How do clients' previous therapy experiences affect how subsequent therapy is experienced and navigated by CBT therapists in NHS Talking Therapies services?

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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: Around a third of clients return to NHS Talking Therapies (NTT). Findings from practice-based studies suggest; (a) clients with previous NTT referrals have poorer outcomes; (b) therapists can find working with returning NTT clients stressful. This study aimed to explore NTT high-intensity cognitive behavioural therapists' experiences of working with therapy-experienced clients. Specifically, the study aimed to understand the impact clients' previous therapy experiences have on how therapists navigate and experience therapy, and the ways in which these experiences may facilitate or hinder subsequent therapy.

Method: Semi-structured interviews were carried out with twelve therapists. Therapists were invited to talk about examples of work with clients whose previous therapy experiences had appeared impactful. The resulting interview transcripts were analysed using reflexive thematic analysis.

Results: Four themes were created which represented therapists' diverse experiences with therapy-experienced clients. A single contextual theme: **Preventability of return – therapist lenses** described therapists' views on how therapy works, and the pressures therapists are subject to working in the NTT service context. Three further themes followed a temporal flow: (1) **Conducting a post-mortem of previous therapy**, captures therapists' approach to and interest in building a picture of clients' previous therapy experience; (2) **Previous therapy as a wellspring – setting the therapist's course**, explores how the picture of clients' previous therapy experiences generates emotional responses within therapists and influences how they approach therapy; and (3) **The big finale**, describes how therapists are left feeling in relation to the outcome of therapy and the extent to which their own therapy expectations were met.

Discussion: The findings are discussed in relation to the available literature. Clinical implications and directions for future research are outlined. Strengths and limitations of the study are also explored.

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Introduction

This thesis is focused on high-intensity cognitive behavioural therapists' experiences of working with therapy-experienced clients in the context of NHS Talking Therapy for depression and anxiety (NTT), previously known as Improving Access to Psychological Therapies (IAPT) services. Here, therapy-experienced refers to clients with a history of previous episodes of therapy, excluding interventions with minimal therapist input.

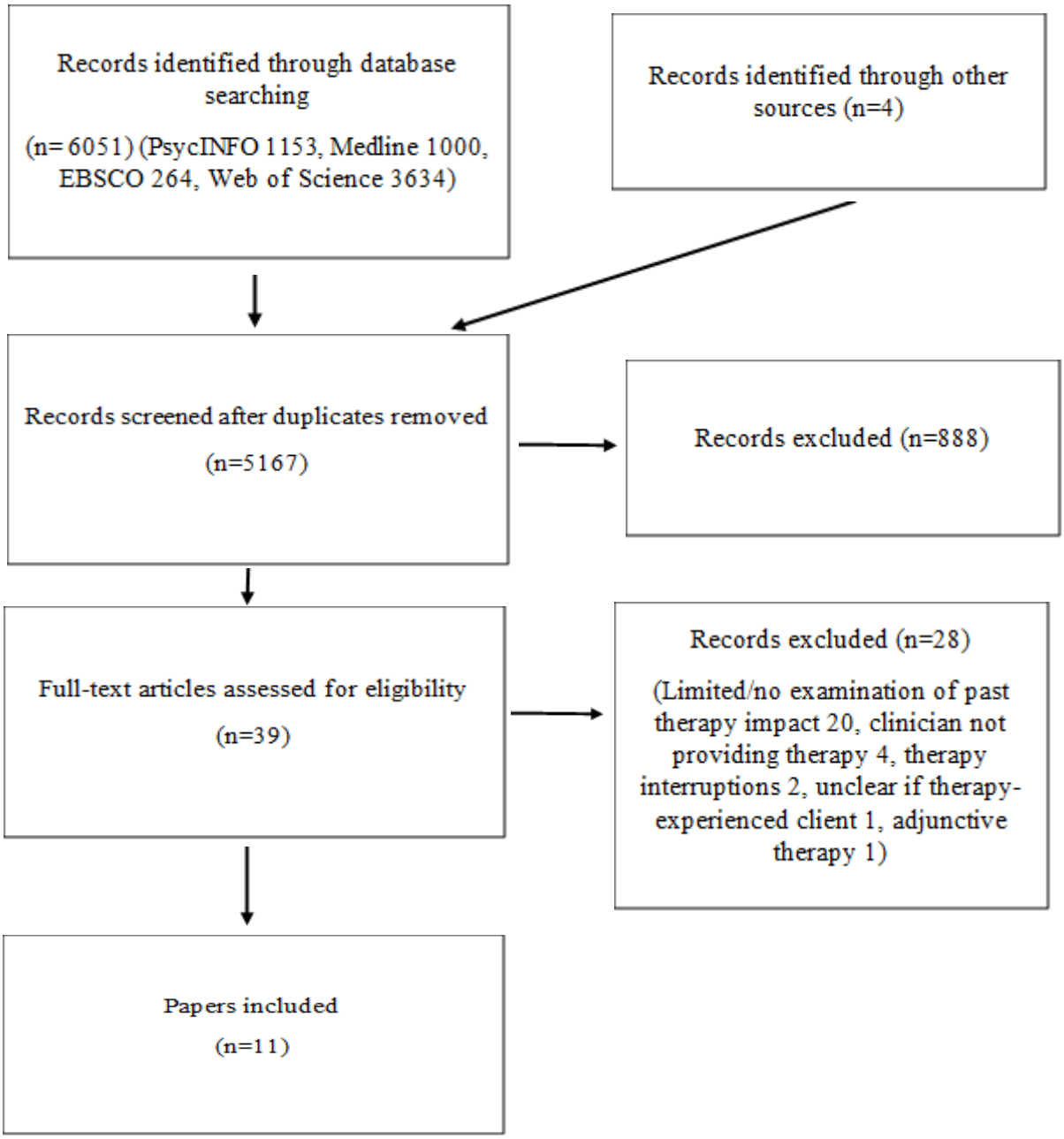
This chapter will present the following: literature searching approach; study setting and phenomenon of interest within it, including the rationale for this study; a summary of the broader psychotherapy process and outcome literature to contextualise the proposed study.

Approach to literature searching

Based on initial literature searches, it appeared that, to date, this research question not been answered and that few papers addressed this topic at all. A scoping search focused on therapists' experiences of working with therapy-experienced clients was completed to (a) ensure that these assumptions were correct; and (b) gather relevant material to guide study design. To reduce the risk of overlooking relevant papers, inclusive search terms were devised (see **Appendix A**) and executed in four major databases (PsycINFO, MEDLINE, EBSCO, Web of Science). This yielded many titles and abstracts to review, a limited number of full text articles to review, and a handful to include in this chapter (See **Figure 1.1**). The review process was guided by inclusion and exclusion criteria (See **Appendix A**).

Figure 1.1

Flow diagram for scoping review process



To identify any relevant papers published since the research was originally proposed, searches were repeated in July 2024 after the results were finalised (see **Appendix A**).

More informal searches were carried out to identify relevant literature to contextualise this study.

Working with therapy-experienced clients in NTT

In 2008, the NTT, or then IAPT, programme was initiated to provide access to evidence-based psychological therapies, as recommended by the National Institute of Health and Clinical Excellence (NICE), for common mental health problems, such as stress, depression, and anxiety-related disorders (Wakefield et al., 2021). Clinically, NTT was introduced to reduce a significant treatment gap and meet patient preferences for psychological therapies over medication. Economically, an invest-to-save case was made that successful treatment of common mental problems would reduce absenteeism and enable unemployed people to return to work, thereby increasing productivity and reducing benefit expenditure, as well as reducing use of NHS services in the longer term (Layard et al., 2007).

NTT services offer highly standardised, protocol driven therapies according to a stepped care model, starting with the least intensive and intrusive intervention likely to be successful (Wakefield et al, 2021). To reduce access barriers, self-referral to NTT services is encouraged. Clients are initially offered a brief screening assessment, often by telephone or increasingly online, to establish whether the service is suitable for their needs. Following this, clients deemed suitable are allocated to the appropriate step for their problem and level of need (Thornicroft, 2018; Rollwage et al., 2023). Progress in therapy is monitored every session using standardised symptom measures and if there is not improvement, clients may be stepped up to more intensive therapies (Clark et al., 2018).

The NTT stepped care model consists of Step 2 low-intensity therapies and Step 3 high-intensity therapies. Low-intensity therapies are brief, typically around six sessions and involve limited practitioner input. Clients are supported to use cognitive behavioural therapy (CBT) principles to alleviate distress in a variety of formats, including psychoeducational courses, computerised cognitive behavioural therapy, and individual guided self-help sessions (Wakefield et al., 2021).

High-intensity NTT therapies are longer in duration, between 10-20 sessions, and involve greater therapist input. Both individual and group formats are used (Wakefield et al., 2021). Most services offer a range of therapies, including interpersonal therapy, counselling, eye movement desensitisation and reprocessing therapy, mindfulness-based cognitive therapy. Several therapies are endorsed in NICE guidelines for depression (NICE, 2022). However, reflecting its dominance as therapy of choice in NICE guidelines, particularly for anxiety disorders (NICE, 2005; NICE, 2013; NICE, 2018; NICE 2020), at Step 3, most clients access individual CBT (Perfect et al., 2016), delivered by CBT therapists trained to postgraduate diploma level. Prior to undertaking NTT high-intensity CBT training, which prepares them to treat depression and anxiety disorders according to treatment manuals, therapists often have a core profession (e.g., mental health nursing) or are experienced psychological wellbeing practitioners (PWPs; Liness et al., 2019).

The NTT programme and its services are evaluated against various indicators of clinical performance, including access, reliable recovery (i.e., symptoms of depression and anxiety move from the clinical to the non-clinical range over the course of therapy), and reliable improvement (i.e., magnitude of symptom change exceeds that expected by chance; Clark et al., 2018). In 2021-2022, the NTT programme received 1.81 million referrals and provided access to therapy for 1.24 million (short of its 1.5 million target; Clark et al., 2018). Over half (53.4%) of referrals entering treatment were recorded as completed treatment episodes. Of those, two-thirds (66.9%) met criteria for reliable improvement, and half (50.2%) were recorded as having “moved to recovery” (NHS Digital, 2022). From April 2024, in response to concerns about large numbers of inappropriate referrals, targets for numbers of completed therapy episodes have replaced access targets (NHS Talking Therapies, 2024).

In addition to nationally reported performance statistics, evidence for the effectiveness of the programme can be derived from NTT practice-based studies. The results from a meta-analysis of 47 studies indicated large pre-post effect sizes of 0.87 (95% CI 0.79-0.97) for improvement in depression measured by the PHQ-9 and 0.88 (95% CI

0.790.97) for anxiety measured by the GAD-7, whilst a medium pre-post effect size of 0.55 (95% CI 0.48-0.61) was indicated for functional impairment measured by the WSAS (Wakefield et al., 2021). The effect sizes were robust to sensitivity analyses. Larger effect sizes were obtained for completer vs. intention to treat samples, studies with higher baseline GAD-7 scores and greater mean number of attended sessions (Wakefield et al., 2021).

