therapy techniques. The aspect of the finding regarding practical difficulties are due to scaffolding problems is interpretative and so there may be other meanings to explain this. **Adequacy (serious concerns):** A relatively small number of papers contributed to this finding. Contributions were divided across studies; however, data was thin and were from a relatively small number of participants. The therapies that participants typically reported for this finding were more guided or skills based such as mindfulness and CBT. **Relevance (minor concerns):** Five studies were directly relevant, one study was partially relevant due to authors' operationalisation of lack of improvement (less than 60% improvement on outcome measure), which could encapsulate additional outcome categories.	Low confidence
	Lack of culturally sensitivity and flexibility	3, 8	**Methodological limitations (serious concerns):** One study with high concern, and one study with moderate concerns which was published in the Clinical Psychology Forum, therefore the word limit likely contributed to the low methodological quality appraisal, nevertheless there was limited or no reporting of theoretical coherence, researcher reflexivity, research design and analysis stages. **Coherence (minor concerns):** The data were consistent within and across the two studies regarding a lack of cultural sensitivity. **Adequacy (serious concerns):** One study provides rich in-depth data; the second study's data is thinner. This finding is based on a very small number of participants. **Relevance (no or very minor concerns)**: Both contributing studies were of direct relevance.	Low confidence
	Emotional trade-off	1, 2, 4, 5, 6, 7, 9, 10, 11, 12, 13, 15, 16, 17	**Methodological limitations (moderate concerns):** Nine low concern, three moderate concern, and two high concern studies contributed to this finding. The main limitations regarded unclear theoretical underpinnings and researcher reflexivity, limited justification of research design and stages of analysis were also problems in the lower quality studies. **Coherence (moderate concerns):** The finding that therapy was emotionally demanding is grounded in the data from contributing studies. There were clear descriptions of increasing insight being an unwanted experience. The idea of an emotional trade-off is more interpretative and thus should be	Moderate confidence

			acknowledged that this was a sense of the data from the primary reviewer, and there may be other interpretations of this phenomenon. **Adequacy (moderate concerns):** Most of the data were supported by two phenomenologically orientated theses which provided rich participant quotes. Although the remaining studies contributed, this data was thinner across fewer participants. **Relevance (minor concerns):** Nine studies are directly relevant, and five studies are partially relevant due to self-defined dissatisfaction as there is potential for this to be exploring an alternative phenomenon.	
	Different from expected	1, 2, 5, 6, 7, 8, 9, 11, 12, 13, 15, 16, 17, 18	**Methodological limitations (minor concerns):** Nine low concern studies, four moderate concern studies, and one high concern study contributed to this finding. Main limitations: unclear methodological congruence, unreported researcher reflexivity, and limited justification of research design and stages of analysis. Recruitment strategy was unclear in one study. **Coherence (moderate concerns):** There was coherence in the data between and within contributing studies, regarding clients describing wanting a different type of therapy approach, however some studies contributed more rich detail than others, therefore some studies offered thinner data. More participants reported wanting more activity from their therapist, however this was not always the case as some reported a want for more exploratory methods. **Adequacy (minor concerns):** Detailed data provided from most studies; two studies provided thinner data. **Relevance (minor concerns):** Ten studies are directly relevant, and four studies are partially relevant due to self-defined dissatisfaction as there is potential for this to be exploring an alternative phenomenon.	Moderate confidence
<u>Disconnected Relationship</u> • Therapy and the therapist were not seen as a safe base for clients to fully open-up and be vulnerable. Clients feared judgement from their therapist. The relationship was not fully trusting and so clients avoided feelings of shame and judgement by not sharing everything with their therapist. • There was a lack of mutual collaboration	Not enough trust	1, 2, 3, 6, 7, 8, 9, 11, 12, 13, 14, 15, 16, 17	**Methodological limitations (minor concerns):** Nine low concern, four moderate concern and one high concern study contributed to this finding. The main limitations were around the unclear position to the researcher in relation to the phenomena explored. **Coherence (moderate concerns):** The theme lack of trust was relatively interpretative