Whilst, overall, it appears that the NTT programme has increased access to effective therapies, across NTT services there is significant variability in outcomes achieved (Clark, 2018). Cost effectiveness evaluations of NTT services have yielded inconsistent conclusions (McCrone, 2013; Mukuria et al., 2013; Radhakrishnan et al., 2013; Steen, 2020), and concerns about inadequate doses of therapy (Steen, 2020). Evidence suggests that poorer outcomes in NTT services correlate with service delivery factors (e.g., longer waiting times), wider systemic factors such as social deprivation (Clark et al., 2018; Delgadillo et al., 2016), and greater clinical complexity, including symptoms of psychosis (Knight et al., 2020); childhood trauma (Hepgul et al., 2016; Verbist et al., 2021); and personality disorder (Goddard et al., 2015; Hepgul et al., 2016). This has led to concerns about NTT therapists' competencies to work effectively with more complex presentations (Martin et al., 2022).

The NTT programme is criticised for promoting a highly medicalised, Western model of distress (Pickersgill, 2019). Specifically, distress is categorised into a particular disorder, quantified and monitored using outcome measures, and treated according to the corresponding protocol (Pickersgill, 2019). This locates sources of distress within the individual and de-emphasises systemic influences. The rigid application of disorder-specific protocols according to session numbers, determined by commissioners and services rather than clinical guidelines, is argued to reduce scope for a personalised, responsive approach to formulation and intervention (Roscoe, 2019). Therapy is cast as a technical enterprise, rather than a relational, dialogic one (Leonidaki, 2021). Evidence from qualitative studies supports some of these concerns. A study observing PWPs' sessions highlighted failures to

attune and respond to client distress, which were attributed to the protocolised approach to assessment and intervention (Drew et al., 2021), echoing reported client experiences (Marshall et al., 2016). Several studies examining NTT therapists' experiences have highlighted difficulties managing inflexible protocols, working in a target-driven culture, having limited space to reflect on responding to more complex needs, and the impact on their practice (e.g., depersonalising clients; Painter, 2018; Scott, 2018; Otero, 2019).

Another aspect of complexity of client need is treatment history. NTT services do not routinely report on re-referral rates. However, estimates derived from studies suggest between 32-38% of clients accepted for therapy in NTT have previous referrals to NTT (Hepgul et al., 2016; Verbist et al., 2022). This corresponds well with an estimated 32% re-referral rate derived from national NTT statistics acquired via a Freedom of Information request (Cotton, 2019). Re-referral rates are likely to differ across services: a recent cohort study based in one service reported a re-referral rate of 27% in a five-year period (Lorimer et al., 2024). Given these rates, a significant minority of any CBT therapist's caseload is likely to be re-referred clients.

Three studies have examined the impact of previous NTT referrals on therapy outcomes. Cairns (2014) found that just 12% of NTT re-referrals resulted in clients completing a course of therapy (cf. 43.4% of all referrals; NHS Digital, 2021). Consistent with this finding, compared to clients with no previous referrals to NTT, for those with previous referrals, the odds of drop out were increased by 50% per previous referral up to a limit of three (Verbist et al., 2022). The odds of recovery were also reduced by 30% per previous NTT referral (Verbist et al., 2022). These analyses controlled for several potential confounders, strengthening the conclusion that previous therapy referrals negatively influenced outcomes over and above disorder chronicity, baseline symptom severity, impaired functioning, and motivation for change (Verbist et al., 2022). A third study reported significantly lower recovery and reliable change rates for clients returning to an NTT service within a five-year period (Lorimer et al., 2024). However, in this sample, neither treatment effect sizes nor drop out were significantly associated with returner status.

Whilst the latter two studies used different statistical tests to estimate the effect of prior NTT experience on outcomes, other methodological differences could also account for these diverging findings. Lorimer and colleagues' study had a restricted follow-up period (1-5 years) and used database-recorded episodes consisting of two or more sessions as a measure of previous NTT input (Lorimer et al., 2024). In contrast, Verbist and colleagues' study used clinician-reported previous NTT referrals (Verbist et al., 2022), this may have included initial assessments only, increasing the number of referrals and ostensibly increasing the numbers of clients with histories of non-engagement (i.e. who only attended initial assessments). Nonetheless, taken together, these studies suggest clients returning to NTT are less likely to have their needs met, and that this likelihood increases with the number of previous NTT referrals.

Despite significant return rates in NTT services and poorer outcomes for returning clients, it appears there has been very limited exploration of how NTT therapists navigate working with therapy-experienced clients. The two available studies which addressed broader aspects of NTT clinicians' experiences highlighted challenges experienced by therapists working with clients who return to the service. Therapists' responses to a wellbeing survey highlighted that working with clients with repeated NTT referrals was a stressful experience which could bring up feelings of failure (Harper et al., 2020). This study suggests two pressures on therapists: the experience of providing therapy unlikely to meet client needs and the service pressure to offer therapy to clients unlikely to benefit from it. A longitudinal qualitative study following NTT therapists through their training and post-qualifying year identified similar concerns about working with clients with an extensive history of mental health service contacts (Hutten, 2018). Accordingly, what little that is known suggests, in the context of historical unmet mental health needs, working with therapy-experienced clients can be a source of stress for NTT therapists. Several studies indicate stress and burnout levels in NTT therapists exceed those of other health professionals (Steel et al., 2015; Turnpenny, 2019; Kostaki, 2018; Morris, 2019). Moreover,

burnout is correlated with caseload dissatisfaction, perceived pressure from targets (Morris, 2019) and poorer client outcomes (Delgadillo et al., 2018).

Taken together, this suggests working with therapy-experienced clients is a concern from the perspectives of staff wellbeing and client outcomes. This underlines the importance of gaining an understanding of how difficulties manifest in therapy and the therapeutic relationship with therapy-experienced clients, and how these are navigated by therapists. Given it is relatively common for NTT clients to have previous therapy experience, this also invites consideration of when and how this experience has a helpful impact on the therapeutic process. It is hoped answering these questions will provide valuable insights for NTT trainers, supervisors, and services that could improve client experience and reduce therapist burnout.

To focus the current study, high-intensity CBT therapists' experiences of working with clients who have previously accessed therapy, excluding interventions with minimal therapist input, will be examined. The reasons for this are three-fold: CBT is the dominant model in NTT; most clients accessing Step 3 therapies have CBT; focusing on clients with previous therapy experiences allows consideration of how these experiences may help or hinder subsequent CBT.

Research aims

The primary aim is to establish whether and how NTT clients' previous therapy experiences affect how subsequent therapy is experienced and navigated by high-intensity CBT therapists. Within this it is hoped to establish, how these previous experiences hinder or facilitate the subsequent therapy.

Contextualising the study

Having reviewed the NTT literature and introduced the research aims, the purpose of this section is to summarise salient findings from the broader psychotherapy outcome and process literature, with a particular focus on CBT where possible. Following this, literature examining outcomes for, and therapy process and therapists' experiences with,

therapy-experienced clients will be reviewed. Finally, the specific research questions will be introduced.

Psychological therapies: Efficacy and limitations

Pre- to post-treatment comparisons from NTT practice-based studies and national outcome data demonstrate the effectiveness of therapies, in reducing depression and anxiety symptoms, as delivered in routine practice. However, these effectiveness estimates do not account for the effects of spontaneous remission and natural symptom variation (Wakefield et al., 2021). By employing a control condition, efficacy estimates from randomised controlled trials do account for these effects, and so examining these patterns is instructive. Meta-analyses of RCTs indicate psychological therapies typically have a medium to large effect on reducing anxiety and depression symptoms compared to a wait list control (Asay & Lambert, 1999; Chen et al., 2019), and significantly smaller, in the small to medium range (Cuijpers et al., 2013; Zhang et al., 2019), or negligible (Chen et al., 2019) when compared to a psychological placebo. Some meta-analyses report effect sizes which do not significantly differ across therapies (Cuijpers et al., 2013; Santoft et al., 2019; Cuijpers et al., 2021). Other meta-analyses report significantly larger effect sizes for CBT (Mayo-Wilson et al., 2014; Zhang et al., 2019; Maass et al., 2020; Papola et al., 2022), albeit small to medium ones compared to a psychological placebo or care as usual (Cuijpers et al., 2013; Cuijpers et al., 2016; Santoft et al., 2019). Differences in effect size associated with the controls used, is thought to reflect the nocebo effect of temporarily withholding treatment (as wait list controls do) leading to decreased self-help efforts and symptom deterioration (Furukawa et al., 2014). Taken together, this points to two concerns: NTT recovery rates and effect sizes are likely to inflate stakeholder impressions regarding the success of therapies by failing to account for natural variation and remission; and given long waits for NTT therapies, some clients are likely to deteriorate prior to starting CBT (Baker, 2020).

Using mean symptom reduction as an efficacy estimate has its limitations and can obscure the poorer outcomes some clients experience (Westen & Morrison, 2001). By the end of therapy, a substantial proportion of clients are classed as non-improved (i.e.,

achieved less than 50% symptom reduction): 59% in acute phase therapy for depression; 46-54% post-therapy for anxiety disorder. Non-remission rates are also high: 66%-74% in acute phase therapy for depression (Cuijpers et al., 2021). Estimates of relapse rates for depression range from 29% within 12 months to 59% within two years among therapy responders (Vittengl et al., 2007). Lower relapse rates among clients accessing CBT are reported for anxiety disorders ranging from 14% for clients who achieved remission (mean follow-up nine months) to 23% (follow-up one to nine years; Lorimer et al., 2021; Levy et al., 2021), with residual symptoms predicting relapse (Lorimer et al., 2021). Extrapolating these findings to routine practice in NTT would suggest that even among clients who appear to respond to therapy, a recurrence of symptoms is likely, particularly among clients with residual symptoms and a previous history of difficulties. This may precipitate a return to NTT.

Looking beyond symptom data, client reported negative effects attributed to therapy include unmet expectations, difficulty understanding the therapy or therapist, feelings of failure, loss of hope, and loss of coping skills (Hardy et al., 2019; Strauss et al., 2021). Around 5% of clients accessing primary care therapy reported lasting negative effects (Crawford et al., 2016). Among 200 clients accessing CBT in routine practice, 15% reported negative effects (Gerke et al., 2020). In this sample, previous history of therapy was a significant predictor of reporting negative effects, providing further evidence that therapy-experienced clients are more likely to have negative experiences in therapy. Two qualitative studies of clients' experiences of unsuccessful therapy highlight difficulties understanding the therapy or engaging with painful material, superficial compliance or changes, self-blame for lack of desired changes, and reinforcement of negative self-narratives. Despite these experiences, some clients reported seeking further therapy (Werbart et al., 2015; Radcliffe et al., 2018).

Taken together, evidence suggests that psychological therapies have modest effects in reducing symptoms of anxiety and depression compared to care as usual or a psychological placebo, however, many clients do not improve and among those that do, relapse is

common. Unsuccessful therapy can evoke or reinforce feelings of failure and self-blame. Against this background, clients may still seek further therapy and be at greater risk for experiencing negative effects in therapy.

How does therapy work?

The purpose of therapy is to effect beneficial change in areas including thoughts, feelings, behaviours, interpersonal relationships, personality functioning, or quality of life (Hanna, 2002). Current understandings of how therapy might cause such change are limited to putative mediators and moderators of symptom change (Kazdin, 2009). Most of the research is correlational and does not suggest causation (Kazdin, 2009). Attempts to strengthen study designs involve use of repeated measures, time-lagged data, and adjustment for confounders (Cuijpers et al., 2019). Little progress has been made in identifying mechanisms of change, which describe and explain how change occurs within clients in more precise terms (Kazdin, 2009; Cuijpers et al., 2019). Two models are proposed: specific-factor models, which posit that therapy works because its specific methods facilitate theory-consistent changes in psychological functioning, and common factor models, which posit that processes common across therapies account for change (Cuijpers et al., 2019).

Within the broad church of CBT, it is assumed that distress is maintained by the content of and/or responses to thoughts, or by behavioural patterns which reduce opportunities for meaningful engagement with the world (Kennerley et al., 2017). These maintenance processes are targeted using attentional strategies (e.g., defusion), cognitive strategies (e.g., cognitive restructuring), or supporting behavioural change (e.g., graded exposure; Kazantzis et al., 2018). Consistent with a specific-factor model, meta-analyses indicate CBT has small to large effects on cognitive variables in both anxiety disorders and depression; small to large effects on behavioural change or processes in anxiety disorders; the addition of a specific CBT method has a small, significant effect on targeted outcomes (Bell et al., 2013; Kazantzis et al., 2018). More problematic for the specific-factor model of CBT are findings indicating cognitive change is observed with other therapies and

medication (Cristea et al., 2015). Further, cognitive change occurs concurrently with symptom change, at odds with the expected temporal relation (Quigley et al., 2019). The relative influence of specific over common factors may be disorder-specific (Norcross & Lambert, 2011). In CBT for depression, common factors were positively correlated with symptom improvement, whereas cognitive techniques were negatively correlated (Castonguay et al., 1996). However, for OCD, specific factors (i.e., exposure and response prevention) accounted for a significant proportion of the variance in symptom reduction, yet common factors did not (Strauss et al., 2018). Taken together, this suggests evidence for the specific factor model is mixed.

Among common factor models, Wampold's contextual model (2015) is most prominent (Cuijpers et al., 2019). According to this model, psychological therapies lead to change via one of three possible pathways; (a) a genuine relationship where negative affect can be freely expressed, providing clients, particularly those with difficult relational histories, with corrective experiences; (b) positive therapy expectations, clients are provided with compelling explanations of their difficulties and effective methods to reduce them; (c) promotion of healthy actions through therapy-specific methods, which rather than correcting a particular deficit, provide general benefit to the client. Each pathway is dependent upon the development of a therapeutic relationship (Wampold, 2015; Cuijpers et al., 2019). Providing support for the primacy of the therapeutic relationship, at least in the treatment of depression, a meta-analysis comparing non-directive counselling with therapies incorporating specific methods, estimated change in outcome due to extra-therapy factors was 33%, common factors 50%, and specific factors 17% (Cuijpers et al., 2012).

Meta-analyses have evaluated the association between elements of the therapeutic relationship and therapy outcomes in individual psychological therapies; results are summarised in **Table 1.1**. Each element is associated with a small to medium effect on outcomes, accounting for between 1-14% of the variance in outcome. Examining estimates of significance individually is somewhat misleading as these elements are likely to be closely correlated (Norcross & Lambert, 2018). In support of this, factor analysis of client

ratings of therapeutic relationship elements suggested two underlying, interrelated factors: confidence in the therapist (i.e., in their relational qualities) and confidence in the treatment (Finsrud et al., 2022a), suggesting critical roles for client expectations of therapy and the alliance.

Table 1.1

Therapeutic relationship elements and their strength of association with outcomes

Element of therapeutic relationship	Estimate of association with therapy outcomes as measured by r (95% CI)
Alliance	0.28 (0.26, 0.30)[a]
Goal consensus	0.24 (0.19, 0.28)[b]
Client-therapist collaboration	0.29 (0.24, 0.34)[b]
Positive regard	0.27 (0.16, 0.38)[c]
Empathy	0.28 (0.23, 0.33)[d]
Collecting client feedback	0.23 (0.15, 0.31)[e]
Treatment credibility	0.12 (0.04, 0.20)[f]
Congruence/genuineness	0.23 (0.13, 0.32)[g]
Outcome expectations	0.18 (0.14, 0.22)[h]
Repairing ruptures	0.29 (0.10, 0.47)[i]

[a]Flückiger et al. 2018; [b]Tyron et al., 2018; [c] Farber & Doolin, 2011; [d] Elliott et al., 2018; [e]Lambert & Shinokawa, 2011; [f]Constantino et al., 2018a; [g]Kolden et al., 2018; [h]Constantino et al., 2018b; [i]Eubanks et al., 2018

Despite the dominance of these models, dichotomising common and specific factors may be unsound, since they operate at different levels, and unproductive, by drawing attention away from understanding how they interact (Hill, 2005; Castonguay & Beutler, 2006). A panel of expert psychotherapy researchers agreed common and specific factors are interrelated, such that each common factor has a unique profile of associated specific therapeutic methods (Tschacher et al., 2014). Consistent with this view, the therapeutic relationship in CBT is characterised by generic elements such as alliance and empathy, and CBT-specific elements such as collaborative empiricism and Socratic dialogue (Kazantzis & Dobson, 2022). The therapeutic relationship is viewed as necessary for change, by providing scaffolding for the CBT techniques, strategies, and processes

(Dobson, 2022). Meta-analyses indicate that elements of the therapeutic relationship including alliance, goal consensus, collaboration, collecting feedback, setting homework, are each associated with small to medium effects on symptom and dropout outcomes in CBT (Cameron et al., 2018; Kazantzis et al., 2018; Luong et al., 2020). Alliance appears to have a more influential effect on outcomes for some clients, including clients with a low aptitude for CBT (Impala et al., 2022), and those with fewer previous episodes of depression (Lorenzo-Luaces et al., 2014, 2016).

Despite deficiencies in understandings of how therapy leads to change, there appears to be a broad consensus that the therapeutic relationship plays a crucial role. In CBT, this relationship provides an important context for specific interventions, which may be particularly influential in outcomes for some disorders.

Returning for therapy

Available studies suggest that returning for therapy is commonplace. Estimates of the percentage of clients who return to the same service are variable across setting and timeframe (for NTT figures see **Working with therapy-experienced clients in NTT**): 27% within a four-month period (Siddall et al., 1988); 14% within a year (Boerema et al., 2016); 32% to 39% within four years (Buchholz et al., 2017; Kilcullen et al., 2020) and 58% within five years (Bennett & Feldstein, 1986). The proportion of clients who are therapy-experienced may depend on the therapy provider; 80% of psychoanalysis clients have engaged previous therapy (Doidge et al., 2002).

Why do clients return?

For clients who cannot afford private therapy, the limitations of the healthcare system dictate the conditions under which they can return to access further therapy. US managed care programmes offer brief intermittent therapy, recognising each piece of work may not address all difficulties, with clients actively encouraged to return for further therapy (Neill, 2001; Barry et al., 2020). Often therapy access is capped: the Australian Better Access programme offers up to 10 therapy sessions per year (Beaton & Thielking, 2020); in Norway, clients on sick leave can access 15 therapy sessions to support them to

return to work (Stige et al., 2021). The NTT for anxiety and depression manual (2024) stipulates that clients should access up to the number of sessions recommended by NICE to achieve recovery from anxiety and/or depressive symptoms, however, does not place limits on returning for therapy. Some NTT services have introduced limits on returning clients (Leeds Mental Wellbeing Service, 2022).

Notwithstanding such practical limitations, within the literature, two narratives of client return dominate. The first frames returning to therapy as part of a developmental process, often prompted by new challenges; the second, as a consequence of therapy failure.

Developmental process

Within existential, humanistic, and psychodynamic models, which promote therapy for personal growth and personality integration (Tallis, 2020), returning to therapy is framed as an understandable consequence of lifespan development; confronting new crises, which evoke previously identified conflicts or hitherto unrecognised ones, and becoming stuck again (Siddall et al., 1988; Stern, 1988; Malin, 1990; Adatto, 1995; Motherwell et al., 2004). Freud (1937) suggested therapy should be terminated when the processes underlying client symptomatology have been addressed to such a degree there is no concern about return. However, he also recognised several factors (e.g., client characteristics, further life events) could challenge the likely success of such an endeavour. From this perspective, the notion of a successful complete therapy is a myth (Malin, 1990; Motherwell et al., 2004; Mendenhall, 2009) and many clients will access therapy throughout their lives, prompted by the recurrence of difficulties or readiness for further change (Budman & Gurman, 1988; Beitman, 1991).

It is argued clients are likely return because they found the previous therapy helpful (Stern, 1988). In line with this, around three-quarters of returning clients reported previous therapy was helpful, and over half wished to work on a new problem (Siddall et al., 1988). Survey-based studies examining therapists' perspectives on return highlighted clients briefly return in the context of symptom recurrence (Firestein, 1982), or to re-establish self-

analytic function temporarily overwhelmed by current circumstances (Hartlaub et al. 1985). Case studies of returning clients suggest continued development in the intervening period, with subsequent therapy providing an opportunity to build upon progress (Malin, 1990).

Therapy failure

Framing returning for therapy as a consequence of inadequate therapy (i.e., duration, delivery, content; VanDyke & Pollard, 2005; Stobie et al., 2007; Krebs et al., 2015) or a failure to provide therapy clients can make use of (Hanna, 2002) is associated with a medicalised approach to therapy, emphasising the treatment of disorders (Scott, 2006). From this perspective, so-called treatment resistant disorders or refractory cases occur because therapy was inadequately delivered, specialist therapy is required, or suitable therapies are yet to be developed (Hollon, 2010; Sookman, 2014).