in nature therefore there may have been other understandings of this process, however there were descriptions in the data of an insecure relationship and mistrust which provided strength to the coherence. Poor match of therapist was clearly grounded in the data. Although there are rich descriptions provided by sufficient number of participants, there are different aspects to this theme which may lessen the coherence overall of the understanding of lack of trust. **Adequacy (minor concerns):** The studies of lower quality contributed less to this finding. There was rich detailed data provided by studies of higher quality. **Relevance (moderate concern):** There were nine studies of direct relevance, and five studies of partial relevance which used self-defined dissatisfaction and drop-out due to no change. It is possible that these different outcome categories other than non-response were captured.	Moderate confidence
	Holding back is self-protective	1, 2, 5, 6, 7, 9, 10, 11, 12,	**Methodological limitations (minor concerns):** Nine low concern, four moderate concern, and one high concern study contributed. Limitations were around the unclear position to the researcher in	High confidence

as therapists and clients were not always in agreement of therapy goals, focus and/or direction. This lack of agreement led to clients feeling unseen, thus increasingly reluctant to engage. • A lack of rupture and repair meant that the therapeutic relationships did not feel genuine.		13, 14, 15, 16, 17	relation to the phenomena explored due to theoretical underpinnings and researcher reflexivity not reported sufficiently. **Coherence (minor concerns):** The findings are well grounded in the data across studies there are descriptions of clients resisting full engagement through withholding information and not committing to the process of therapy. There were descriptions consistent with not opening-up being a process of clients protective themselves. **Adequacy (minor concerns):** Contributions were divided across the papers with detailed rich data to explain the finding, this was also across a sufficient number of participants. **Relevance (minor concerns):** Nine studies were of direct relevance, five were of partial relevance.	
	Not on the same page	1, 2, 3, 5, 6, 7, 8, 9, 11, 12, 13, 14, 15, 16, 17, 18	**Methodological limitations (minor concerns):** Ten low concern, five moderate concern, and one high concern study contributed to the finding. Main concerns are last of researcher positioning in relation to the research, and unclear recruitment strategies for two papers. **Coherence (moderate concern):** The theme is vague in name, not being on the same page referred to clients describing a lacking in collaboration. Although this finding is grounded in the data, there are multiple aspects to the theme such as clients blaming therapists, which is less supported by the data overall. **Adequacy (minor concern):** Rich data provided within and across studies across a sufficient number of participants. **Relevance (minor concerns):** Eleven studies were directly relevant; five studies were partially relevant due to the use of dissatisfaction in primary studies.	Moderate confidence
	Feeling uncared for and invalidated	1, 2, 7, 11, 13, 14, 15, 16	**Methodological limitations (no or very minor concerns):** Seven low concern and one moderate concern studies contributed to the finding. **Coherence (minor concerns):** Clear descriptions of lack of care and invalidation from across and within contributing studies. One difference within the finding is that there are some participants who describe a more harmful experience of invalidation. **Adequacy (moderate concerns):** Rich contributions from five of the studies, whilst the remainder contributed thinner data. However, this was from a relatively limited number of participants. **Relevance (moderate concerns):** Four studies were directly relevant and four partially relevant.	Low confidence
<u>Staying Involved</u> • Although the majority of clients mainly described more negative experiences than good, clients remained in therapy showing therapy was not a wholly negative experience.	It's not just me?	2, 3, 6, 9, 10, 11, 12	**Methodological limitations (serious concerns):** Three low concern, three moderate concern, and one high concern study contributed to this finding. Main limitations included limited reporting on data analysis stages, unclear epistemological underpinnings, not reported researcher reflexivity. **Coherence (minor concerns):** Normalising and group cohesion experiences were grounded in the data. **Adequacy (moderate concerns):** Data richness and detail were varied across studies, furthermore this experience was reported more often in group therapy. **Relevance (moderate concern):** Six studies were directly relevant, and one was partially relevant due to the operationalisation of non-response in the original study.	Low confidence