From this perspective clients may return to therapy to fulfil unsatisfied needs. In support of this, a qualitative study examining 18 clients' experiences of time-limited therapy highlighted that over half of the clients left therapy with a sense of unmet need and desired further therapy (Stige et al., 2021). Two-thirds of brief therapy clients sought further therapy in the following year; half of these clients considered their original therapy too brief (Patterson et al., 1977). Whilst some studies suggest that clients accessing brief therapy are more likely to return (Gelso & Johnson, 1983; Boerema et al., 2016), return has also been associated with attending a longer course of therapy (Kilcullen et al., 2020).

Adequacy may also be conceptualised in terms of symptom change. In a cohort of over 1600 therapy clients, greater degree of post-therapy symptom change significantly predicted attending fewer therapy sessions over the subsequent 12-month period (Altmann et al., 2018). However, a study examining predictors of return to therapy over a four-year period failed to corroborate this finding (Kilcullen et al., 2020). Moreover, large studies comparing therapy-seeking clients and controls suggest therapy significantly increases (Fenger et al., 2014) or does not impact (Lazar et al., 2006) subsequent therapy or mental health service use, despite outcome data suggesting, on average, therapy clients had

benefited from therapy. Taken together, these studies suggest factors other than initial response to therapy are important in understanding why clients return.

Beyond client difficulties

A third possibility recognises a need to look beyond client difficulties as a reason for return, whether arising out of an understandable developmental process or inadequate previous therapy. Clients may use therapy in different ways at different times, and therefore understanding therapy returns requires consideration of clients' idiosyncratic needs, life context, as well as current difficulties (McKenna & Todd, 1997; Rodgers, 2003). Psychodynamic therapists provide case examples of therapy-experienced clients who appear to re-enter therapy to have their story heard (Rosengarten, 2009) or have contact with a "captive audience" (Szalita, 1982), rather than engage in insight or change-focused work. This suggests that for clients, therapy may fulfil a relational need at odds with the therapy's aims.

Findings from a qualitative interview-based study of lifetime psychotherapy experiences suggest that therapy episodes primarily function in one of a variety of ways; to *expose* clients to therapy and its possibilities, often without lasting impact; to help clients *discriminate* whether a particular therapy or therapist offers a good fit; *holding* offering connection but minimal change; *formative* change; and finally *consolidation* of previous ideas and reinforcement of changes (Todd & McKenna, 1997). Consistent with these categories, a study exploring dropout from long-term therapy highlighted that this episode had helped participants to discern whether they could work with a particular therapist or new model, thus functioning as a discrimination or exposure episode (Wilson & Sperlinger, 2007).

From the preceding discussion, it seems possible that clients, therapists, and services hold different understandings of the appropriate use of therapy and conditions under which return is legitimised. These narratives may influence expectations of therapy and how the therapeutic process unfolds.

How could previous therapy affect subsequent therapy?

Possible ways in which previous therapy influences subsequent therapy will now be explored, making use of relevant concepts, models, and research evidence.

Dropout and attendance

Past behaviour can be a powerful predictor of subsequent behaviour over and above behavioural intentions (Ouelette & Wood, 1998). In one study, whilst attendance intentions did not significantly predict therapy attendance, prior mental health service utilisation did (Mazzotti & Barbaranelli, 2012). This highlights the potential significance historic patterns of engagement with therapy may have on subsequent episodes. Several studies indicate previous mental health service utilisation or therapy is associated with reduced risk of nonattendance and dropout (Loumidis & Shropshire, 1997; Werner-Wilson & Winter, 2010); and more sustained engagement in therapy (Oliver et al., 1988; Flaskerud, 1986). Although these studies report unadjusted associations, an exception to this is Marsden (2014). This study found therapy-experienced clients attended a greater number of sessions, controlling for baseline distress, outcome and process expectations.

In other studies, the reverse pattern is observed, in that therapy-experienced clients appear more likely to dropout. In an RCT comparing online and face-to-face CBT for eating disorders, a significant predictor of dropout status was prior experience of CBT, increasing the likelihood of dropout by 77% (Watson et al., 2017). Consistent with this, history of psychotherapy increased the odds of dropout by 10 times in a small sample of therapy clients, the wide confidence intervals suggest imprecision in this estimate (Swift et al., 2012). In a larger sample of almost 300 therapy-experienced participants, over half reported prematurely dropping out of therapy. In the multivariate analysis, which included the therapeutic alliance and depression status, the only significant predictors of dropout from the most recent course of therapy were previous history of early termination and never completing a course of therapy, yielding respective odds ratios of 173 and 64 (Anderson, 2016). Whilst, again, wide confidence intervals suggest these estimates are imprecise, the

results are consistent with the idea some clients exhibit a repeated pattern of not completing therapy.

In addition to previous therapy dropout, which appears be to a powerful predictor of subsequent therapy dropout, other factors are likely to be relevant. One study has examined how previous therapy utilisation interacts with help-seeking beliefs. Among veterans expressing any agreement with the idea they did not need help for trauma, history of prior PTSD treatment had a large effect on the number of attended trauma-focused therapy sessions, such that, on average, they attended less than half the number of sessions as those veterans without this history (Fleming et al., 2018). This suggests the effect of any ambivalence about therapy may be amplified in therapy-experienced clients and they are quicker to withdraw.

Building on previous therapy gains

According to the phase model (Howard et al., 1993), change in therapy occurs in a progressive fashion over three phases. In the first *remoralisation* phase, improvements in distress are achieved, potentiating subsequent symptomatic relief in the *remediation* phase, in turn facilitating functional improvements in the final, more protracted *rehabilitation* phase (Howard et al., 1993). The impact of previous therapy experience on client outcomes has been evaluated using the phase model. One study, evaluating outcome trajectories in over 1000 therapy clients, observed some clients followed a trajectory characterised by rapid improvement in distress and symptoms, without functional improvement. This trajectory was significantly predicted by self-rated extensive previous therapy experience, whilst controlling for clinician-rated functioning, chronicity and outcome expectations (Stulz & Lutz, 2007). This provides preliminary evidence that therapy-experienced clients may make rapid improvements in distress and symptom reductions yet remain substantially functionally impaired. A second study examined whether change across therapy episodes occurs in accordance with phase model in clients returning to a therapy provider (Horn, 2002). In the full sample, there was no evidence of therapy gains in distress, symptoms, or

functioning carrying over to, or achieving greater gains in, the second course of therapy relative to the first. However, among clients who reliably improved in both courses of therapy, compared to the first course, there was a trend for better functioning at the beginning, and end of the second course, suggesting cumulative improvements in functioning. Among these clients, greater overall change was attained in the second course, and trends for greater reductions in distress in the first course, and greater improvement in functioning in the second course (Horn, 2002). Accordingly, when therapy is successful, clients may achieve greater amelioration of distress in the initial course, with greater changes to functioning attained in the subsequent course (Horn, 2002). This suggests clients who respond well to therapy may achieve a deeper level of change in subsequent courses of therapy.

Building on previous gains in subsequent therapy may depend on whether strategies were independently applied during therapy and likely to be retained (Strunk et al., 2007). Consistent with Grawe's (1997, 2004) model of change in therapy, therapists engage clients in a process of resource activation, supporting clients to access and utilise motivation and strengths in therapy. Studies suggest client self-reported strengths are predictive of early alliance (Schürmann-Vengels et al., 2022a) and eventual therapy outcome, controlling for initial symptom severity and interpersonal difficulties (Schürmann-Vengels et al., 2022b) and resource activation improves post-session outcomes (Flückiger et al., 2009). It is plausible that clients with previous successful therapy experiences have more strengths which can be utilised to facilitate change. Consistent with this, veterans reported coping skills acquired in earlier episodes of therapy supported them in their subsequent trauma-focused therapy (Hundt et al., 2015).

In contrast, other studies examining the impact of prior therapy on subsequent therapy symptom outcomes have produced inconsistent findings, including mixed effects (Grenyer et al., 2008), negative effects (Boswell et al., 2012) and no effect (Spear, 2018). Whilst each study controlled for baseline symptom severity, Lutz and colleagues (1999) found previous therapy predicted worse outcomes, whilst also controlling for several other

baseline characteristics including chronicity, treatment expectations and functioning. This suggests that previous therapy can negatively influence outcomes over and above other markers of complexity.

The effect of client-rated success of previous therapy on subsequent therapy outcomes has been examined in one study. Interestingly, clients reporting prior unsuccessful therapy improved significantly more than those reporting prior successful therapy. This pattern held whilst controlling for baseline symptom severity. However, only among clients with previous unsuccessful experiences did level of engagement significantly predict outcomes (Delsignore, 2008). This suggests that therapy-experienced clients with previous unsuccessful therapy may benefit from therapy if their engagement is high.

The limited studies available suggest two possibilities: (a) previous therapy experience may facilitate improvements in subsequent therapy if there are gains to build upon or strengths to utilise; (b) previous therapy experience may be associated with reduced symptom improvement, however, this may be mitigated by other factors such as high engagement.

Previous therapy influences common factors

Finally, it is possible that previous therapy impacts engagement and outcomes because of its influence on common factors, which are known to have a significant effect on outcomes (see **Table 1.1**).

Client-related common factors

Treatment expectations

Previous therapy experiences are assumed to influence the degree of socialising to therapy roles and tasks required by clients (Menaker, 1997; Swift, 2015). There is mixed evidence as to whether these therapy expectations differ between novice and therapy-experienced clients. One study identified significant differences in treatment expectations between novice and therapy-experienced clients (Pamukcu & Meydan, 2018), with others report no such differences (Bleyen et al., 2001; Patterson et al., 2008; Anderson et al., 2013;

Tzur Bitan & Abayed, 2020). Two studies reporting that therapy-experienced clients endorsed more realistic treatment expectations compared to novice clients explored the impact of these differences on outcomes. One study identified a positive effect on outcomes (Callahan et al., 2014), and another, no effect (Menaker, 1997). Qualitative studies suggest that therapy-experienced clients grow clearer about what they want from therapy and withdraw from therapy more quickly when they do not perceive these needs are being met (Shaw, 2003; Knox et al., 2022).

Previous therapy experiences may also affect beliefs about the consequences of engaging with therapy (Constantino et al., 2011). Outcome expectations appear to affect outcomes through their influence on hope, alliance, and engagement in the tasks of therapy (Glass et al., 2001; Westra et al., 2007; Swift & Derthick, 2013; Constantino et al., 2018). Whilst some studies report therapy-experienced individuals have more positive attitudes towards therapy (Goh et al., 2007; Fleishman-Pogach, 2008; Sandell et al., 2011; McCausland et al., 2021), a different picture emerges when the quality of previous therapy experience is considered. Case studies suggest that clients with unsuccessful therapy experiences enter therapy with negative outcome expectations (Bugatti & Boswell, 2016; Coyne et al., 2019), and that unaddressed outcome expectations precipitate premature dropout (Bugatti & Boswell, 2016). Consistent with these observations, surveys of therapy-experienced clients indicate satisfaction with previous therapy is negatively correlated with outcome expectancies (Constantino et al., 2017; Seidler et al., 2020; Garibaldi et al., 2020). However, due to the cross-sectional nature of this data, it is unclear whether low outcome expectancies were consequence of, or causal factor in, previous unsuccessful therapy.

Whilst it is known that outcome expectations have a small influence on outcomes, this has not been rigorously evaluated in therapy-experienced clients. A single qualitative study suggested some therapy-experienced clients retain their belief that therapy will help, however, enter therapy less emotionally invested following unsuccessful experiences (Shaw, 2003). Therapy-experienced clients may be more likely to retain belief in the

helpfulness of therapy despite unsuccessful experiences if they make situation-specific rather than global attributions (Shaw, 2003).

Therapeutic alliance

The effect of alliance on therapy outcomes is robust to initial symptom severity, alliance and outcome measures, alliance assessor, and diagnosis (Flückiger et al., 2018; Flückiger et al., 2020). Few studies have examined how previous therapy experiences influence therapeutic alliances in subsequent courses of therapy. One study reported therapy-experienced clients had significantly higher emotional bond and goal agreement scores early in therapy, with previous therapy accounting for 8% and 12% of the variance in these measures (Patterson et al., 2008). Using a consensual qualitative research approach, one feature of client-defined therapy failure was problems in the therapeutic relationship (Knox et al., 2022). Most participants sought further therapy and reported troubled subsequent therapeutic relationships (e.g., preoccupation with therapist's reactions or trust difficulties). For participants, difficulties in therapeutic relationships were attributed to previous therapy rather than reflecting pre-existing problems (Knox et al., 2022). Consistent with this finding, an interview study with former CBT clients from NTT services highlighted that for some clients, previous CBT experiences negatively impacted their experience of subsequent CBT, for example, not feeling understood by a previous therapist led to difficulties trusting the subsequent one (Omylinska-Thurston et al., 2019).

Therapist-related common factors

Hope

A crucial aspect of the therapist role is instilling hope in clients, engendering increases in client motivation and agency (Frank, 1961; Hanna, 2002). Hope is conceived as a relational process between therapist and client (Weingarten, 2010). Therapists' accounts of their experiences of hope suggest it is influenced internally, for example, by possibilities generated for clients, and externally, by client engagement in therapy (Bartholomew et al., 2019). Studies suggest that therapist hope is positively associated with

quality of alliance, use of client strengths (Bartholomew et al., 2020); and predicts client symptom change in the first session and end of treatment outcomes, controlling for baseline symptom severity (Coppock et al., 2010).

Two qualitative studies employing phenomenological analysis have highlighted the role of hope in working with therapy-experienced clients. Bartholomew and colleagues (2019) reported that therapist ability to hold hope is compromised by clients who repeatedly attend therapy and appear to engage minimally. However, it is unclear if difficulty in holding hope is apparent from the outset of therapy or emerges with clients' difficulties engaging. Hopper (2015) provides a longitudinal perspective on the course of hope throughout therapy with non-responding clients. Therapists reported generating hope for client change early in therapy, recognising, in retrospect, they underestimated the extent of clients' difficulties and appeared to collude with the clients' desperation for therapy to provide a solution. Therapists working with clients with previous unsuccessful therapy experiences positioned themselves as the therapist who could break this pattern. This early hope was subsequently eroded as the therapeutic process unfolded.

Therapist hope is negatively correlated with therapist burnout (Cicone, 2003), raising the possibility that diminished therapist hope may contribute to therapist burnout. Therapist burnout has been examined as a phenomenon reciprocal to client burnout. Pretreatment client therapy burnout (i.e., therapy-related emotional exhaustion, reduced accomplishment in therapy and depersonalisation of therapists), predicted therapist burnout four months into therapy, controlling for client baseline symptom severity and therapist burnout (Linehan et al., 2000). This indicates the possibility that some therapy-experienced clients enter therapy less present and able to fully take part in the process, which in turn impacts on therapists' presence and ability to fully engage in the therapeutic process.

Therapists' experiences of working with therapy-experienced clients

Published work exploring therapists' experiences of working with therapy-experienced clients is surprisingly limited. The experience of working with therapy-experienced clients has been examined by psychodynamic therapists and psychoanalysts in essays drawing on

case examples (Szalita, 1982; Coltart et al., 1988; Werman, 1989; Clemmens, 1992; Natterson, 1993; Clemens, 2004; Mazzetti, 2010; Hampton, 2013; Orgel, 2013). These papers highlight issues therapists working with therapy-experienced clients grapple with, such as transferential reactions relating to previous therapists; clients struggling to make use of therapy; previous therapy reinforcing unhelpful ways of coping; and difficulties obtaining an account of the previous work. However, these reports employ a narrative approach of uncertain rigour.

To date, a single study focused on therapists' experiences of working with therapy-experienced clients has been carried out (McKenna, 1999). This was a US-based qualitative study interviewing eight psychodynamic therapists employing a thematic analysis. The themes appear broadly consistent with the narrative accounts reviewed above in highlighting therapists encountered some differences working with therapy-experienced clients. These included client differences appearing to facilitate therapy such as greater socialisation to therapy, positive outcome expectations, and clearer ideas about their needs, facilitating alliance building, as well as challenges to navigate such as unresolved feelings towards previous therapists. Therapists placed importance upon awareness of triangulation in the therapy relationship, and invitations to the role of *good* therapist, in contrast to the previous *bad* one, to avoid colluding with splitting. Therapists expressed a belief that clients' relational experiences with previous therapists were likely reflective of early relational experiences. Therapists' emotional responses depended on the circumstances of previous therapy ranging from a feeling threatened by previous positive experiences to hopeful if previous therapy had been helpful for a similar difficulty. These psychodynamic therapists expressed generally positive attitudes towards clients continuing need for therapy and therefore their return to it. An exception to this related to clients who appeared dependent on therapy or had difficulty making effective use of therapy. Therapists varied on whether they felt able to hold hope for clients who had previous unsuccessful therapy experiences (McKenna 1999).

Now that the broader literature has been explored to contextualise the **Research aims** presented earlier in this chapter, the specific research questions are presented below.

Research questions

- Do clients' previous therapy experiences affect how NHS Talking Therapies CBT therapists experience and navigate the subsequent therapy?
- How do clients' previous experiences appear to hinder or facilitate the subsequent therapy?

Method

This chapter will outline the methodology and research design for the study, including ethical considerations.

Chosen methodology

As outlined in the **Introduction**, though the experience of working with clients returning to therapy has evoked curiosity among therapists, it has rarely been studied in a rigorous and focused way. The current paucity of relevant literature precluded quantitative methodologies such as a survey due to difficulties delineating specific variables or categories. Qualitative methodologies are considered particularly suitable for under-researched areas. Qualitative methodologies are used to understand experiences, what they are like, made sense of and navigated (Willig, 2013) and pursue both exploratory (i.e., describing phenomena) and explanatory aims (i.e., explaining phenomena; Fryer, 2022). Consequently, a qualitative approach was chosen as the most appropriate means to understand based on therapist accounts, if, and how, clients' previous therapy experiences impact on therapy, and consider how clients' previous therapy experiences may facilitate the work, and how they may hinder it.

Semi-structured interviews

Semi-structured interviews were selected as the data collection method for the present study. The semi-structured interview offered a balance between consistency across participants with the flexibility to probe for further reflections and ask follow-up questions, to help the participant explore the topic more fully, if needed. Broad, open questions were used in the hope of producing richer data (Ogden & Cornwell, 2010).

Philosophical framework

Several qualitative methodologies are available, each underpinned by philosophical frameworks shaped by the fundamental theories of reality and knowledge production they ascribe to. Ontologies postulate ideas about the entities comprising reality, and thus inform the phenomena studied. Epistemologies propose ideas about knowledge production (Giacomini, 2010). The ontological and epistemological positions researchers adopt provide

implicit scaffolding for the research process, from the development of a research question to the conclusion of a study (Creswell & Poth, 2018). Accordingly, it is crucial that the research aims, research methods and fundamental theoretical framework are well aligned. Before describing the study's methods, critical realism, the selected philosophical framework will be outlined and justification of its appropriateness offered.

Critical realism

Critical realism, a philosophy of science originally developed by Bhaskar (1978), differentiates the nature of reality from human understandings of it. Whilst there are different strands of thought within critical realism, ontological realism, causality, and epistemological relativism are considered shared features (Willis, 2023).

Ontological realism contends there are psychological and social processes, which: (a) exist independently of researcher constructions or theories about them; and (b) impact how individuals and groups experience and navigate the world, often without their awareness (Braun & Clarke, 2022; Willig, 2013; Willis, 2023). From this perspective, mental phenomena such as meanings, intentions, beliefs, values, and emotions are an influential part of reality, involved in causal processes (Maxwell, 2012; Willig, 2013). As such, critical realism offered a framework to understand the process through which aspects of therapists' experiences, such as their intentions, beliefs, and emotions, occurring in their work with therapy-experienced clients, influence how they navigate therapy in the NTT service context. Furthermore, understanding these influences can offer a means of recommending and facilitating change (Fryer, 2022), therefore offering a good fit with the practical aims of this study.

Epistemological relativism argues knowledge produced about reality is influenced by the social, cultural, and historical context (Archer et al., 2016; Fryer, 2020). Knowledge produced in research will be grounded in the researcher's perspective and worldview, as such there is no direct, uncomplicated access to reality or the possibility of gaining objective knowledge (Maxwell, 2012). Accordingly, critical realism will permit acknowledgment of the influence of researcher subjectivity and the methods employed to

acquire knowledge on the study results so that they may be understood in this context. To this end, researcher reflexivity is required throughout the research process (Lauzier-Jobin et al., 2022), the means for achieving this will be set out in the below sections.

In line with critical realism, the interview data provided by participants was understood to provide access to a mediated reflection of their perceptions of reality shaped by their contexts (cultural, social, historical) and language (Braun & Clarke, 2022). The chosen approach to thematic analysis, reflexive thematic analysis, will be outlined in the next section.

Reflexive TA

Reflexive TA (RTA) is considered a method, rather than a methodology because it can be used with a range of epistemologies, ranging from social constructionism to essentialism (Braun & Clarke, 2022). In RTA, analysis requires both immersion in the detail of the data, and distancing from it. Three processes are involved: familiarisation, is the initial engagement with the data from which ideas for potential codes are generated; coding, involves selecting data extracts pertinent to the research question and creating a code label which captures the relevant meaning or idea; and theming, which draws together patterns of meaning represented by codes anchored by a shared idea or concept. Whilst remaining systematic, the analysis is construed as an art rather than science, involving creativity contained by framework of rigour (Braun & Clarke, 2022). In RTA, the researcher owns their active role, this means that codes and themes are actively drawn out and created by the researcher. For these reasons, the researcher must make explicit their theoretical assumptions, understood to underpin the analysis, and perspectives, so that the analysis can be understood in this context. This requires researcher reflexivity, so that perspectives are owned, understood and made explicit (Braun & Clarke, 2022). To demonstrate this, reflexive commentary and the means for generating reflexivity are offered in the following sections: **Situating self in research**, **Reflexivity in recruitment, Reflexivity in data collection, Reflexivity in analysis, A return to reflexivity**.