• Normalising was a validating part of clients continued engagement with therapy, learning that this is a very common experience and a shift in perspective with the help of therapists was seen to be helpful. • Not all clients had a negative relational experience.	Relationship positives	2, 3, 5, 8, 11, 12, 13, 16, 18	**Methodological limitations (moderate concerns):** Five low concern, three moderate concern, and one high concern study contributed to this finding. Main limitations included limited reporting on data analysis stages, unclear epistemological underpinnings, not reported researcher reflexivity. **Coherence (moderate concerns):** Relational positives were detailed across studies, however there was nuance in this finding as some participants had a majority positive relational experience whereas other clients spoke of only minimal positive elements. Therefore, experience was varied, limiting coherence. **Adequacy (moderate concerns):** Most contributing studies provided rich and detailed data regarding positive relational experiences. However, 50% of studies did not contribute to this finding so there are reasonable concerns to be acknowledged regarding adequacy due to this. **Relevance (minor concern):** Eight studies were directly relevant, and one was partially relevant due to the operationalisation of non-response in the original study.	Moderate confidence
	Hope remains	7, 11, 13, 14, 15	**Methodological limitations (minor concerns):** Five low concern studies contributed to this finding. **Coherence (moderate concerns):** There are different aspects to this finding, as there is the aspect of hope remaining, which is relatively interpretative despite some clients and authors explicitly reporting this. There is also the aspect of acceptance and adjustment of expectations, therefore this causes some concern with coherence. **Adequacy (serious concerns):** Most contributing studies provided rich data to show this finding, however there is a limited amount from studies, for example from a small number of participants within studies. Additionally, there were only 5/18 studies to contribute. **Relevance (moderate concern):** Two studies were directly relevant, and three were partially relevant due to the operationalisation of non-response in the original study.	Low confidence
<u>Not Worth the Investment</u> • Therapy was experienced as disappointing, although some therapeutic gain, this was not enough to produce meaningful change for all clients.	An unfulfilling experience	1, 2, 5, 6, 7, 10, 11, 13, 14, 15, 16, 18	**Methodological limitations (moderate concern):** Nine low concern, two moderate concern, and one high concern study contributed. **Coherence (moderate concerns):** Data appear consistent between and within studies regarding an unfulfilled and disappointing experience. However, the overall theme of it not being worth the investment is interpretative and thus it is possible to have other underlying explanations. **Adequacy (minor concerns):** There are rich descriptions provided of clients describing disappointment with the therapeutic experience. Most papers offered detailed and rich data to support this finding. **Relevance (moderate concern):** Eight studies were directly relevant and four partially relevant due to original authors conceptualisations of poor outcome and drop-out studies.	Moderate confidence

Therapy had a limit to how helpful it was. • Clients got to a point of feeling stuck, they experienced cognitive dissonance in wanting to change but not achieving change. • Clients blamed themselves for non-response.	Feeling stuck	4, 5, 6, 7, 8, 9, 11, 13, 16	**Methodological limitations (moderate concern):** Six low concern, one moderate concern, and two high concern studies contributed. The main methodological concerns were regarding unclear theoretical coherence, lack of researcher reflexivity, and limited data analysis explanation in the lower quality studies. **Coherence (moderate concerns):** Data appear consistent and coherent within and between studies, participants described ambivalence and wanting to move forward without progression. However, there is interpretation within this finding of a sense of feeling 'stuck', this may not be how all participants would have described this experience for them. **Adequacy (minor concerns):** Most papers offered detailed data to support this finding, however some studies contributed quotes from a small number of participants from the contributing studies, limiting adequacy somewhat. **Relevance (minor concern):** Seven studies were directly relevant and two partially relevant due to original authors conceptualisations of poor outcome and drop-out studies.	Moderate confidence