Reasons for selecting reflexive thematic analysis

RTA was selected because it allowed similarities and differences between and within each therapist's account of their experiences of working with therapy-experienced clients to be drawn out and represented as interrelated themes. RTA offered a good fit with the critical realist philosophical framework (see **Critical realism** above for rationale; Braun & Clarke, 2022). The flexibility offered by RTA allowed the qualitative framework, orientation to the data and focus on meaning in the data to be positioned to answer the research questions in a way that added depth and originality to the analysis. The positioning is outlined in **Table 2.1**.

Table 2.1

Positioning of reflexive thematic analysis and advantages offered

Aspect of variation	Positioning	Advantage
Qualitative framework Experiential-critical continuum	More experiential (i.e. exploration of individual perspectives and understandings)	Explore participants' contextually situated experiences in their work with therapy-experienced clients in NTT services.
	Some critical influence in the interrogation of broader meanings	Consideration of influence of NTT service context in exposing participants to ideas and meanings affecting sense-making and work with therapy-experienced clients.
Orientation to data Inductive-deductive continuum	More inductive	Codes and themes were more driven by data offering greater scope to generate unanticipated findings.
	Some deductive influence	Theoretical constructs were used as a resource for theme creation and acknowledged in the **Discussion** to make the conceptual underpinning of themes apparent.
Focus on meaning Semantic-latent continuum	Both semantic meanings staying close to participants' language and latent hidden meanings were explored.	Gives voice to participants' experiences such that therapists might recognise these experiences. Increases awareness of therapist experiences which they may be less conscious of.

Situating self in research

Due to the influence of the researcher on framing the research question, data collection and analysis, I will now provide a short summary of my alignment with the philosophical framework for this study. I will also outline the experiences shaping my motivations to pose these research questions and what I anticipated to find.

Alignment to critical realism

It is contended that critical realism is the dominant, if often unacknowledged, position within social sciences, evident in assumptions and practices (Lauzier-Jobin et al., 2022). This goes some way to explaining my personal alignment with critical realism. It is most congruent with how I see the world and operate clinically. Critical realism is often cast as a middle ground position between positivism/naive realism and constructivism/idealism (Braun & Clarke, 2022). Although I take the view that constructs discussed in the **Introduction** such as outcome expectations and hope refer to phenomena that exist in the world and impact on the therapy process, I find positivism and naïve realism limiting in that they involve taking participant accounts at face value without considering implicit meanings and the influence of the social context (Willig, 2013). From constructionism, I appreciate that social constructs are influential and language functions to create meaning which shapes reality. Critical realism seems to offer a balance of maintaining a critical perspective on research, clinical theory, concepts, and practice, acknowledging the role of social forces in shaping these, on one hand, whilst attempting to promote practical change in existing systems.

Interest in the research question

Having worked in NTT for several years as a PWP prior to commencing clinical psychology training, it is a service context I believed that I understood well, and this was a key motivation for identifying a project based in NTT. A paper highlighting that clients with previous NTT referrals have poorer outcomes led me to reflect on my own experiences. I recalled opening case records for clients with several previous referrals and being curious about the story that told. As I gained experience, my initial assumptions were these were

stories of unmet need and difficulties feeling safe in therapeutic relationships. I pondered longer over post-assessment decisions when clients had previous unsuccessful therapy episodes. I felt caught between wanting to give clients a further opportunity if they believed therapy would benefit them again, or believed they were now in a better position to make use of it, and a responsibility to protect clients (and therapists) from difficulties if it transpired NTT therapy was not a good match for their needs.

I appreciate NTT's achievements in widening access to therapies and understand that its scale rests on highly proceduralised processes. Over the course of training, I have become more questioning of the philosophical underpinnings of the NTT system with its focus on more medicalised approaches to distress. I prefer to see therapy as a flexible, relational process, guided by theoretical principles, and shaped according to the needs of the client, which allows new meanings and possibilities for action to emerge.

On my therapy placements as a psychologist in training, I have encountered novice clients with idealised expectations of therapy, and therapy-experienced clients who idealised or devalued previous therapists. These experiences have piqued my interest in the influence client relationships to therapy and previous therapists have on therapist experience and therapeutic process.

Based on my experiences and reading, at the point of conceiving and designing the study, I expected that participants would reflect on previous therapy having a beneficial effect on subsequent therapy when the client is socialised to CBT and has previous therapeutic gains to build upon. Conversely, I expected participants would talk about finding previous therapy had a detrimental effect on subsequent therapy, when clients show signs of therapy burnout and find it harder to actively engage.

Ethical considerations

Ethical clearance was obtained through the University of Leeds School of Medicine Ethics Panel (see **Appendix E**). The following potential ethical issues were given consideration in the application.

Participant distress

As reviewed in the **Introduction**, several studies indicate that therapists working in NTT services often experience high levels of stress and burnout. This prompted concern that participants could become distressed in discussing challenges encountered in their work. This possibility was highlighted in the participant information sheet (PIS; see **Appendix B**), and participants were assured that they could pause the interview if they became distressed. At the end of the interview, a checking out procedure was used, which asked participants to reflect on their experience of being interviewed. It was assumed participants, as therapists, had access to their own self-care practices. No participants appeared distressed during the interview, nor were any concerns about the impact of interview process raised.

Disclosures indicative of professional misconduct

As participants were required to talk about their clinical work with clients, it was conceivable they could describe unethical practice (e.g., intentional discrimination, failure to act to protect health and safety of clients or others; BABCP, 2022). This possibility was highlighted to participants, both in the PIS and at the start of the interview. Participants were advised that any concerns arising would be discussed with project supervisors in the first instance, and concerns raised with the appropriate professional body, if necessary. No participants described unethical practice during the interviews.

Maintaining confidentiality

Participants were asked to prepare to discuss their work with one or two therapy-experienced clients in the interviews. Participants were advised, both in the PIS and prior to commencing the interview, to omit any person identifiable information (e.g., names). Interview recordings and transcripts were stored using the password-protected university server. Any person identifiable information was anonymised to maintain confidentiality. The PIS outlined all the steps taken to maintain confidentiality. Participants were invited to discuss concerns regarding any information shared for one week after the interview has

taken place. One participant redacted some data after requesting the interview transcript to review.

Participants were informed, in the PIS, that pen portraits of each therapist participant would be included in the thesis, a publicly available document. Participants were made aware that no person-identifiable information would be included in pen portraits.

Sampling strategy

A purposive sample was used, such that potential participants self-identifying as having experiences relevant to the purpose of the study were recruited. Potential participants were initially asked to assess their own eligibility to take part based on information available in recruitment materials reflecting the inclusion and exclusion criteria outlined in Table 2.2. The criteria were kept broad to maximise opportunities for recruitment, for example, participants could still take part if they had recently left NTT services. Potential participants were asked to volunteer if they considered themselves able to talk about one or two pieces of work with therapy-experienced clients for whom they perceived the previous therapy impacted the therapy, exerting a facilitative and/or hindering influence. Suitable therapy-experienced clients were those participants considered by therapists to have undertaken an adequate course of therapy previously. Because the focus of the present study was on the impact of previous therapy experiences, it was hoped this would help to exclude pieces of work in which clients had not had a fair trial of therapy previously (e.g. attending assessment sessions only). Potential participants had the opportunity to ask the researcher questions about the suitability of potential client work examples. During the recruitment process, some participants and potential participants checked whether the client's previous therapy experiences sounded suitable.

To capitalise on potential opportunities to draw on snowballing as a sampling strategy, after interviews, participants were encouraged to inform other high-intensity CBT therapists about the study.

Table 2.2

Participant inclusion and exclusion criteria

Inclusion criteria	Exclusion criteria
Qualified CBT therapists	Trainee CBT therapists
Worked/recently worked in NTT	Have not worked/recently worked in NTT
Able to talk about work with one or two therapy-experienced clients	Unable to talk about one or two therapy-experienced clients

Sample size considerations

Anecdotally, recruiting between six and sixteen participants for an interview-based study using thematic analysis is considered reasonable for the scope of a DClin project. For the present study, it was estimated that 12 participants would be ideal. This estimate was based on judgements about information power, which describes the information held by the sample relevant to the study's aims (Malterud et al., 2016). Greater information power means that fewer the participants will be required. Information power was assessed as the interviews proceeded, had this been weaker than anticipated, more participants would have been recruited.

The five aspects of information power: a) the aim of the study; (b) sample specificity; (c) use of established theory; (d) quality of dialogue; and (e) analysis strategy (Malterud et al., 2016), were considered and are described below.

Aim of the study

The existing literature on therapy engagement and outcomes for therapy-experienced clients and therapists' experiences of working with these clients in NTT services suggested: (a) client engagement and outcomes were poorer; and (b) therapists could find working with these clients stressful. The present study's aim was to explore more broadly whether and how these previous experiences impacted how therapists experienced and navigated therapy. Within this, it was hoped to understand when previous therapy experiences may appear to hinder or facilitate the subsequent therapy. As such, the broader

scope of this phenomenon (i.e., encompassing more positive and more negative impacts) required more participants to help explore it adequately.

Sample specificity

Sample specificity refers to the specificity of the participant experiences with respect to the study aims. The more specific the participant experiences are, the fewer participants will be required (Malterud et al., 2016). Early in the design it was decided that the study would be focused on high-intensity CBT therapists rather than high-intensity therapists (e.g., counsellors, IPT therapists) more broadly. It was anticipated this would help to reduce the number of participants required, given differences in therapeutic process (e.g. more technique-based vs. more relationally focused therapies). As noted above, participants were recruited according to inclusion and exclusion criteria (see **Table 2.2**). These criteria considered whether participants were likely to have relevant experiences to draw on. Crucially for interviews, potential participants were invited to self-identify whether they could talk about one or two pieces of work in detail when client previous therapy experiences had impacted the work. It was assumed that most therapists working in NTT services would have these stories to tell, however, the reality of large caseloads in busy services may mean that only a sub-set of these therapists would feel confident and motivated to do so in sufficient detail at interview.

Use of established theory

The use of established theory to draw on in planning and analysis could have reduced the number of participants by providing scaffolding to make sense of the data (Malterud et al., 2016). Whilst the literature review indicated there were candidate theories (e.g. phase model, Howard et al., 1993; resource activation model, Grawe, 1997, 2004) and concepts (e.g., therapist hope, therapy expectations, medicalisation of therapy) to support in making sense the impact of previous client therapy experiences may have on therapists' experiences, no established theory was systemically applied in the planning or analysis phases. The analysis was influenced a variety of models and ideas. The lack of established

theory to support the planning and analysis phases increased the number of participants required.

Quality of dialogue

The quality of the dialogue (i.e., clarity of expression) is linked to researcher interviewing skills, participants' ability to articulate their experiences at interview, and interviewer-participant rapport. Stronger quality of dialogue means that fewer participants are required (Malterud et al., 2016). It was anticipated that, as a therapist researcher who had previously worked in NTT services, these experiences could assist with rapport building and I would be well-positioned to help participants explore their experiences fully and deeply. The quality of the dialogue was assessed throughout the interviewing stages and was a key factor in deciding whether further interviews were required.

Analysis strategy

Using a cross-case analysis means that more participants are required, compared to detailed within-case analysis of a handful of accounts (Malterud et al., 2016). RTA, which fits with the practical aims of the study to generate clinical implications for practice, analyses patterns in meaning, both within and across cases.

Recruiting participants

To streamline the ethical approvals required (i.e., University only rather than University and NHS approvals) and permit access to wider range of therapists (i.e., across NTT services, therapists on maternity leave), participants were recruited as members of the public, rather than via NHS services.

Recruitment procedures

Initially, several contacts working in NTT services across the country were enlisted to publicise and promote the study via word of mouth and using their social media platforms. To maximise recruitment, the study was also posted on the X (formerly Twitter) account of the NTT services National Networking Forum.

The social media posts (see **Appendix D** for samples of the materials used) used to publicise the study contained the researcher's university email address and a link to an Online Surveys page which presented the PIS. This provided two means of establishing contact between the research and potential participants to discuss the study further: (a) direct email by potential participants to the researcher; or (b) potential participants registering interest to be contacted by the researcher. The purpose of this contact was to answer any questions and check participants had suitable examples of work to discuss in the interviews. These potential participants were provided a participant number and a link to review and complete the consent form and pre-interview questions (see **Appendix C** for consent form and pre-interview questions). An interview was then arranged. For participant numbers, see **Participants**.

Reflexivity in recruitment

Although recruitment was national (i.e., publicised on NTT National Networking Forum X account), the eventual sample of participants was predominantly locally related, possibly attributable to the increased motivation of recruited participants to help a former colleague. I worked in a large NTT service for 13 years. Of the 12 participants who were recruited, 11 had worked in the same NTT service during my period of employment. Six left the service to work in other services.

I sensed this connection had a facilitative effect on the interviews, allowing trust and rapport to build more rapidly. I had worked more closely, as their supervisor, supervisee, or group co-facilitator, with five participants. I was attentive to power dynamics in the interviews, particularly with former supervisees, and used naturally occurring opportunities to signal to participants that I saw them as experts in CBT-based therapeutic practice (e.g., showing when I was unfamiliar with specific CBT models mentioned when this was the case).

Data collection

Participants were offered the choice of being interviewed in person or remotely using

Zoom. Interviews were audio recorded. The accuracy of the digitally produced transcriptions was checked against audio recordings by the researcher. All person-identifiable information was removed from the transcripts.

Pre-interview questions

Upon completion of the consent form, to save time at interview, participants were also asked to complete a brief online questionnaire to provide some background details (e.g., years since qualifying, years worked in NTT services), to supplement the pen portraits.

Reflexivity in data collection

After each interview, as the researcher, I recorded my impressions of the interview process. This included observations about the dynamics between the participant and I; questions or responses that elicited a strong reaction from myself or the participant; and a description of those reactions. Some highlights from those reflections were incorporated into the **Pen portraits**.

Interviews

One semi-structured interview was carried out with each participant. To help increase the richness of participant accounts, ahead of the interviews, participants were asked to prepare to talk about how they had experienced and navigated therapy with one or two therapy-experienced clients from start to finish. To contextualise their accounts, participants were also prompted to prepare to provide an overview of their understanding of these clients' previous therapy episodes. In-line with the research questions, participants were asked to select pieces of work where they perceived clients' previous therapy experiences had facilitated or hindered their work. To help prime participants' memories of their experiences of work, it was suggested they may wish to look at client case notes as part of their preparation.

During the interviews, participants were asked some questions about their practice in general with therapy-experienced clients. They were then asked to talk about their work with the clients they had prepared to talk about (see **Appendix F** for topic guide).

Pilot study

The interview topic guide was piloted on former colleagues working as PWPs in NTT. The aim of these interviews was two-fold: (a) to practice interviewing skills; (b) and to consider how generative the questions were.

Data analysis

Following guidance developed by Braun and Clarke (2022), RTA was used to draw out, describe, organise and analyse key features of the interview data in six phases (see **Table 2.3** for an overview and **Appendix G** for a more detailed account). The process was highly iterative, particularly from phases 3 to 6, as themes were collapsed and re-split to create a more coherent analysis.

Table 2.3

Phases in thematic analysis

Phase	What this involved
1. Familiarisation	Preparation of transcripts. Read and re-read interview transcripts. Creation of mind maps for each interview highlighting ideas and meanings which stood out. Creation of a summary mind map capturing salient similarities and differences across the interviews.
2. Coding	Transcripts were coded line-by-line to record features of the dataset salient to the study's aims. The transcripts were coded twice in a different order on each run. Codes and accompanying data were collated.
3. Theme creation	Codes were collated into potential themes patterns of meaning underpinned by a shared concept or idea. The coded data was then collated under each theme.
4. Theme review	Themes were reviewed to assess their coherence with associated codes. The validity of themes was then reviewed in relation the entire database by re-reading the transcripts.

5.	Theme definition and naming	Themes and subthemes were defined so that the meaning of each theme was made apparent. A short summary of each theme and subtheme was written. Themes were considered in relation to each other to produce a thematic map.
6.	Write up	Themes and subthemes were described and explained to provide a coherent account of the narrative pertaining to the research aims. Illustrative quotes were selected for each subtheme.

Reflexivity in data analysis

A reflexive journal was used to record details of my thoughts and ideas during the analysis process. This was used to reflect on how codes and themes may have been influenced by existing theoretical ideas and researcher perspectives (See **Appendix H** for an extract).

Assessing analysis quality

In keeping with its alignment with the big-Q tradition, in RTA analysis cannot be understood or evaluated in terms of its accuracy or objectivity, instead the analysis is evaluated as stronger or weaker (Braun & Clarke, 2022). As such, the research supervision, which was used during each phase of analysis from familiarisation to write up, helped to clarify and stimulate researcher thinking rather than align ideas. Care was taken to ensure that themes were not summaries of meaning related to a topic and were connected by a shared concept. Theme salience was not reduced to frequency with which it occurs in the dataset, instead judgements as to what constitutes a theme were formed based on relevance to the research question. The analysis was evaluated against the 15-point quality checklist provided by Braun and Clarke (2022; see **Appendix I**).

Results

This chapter will present the findings from the analysis. Firstly, an overview of participants, including background information and individual pen portraits, is provided. A summary of the main themes will be presented in a thematic map. Each theme and subtheme will be defined, and illustrative quotes presented.

Participants

Nineteen potential participants expressed an interest in the study. Five people did not respond to contact to arrange interview and two were excluded. One was excluded at interview as the prepared client was still in the assessment phase of therapy, limiting the usefulness of the data. One was excluded post-interview due to a problem with the recording (i.e., very few words could be discerned).

Twelve high-intensity CBT therapists (see **Table 3.1**) were interviewed about their experiences working with therapy-experienced clients. Interviews lasted between 63 and 119 minutes. All participants were trained in England. Eight participants had fewer than five years post-qualification experience, three between 5-10 years, and one more than 10 years. One participant had worked in NTT services for less than five years, eight between 5-10 years, and three more than 10 years.

Table 3.1

Participant characteristics

Participant[a]	Gender	Ethnicity	Age	Years in NTT	Years as qualified CBT therapist
Ani	F	White Other	45-54	5-10	< 5
Beau	F	Black Caribbean	25-34	5-10	5-10
Marley	F	White British	35-44	5-10	< 5
Suzie	Did not disclose	Did not disclose	35-44	> 10	< 5
Lisa	F	White British	35-44	> 10	> 10
H	F	Mixed Indian & White	25-34	5-10	< 5
Anita	F	British Pakistani	25-34	5-10	< 5
Jo	F	White British	25-34	5-10	< 5
Kate	F	White British	35-44	5-10	5-10
Tania	F	British Pakistani	55-64	5-10	< 5
J	M	White British	35-44	> 10	5-10
Jean	F	White Irish	25-34	< 5	< 5

[a] Participants were asked to select their own pseudonyms. The researcher chose pseudonyms on behalf of participants to protect anonymity when participants opted not to select one.

Pen portraits

Pen portraits were partly based on participant responses to the initial general questions (see **Appendix F**). The pen portraits provide an indication of participant reasons for taking part in the study and a summary of their general experiences and ideas about working with therapy-experienced clients. The reasons participants offered for selecting the pieces of work discussed in the interviews are also included in the pen portraits. See **Table 3.2** for a summary of the information participants provided about clients' previous therapy experiences; specifically, what they knew about the therapy they had undertook and its outcome. There was variability in the level of detail participants were able to provide. Finally, the pen portraits also include a description of how the interview with each participant was experienced by the researcher.

Ani

Ani was the first participant to contact me regarding the study. She was out of contact for several months and I followed her up during the final stages of recruitment. Ani expressed her motivations for taking part in the study in what seemed like general terms:

> "I think it's very important that we understand IAPT services better. What works, what doesn't work. And when we do understand that, then we can make improvements. I like science-based information within psychology... the more studies we have, the more we know of both the human condition of being a patient, a therapist, how the therapeutic alliance works."

Ani placed a strong value on interrogating notes held about clients' previous therapy experiences whilst also sharing her intention to not be "biased by another therapist's journey" and to use this information to benefit the client: "everything I can get my hands on...I use that information based on what the patient wants right now in the most current episode." Ani told me that she used information about past CBT experiences to reinforce positive expectations of therapy, or alternatively, would attempt to generate these by naming and thinking about how difficulties could be usefully responded to.

Ani spoke about a single client, Grace, whom she had recently discharged. Ani shared that she selected Grace because their existing relationship from previous therapy required some consideration in the work. Furthermore, on this occasion, Grace ended the therapy prematurely prior to achieving recovery, contrasting with the previous pattern of engagement and outcomes.

I found Ani talked about her client work with passion and positivity. I thought that out of all participants Ani was most critical of system-level practices in the NTT services. Ani did not express much vulnerability during the interview, despite describing a piece of work that had not been successful by NTT standards. I personally resonated with Ani's view of therapy as a learning process, and sometimes for clients the conditions for that learning to take place may be less ripe. I experienced Ani as speaking with great certainty

and I wonder if this impacted my motivation to probe Ani further at times. I felt disappointed that the interview had not been as rich as I hoped.