	Feeling broken, undeserving, and hopeless about change	1, 4, 5, 6, 7, 9, 11, 12, 13, 14, 15, 16, 18	**Methodological limitations (moderate concerns):** Eight low concern, four moderate concern, and one high concern study contributed. Main limitations involved lack of researcher positioning to the data. **Coherence (minor concerns):** Data was consistent within and across studies, however the experience of feeling underservicing was less well grounded in the data. However, the finding is interpretative as not all participants may have described themselves as being fundamentally flawed, although some did use this language. Therefore, there may be alternative explanations to the finding. **Adequacy (minor concerns):** Most studies contributed detailed data towards this finding, the data appeared consistent across studies. **Relevance (moderate concerns):** Seven studies were directly relevant and six were partially relevant.	Moderate confidence
<u>On a Trajectory for Improvement?</u> • Therapy is a starting point for change for some. Clients described wanting more therapy and thought this would have produced change. • Some clients noted the restraints of healthcare	Therapeutic factors did lead to some improvement	1, 2, 3, 5, 6, 8, 10, 11, 12, 13, 15, 16, 17	**Methodological limitations (minor concerns):** Eight low concern, three moderate, and two high concern studies contributed. **Coherence (minor concerns):** Two studies that used RCI non-response resulted in the majority of data contributions for this finding. The remaining studies found a more balanced experience of some success amongst clear non-response. **Adequacy (moderate concerns):** A high methodologically concerning paper contributed rich and detailed data regarding this subject, this study found the experiences of non-responders were mostly positive with is an alternative majority finding. **Relevance (minor concerns):** Ten directly relevant studies and three partially relevant studies contributed.	Moderate confidence

systems such as time limits as an additional explanation for non-response.	Ending too soon?	3, 5, 9, 10, 11, 13, 14, 15, 16, 18	**Methodological limitations (moderate concerns):** Six low concern, three moderate concern and one high concern study contributed to this finding. One study that considerably contributed of moderate concern, was likely methodologically limited to publication word limitation, other problems were lack of researcher reflexivity. **Coherence (minor concerns):** Clear coherence between clients reporting a wish for more therapy as this would have resulted in a more successful outcome from their perspective. There was also data cogent with flexible therapy pacing. **Adequacy (minor concerns):** Data consistent across and within studies. **Relevance (minor concern):** Eight studies were directly relevant; two studies were partially relevant due to how authors operationalised non-response in original studies.	High confidence
Therapist Perspective**				
<u>High Expectations</u> • Therapists perceived clients to have entered therapy with unrealistic expectations of what therapy could achieve in terms of a positive change for them (for example symptom relief). • Therapists entered therapy with expectations of success and both internal and external pressures from services and clients. A minority of therapists described an initial connection to the client. • Therapists found the case difficult from early in the process, however they	Unrealistic expectations	1, 3, 4, 5	**Methodological limitations (minor concerns):** Three low concern and one moderate concern study contributed to this finding. Main limitations were an unclear recruitment strategy, concerns around the appropriateness of study design, and limited researcher reflexivity. **Coherence (moderate concerns):** Data consistent regarding client high expectations from most studies, study 3 did not contribute to this aspect of the finding adequately. Only study 1 had clear conceptual coherence to therapist internal pressure and service pressures. **Adequacy (moderate concerns):** Rich contributions to the finding divided across studies 1 and 4, thin data provided by studies 3 and 5. The studies include a reasonable number of participants, however as limited contributing studies overall relatively low number to support finding. **Relevance (no or very minor concerns):** The contributing studies were of direct relevance. Each study explored experiences of non-response and poor outcome.	Moderate confidence
	Connecting to the client	1, 4, 6	**Methodological limitations (no or very minor concerns):** Three studies with low methodological concerns contributed to this finding. **Coherence (minor concerns):** Therapists described a therapeutic connection with clients across studies, this is well grounded in the data. Therapists reported a bond with the client which helped it to feel safe to open-up past traumas. **Adequacy (serious concerns):** Two papers provided conceptually rich detail. Study 1 provided limited contribution. A relatively limited number of participants overall contributed to this finding. **Relevance (no or very minor concerns):** The contributing studies were of direct relevance. Each study explored experiences of non-response and poor outcome. There were three deteriorated clients in study 6, however, most were non-responders (*n*=5), seven therapists reflected on the experience of eight clients.	Low confidence

continued to offer therapeutic intervention.	This is challenging	1, 4, 6	**Methodological limitations (no or very minor concerns):** Three studies with low methodological concerns contributed to this finding. **Coherence (minor concerns):** Data appear consistent with review finding within and across studies. The challenge that faced one client in study 4 was described differently from the majority of the data, as their challenge was they found the client did not have severe enough difficulties for the service, rather than a complexity they did not know how to approach, although this was still conceptualised as a challenge. **Adequacy (serious concerns):** Contributions to the finding were seen across the papers however, study 1 contributed most to this finding. This finding is in the context of three contributing papers with a small number of participants contributing to the understanding. **Relevance (no or very minor concerns):** The contributing studies were of direct relevance. Each study explored experiences of non-response and poor outcome.	Low confidence
<u>Experiencing a Disconnect</u> • Therapists experienced a disconnect in the therapeutic relationship compounded by lack of trust. There was not a mutual understanding of clients presenting difficulties, which resulted in a lack of mutually collaborated direction for therapy. • Therapists experienced clients were resistive of full engagement with the therapist and/or therapy, this occurred even in the presence of positive relational experiences. • Therapists felt unable to genuinely discuss non-response clients in therapy in one contributing study (Hopper, 2015) due to fear of criticism and failure.	Limited trust	1, 2, 3, 4, 5, 6	**Methodological limitations (minor concern):** This finding was supported by four low concern, one moderate concern, and one high concern study. Main limitations included lack of justification and detail on research design, data collection and recruitment strategy; unclear theoretical underpinnings; and limited researcher reflexivity. **Coherence (moderate concern):** Data are consistent across studies regarding a disconnect in the relationship. The finding of a lack of trust was however interpretative, therefore there may be other interpretations of the data that could have led to the relational disconnect. **Adequacy (moderate concern):** Contributions were well dived across most of the studies with rich data to explain the phenomenon. Study 1 provided limited input to this finding and study 3 contributed just one quote. **Relevance (no or very minor concerns):** The contributing studies were of direct relevance. Each study explored experiences of non-response and poor outcome.	Moderate confidence
	Client held something back	1, 3, 4, 5, 6,	**Methodological limitations (no or very minor concerns):** Four low concern and one moderate concern study contributed to the finding. **Coherence (minor concerns):** Data are consistent within and across contributing studies. The finding is grounded in the data, although there is an interpretative element to this finding, there are examples of client's emotionally and experientially withholding. There were reports of scepticism, avoidance, and reflections that clients found it hard to bring emotion into therapy. **Adequacy (minor concerns):** Contributing studies provided rich detailed data towards this understanding. Study 3 and 5 provided limited contributions despite being coherent. Findings were rich from theses and the published study 6. **Relevance (no or very minor concerns):** The contributing studies were of direct relevance. Each study explored experiences of non-response and poor outcome.	Moderate confidence
	Absence of a shared purpose	1, 2, 3, 4, 5, 6	**Methodological limitations (minor concern):** Four low concern, one moderate concern, and one high concern study contributed. The main limitations regarded insufficient detail on research design,	High confidence

			recruitment strategy, epistemological underpinnings, data collection methods, depth of analysis and researcher reflexivity. **Coherence (minor concerns):** Data are consistent within and across contributing studies. The finding is grounded in the data. There were reports of a lack of understanding of client problems and an unequal collaboration (not working towards agreed goals and direction) in all the studies. **Adequacy (minor concerns):** Detailed, rich descriptions provided regarding a lack of shared collaboration from all contributing studies. The data provided were relatively even across studies. Regarding different perspectives between therapist and client, studies 1 and 4 provided rich detail, whereas studies 5 and 6 contributed with sufficient descriptive detail however was lacking in depth. **Relevance (no or very minor concerns):** The contributing studies were of direct relevance. Each study explored experiences of non-response and poor outcome.	
<u>Feeling Threatened</u> • Experiencing non-response was threatening for therapists. Boundaries blurred as therapists felt they were trying hard. Therapists could hold back from supervision and discussing the case with colleagues meaningfully (possible influence of imposter syndrome and external pressures to succeed). • Once non-response was accepted, therapists could become critical of clients and then self-blame for the outcome which left them feeling inadequate.	Demands of self	1, 2, 4, 5, 6	**Methodological limitations (minor concern):** Four low concern and one high concern study contributed. The high concern study was unclear regarding theoretical coherence, justification of data collection method unclear, reflexivity not reported, data analysis not sufficiently reported **Coherence (minor concerns):** There is a clear and cogent fit between the data and the review finding. Therapists reported challenging emotional reactions. Data regarding boundary blurring reported by studies 1 and 4 concerned therapists working harder than usual, study 6 contributed an understanding of over-involvement, studies 2 and 5 did not contribute to this aspect. **Adequacy (minor concerns):** Studies 1, 4, and 6 contributed the most data to this finding with rich detail. Study 2 and 5 contributed minimally but with direct coherent data. **Relevance (no or very minor concerns):** The contributing studies were of direct relevance. Each study explored experiences of non-response and poor outcome.	Moderate confidence
	Feeling ineffective	1, 2, 3, 4, 5	**Methodological limitations (minor concern):** Three low concern, one moderate concern, and one high concern study contributed. Main limitations in higher concern studies included lack of reporting on epistemological underpinnings, unclear research design, and the depth of analysis was not adequately explained, and no report of research reflexivity. **Coherence (moderate concerns):** Data coherent across contributing studies 1, 2, and 4 which are well grounded in the data. Studies 3 and 5 had limited contribution which could be interpreted in a different way as vague description therefore less cogent. **Adequacy (moderate concerns):** Phenomenological, theses contributed greatly to this finding. Study 2 also contributed detailed data however this is a high methodologically concerning study. Studies 3 and 5 contributed limited data. **Relevance (no or very minor concerns):** The contributing studies were of direct relevance. Each study explored experiences of non-response and poor outcome.	Moderate confidence
<u>Holding onto Hope</u> • Hope for change was key for the continuation of therapy, as therapists perceived clients did	Hope for Ongoing Improvement	1, 3, 4, 5, 6	**Methodological limitations (no or very minor concerns):** Four low concern and one moderate concern study contributed. Studies 5 and 6 were of psychoanalytic theoretical underpinnings in the interpretation which may have been prominent in the understanding in the relational process reported in this understanding. **Coherence (moderate concerns):** Contributing studies reported the positive changes clients were still able to gain from therapy despite simultaneously core remaining problems. Findings for positive	Moderate confidence

• get something from therapy despite problems remaining. • Therapists spoke about learning that they took away from the non-response cases. Their experiences could help them to readjust the pressure and responsibility they placed on themselves to produce change.			changes are well grounded in the data, however the element of hope is more interpretative and thus could be interpreted differently. **Adequacy (minor concerns):** Data was spread evenly across all contributing studies with rich reporting, except for study 5 which contributed only one quote. **Relevance (no or very minor concerns):** The contributing studies were of direct relevance. Each study explored experiences of non-response and poor outcome.	
	Professional Learning	1, 2, 4	**Methodological limitations (minor concerns):** Two low concern and one high concern study contributed to this finding. **Coherence (moderate concerns):** The data from studies 1 and 2 are grounded in the data, particularly from study 1 which reports learning opportunities to take into future clinical practice. However, there was a direct question regarding what learning did therapists take away, therefore this may not have been offered had this not been a direct question. Data from study 4 is more interpretative and provides less direct description of a learning for future clients. **Adequacy (serious concerns):** The majority of this finding is supported by study 1 which provides rich depth. There is very thin data from studies 2 and 4. Learning described from study 2 was also in the context of trainee therapists where they may have been more likely to comment on learning opportunities. **Relevance (no or very minor concerns):** The contributing studies were of direct relevance. Each study explored experiences of non-response and poor outcome.	Very Low confidence

Note. *Client perspective reference: 1. Adler (2013), 2. Archard (2013), 3. Bellesi et al. (2020), 4. Crowe et al. (2012), 5. De Smet et al. (2019), 6. Hjeltnes et al. (2018), 7. Homan (2019), 8. Laszloffy (2000), 9. Lundkvist-Houndoumadi & Thastum (2017), 10. MacLeod (2017), 11. Morton (2019), 12. Olofsson et al. (2020), 13. Radcliffe et al. (2018), 14. Stige et al. (2021), 15. Von Below & Werbart (2012), 16. Werbart et al. (2015), 17. Werbart et al. (2019b), 18. Westra et al. (2010).
**Therapist perspective reference: 1. Hopper (2015), 2. Laszloffy (2000), 3. McGowan (2000), 4. Morton (2019), 5. Werbart et al. (2019b), 6. Werbart et al. (2019a).