Beau

Beau was the first person I interviewed. Beau expressed her motivation for taking part in the study was to share her experiences of navigating the "revolving door of clients coming into IAPT." Beau revealed her concern for returning clients repeating their story. Beau emphasised the value of reading notes in advance to help understand clients' histories, including their therapy journeys, particularly formulations, relapse prevention plans and endings. Beau shared how she used this information to engage clients in sense-making about their return to therapy: "What's the relapse prevention plan going forward so then you can link into that within your sessions to see if that's been followed. If it hasn't, why have they struggled with that and come back?" In describing her methodical approach, I thought that Beau communicated a strong interest in considering the influence of past therapy experiences.

Beau shared two client examples whom she completed therapy with 18 months ago. Suni, coming into therapy with more negative previous therapy experiences, and Cara, far more positive experiences. Beau contrasted her work with Suni where she felt confident to navigate the challenge posed by her negative therapy expectations, with her concern about living up to Cara's previous therapist: "It's the opposite feeling for me of: 'Can I do my job?' Whereas the other one was: 'Yeah, I know I can do it and I'm gonna prove to you that we can do really well.'"

My sense was Beau was giving short, succinct well-constructed answers, confidently delivered. Though I asked Beau some probing questions to explore her experience more fully and observed that often she would add some additional insights; I also felt nervous of probing too much. I would have been curious to understand more about the contrast Beau perceived between her two experiences and how the need to "be the best" might relate to her experiences of the NTT context.

Marley

Marley was one of the four therapists I interviewed in-person. Marley expressed her motivations for taking part in the study as: “It's quite an important research topic to come and see what people get when they see people after they've had a few rounds of therapy. So yeah, always nice in the way of promoting patient recovery.” I was struck that Marley emphasised the potential for understandings from the study to impact recovery specifically, indicating she places a high personal value on this, which was reflected throughout the interview.

Marley described a thorough approach to exploring previous therapy experiences. This involved use of notes as a resource to understand therapy focus and duration, feedback regarding intervention effectiveness, and recovery; as well as talking to clients about their experiences. Marley was one of the few therapists who appeared interested and comfortable in exploring clients’ experiences of the therapeutic relationship. Marley also appeared comfortable to probe clients about what they remembered from previous therapy, using knowledge gleaned from notes about previous therapy to scaffold these conversations. I thought this communicated Marley’s intention to use previous therapy as a resource. Marley relayed her experience as follows: “So, it becomes a lovely reciprocal talk, then, where it’s not just information gathering. But that exchange is like, ‘Oh, let's just fill in some of the gaps and refresh you on that side of things.’” I thought that this positioned therapy-experienced clients as active collaborators in possession of valued knowledge. Marley also reviewed previous therapy and subsequent application of interventions to make hypotheses about outcomes and clients’ return to therapy. There was something methodical, considered, and rule-driven about Marley’s approach to her work.

Marley spoke about a single client, Jules, in the interview. Marley shared selecting this piece of work due as it seemed particularly valuable and poignant with previous therapies experiences making an important contribution to the positive outcomes.

I experienced Marley as enthusiastic, giving interviewee, who placed a value on positively connoting colleagues and clients which I admired. I was struck by Marley’s

optimism, she shared she had not to date experienced clients' previous therapy experiences as a hindrance. I perceived Marley as clear about the purpose of the study and as having thought carefully about the impact of previous therapy on her work with Jules. In this way, I did not get a sense that Marley was doing much thinking with me in the room, and it seemed as though most of it had already happened.

Suzie

Suzie shared their motivation for taking part in the study related to a general interest in research, and a specific interest as:

> "I related to what I thought you were asking for as well and it is something that sometimes when I have worked with patients where I've thought: 'Oh you know that does sound like it's been really unhelpful when you've had therapy before.' And then on the flip side, sometimes it's been really helpful as well, so I was just interested in it on that level as well."

Suzie described asking clients about "previous input, which isn't just therapy, it's anything, so it's medications, it's self-help as well." Suzie described eliciting information from clients about the practicalities of any previous therapy (e.g., therapy provider, therapy focus and duration), and their experiences of therapy, its helpfulness, what was "liked" and what was disliked or unhelpful. I heard Suzie as reluctant to attach too much significance to the role of previous therapy: "It's a jigsaw piece. You're putting it together with everything else you've got in their assessment. It's not on its own necessarily significant. It depends on the whole picture."

Suzie talked about a single client in the interview, Bob. Suzie shared selecting Bob as it was a recent example of work with a therapy-experienced client. As the interview progressed it became clear that this was a particularly affirming piece of work for Suzie's sense of self as a therapist. Suzie shared that many clients they see in NTT services do not benefit from CBT and they refer those clients onto other services.

Suzie and I attempted to meet for an interview a couple of times unsuccessfully. On the day of the interview, Suzie had technical problems, which resulted in them being interviewed with the camera off, and I felt we were not very connected during the interview. I appreciated Suzie had prepared some notes for the interview, but also appeared to be doing some thinking with me in the interview. Suzie's responses were limited when something was not remembered clearly, which made me wonder if Suzie thought that they had to be careful with their answers.

Lisa

Lisa shared her motivations for taking part in the interview were linked to how commonly she worked with therapy-experienced clients and a belief that services can be ineffective:

> "I feel like the majority of people that I see now have had previous CBT... It concerns me quite a lot ... because of … the bigger state of the NHS, and different waiting lists in our service I don't necessarily feel like we're being all that effective...with our provision... then it interests me thinking about taking some time to explore what it is that's going on, and what we could do differently."

In response to questions about how she ascertains previous therapy experiences, Lisa shared that she "always" asks about previous CBT and "briefly" explores clients' experiences to look for clues about "what they might need to do, what we might need to do differently." Lisa spoke of such enquiries being limited "because I feel under pressure to just get started." Lisa also shared some of her assumptions that the return suggests therapy did not work, and questions about whether therapy is sufficient given the challenges in the wider social context.

Lisa reflected that service notes usually offer a restricted view of the previous therapy in that an account of the therapeutic process is often absent, and the focus tends to be on interventions used. I heard Lisa place a high value on her relationships with colleagues throughout the interview. She relayed a "prejudice" whereby, compared to client

accounts, she would “hold in higher regard” her own ideas that colleagues she considers to be “good” will have provided “good therapy”.

Lisa talked about her work with two clients, Carol and Tina. Lisa shared that both were selected as pieces of ongoing pieces of work that could be readily spoken about, and with whom Lisa foresaw she was unlikely to achieve “recovery.” I was struck by how Lisa appeared to wholly frame the effectiveness of therapy in terms of recovery on measures.

I appreciated and was moved by the vulnerability Lisa expressed and how much she was thinking with me and reflecting in the interview. Because of this, as the interview went on, I think I was comfortable to probe Lisa more as I anticipated her openness.

H

H was an in-person interview. H cited her reasons for taking part in the study as having the opportunity to reflect on an aspect of practice she has not given much thought to:

> “It's not something I've particularly reflected on; the effect a client's previous experience would have on their current experience. I have to some degree, but when you proposed that question, it just made me think actually, it's very important perhaps to understand clients’ experiences.”

H shared that she would gather information about clients’ previous therapy experiences, as one aspect of their broader history of experiences, as part of a CBT assessment. H expressed a tension between wishing to understand previous therapy whilst experiencing some reluctance to spend too much time exploring it: “because we appreciate that the first session is always limited, and we don't wanna overwhelm the client.” H shared that she may probe for further information if clients describe “issues” for example, in the therapeutic relationship. H described then pivoting back to the reasons for the current referral and the changes clients wanted to make now. To me, this communicated H’s interest in tuning into clients’ readiness to engage with an active, change-focused therapy. In-line with this, H said that if clients had not made hoped-for changes in previous CBT, then she would seek to identify what might be different this time rather than

understand those difficulties. H told me that most clients provide limited information about previous therapy experiences, with more detailed accounts linked to strong feelings about previous therapy. I had the impression that, outside of these circumstances, H saw having a limited interest in previous therapy as part of being a CBT therapist:

> "If they just you give you a basic 'Yeah, it was helpful', or 'No it wasn't', or 'Yeah, it was okay', and it's got no comment on it, I don't really dig deep or dig around it. As a CBT therapist, I just go, 'Okay this is what things would look like this time around and let's just have those conversations.'"

H talked about her work with two clients, Ana and Bal. H shared that she had brought Ana to speak about as she experienced difficulties socialising her to CBT. H linked Ana's previous experiences of counselling to this challenge, "She felt from what she read that the CBT and counselling were the same thing still." H shared that she had difficulty managing Ana's desire to use the sessions to talk and her requests to use supervision to think about managing the process were denied in favour of focusing on the protocol. In contrast, the reason H provided for selecting her work with Bal was her ability to use ideas from previous therapy as a resource in their work, which she not felt ready to engage with at the time of previous therapy.

I experienced H as open, reflective and shared some aspects of her vulnerability as a therapist which I admired. One aspect I thought I might have explored further with H was her reluctance to speculate why clients' reflections on their previous therapy experiences felt difficult to respond to.

Anita

Anita emphasised an interest in thinking about who CBT works for and understanding the experience of therapy returns from clients' perspectives: "When people have had it, what makes them come back again, or just generally what are their feelings about having it again? So, it's always been something I'd be interested to know."

Anita talked about a conflict between her training, which emphasised the importance of exploring clients' history of experience in "depth", and service pressures. Anita shared her observations that clients were often uncertain about the type of therapy they have had previously. Case notes were viewed as a convenient means of understanding clients' previous therapy history. Anita shared a keenness to check these service notes if the client was presenting with the "same disorder." Anita valued building an understanding of clients' experiences of previous therapy to allow her to personalise therapy, and to contextualise the current conditions for change. Anita shared towards the end of the interview her belief that it was important not to be too influenced by clients' previous therapy experiences. She reasoned that positive experiences could be followed by more negative ones, and vice versa, if adaptations based on past experiences were made to allow therapy to work better.

Anita emphasised a need to build trust, compromise and offer the possibility of doing things differently with returning clients, which I thought possibly suggested an assumption returning clients have often had negative previous therapy experiences.

Anita talked about her work with two clients, Tom and Lin, with whom she had completed therapy with approximately two years ago. Tom was selected because she was interested in the "relapse" of his OCD and "how it then can go into something completely different or something even bigger." Anita shared that she selected Lin as she had experienced "resistance" to her attempts to engage her in CBT, which Anita attributed to Lin's initial experience of CBT.

Anita was interviewed towards the end of her an extended period of leave from work. I thought, at times, I could have probed Anita deeper to understand her experiences with the clients. I wonder if what deterred me from doing so was that Anita sometimes referred to herself as not remembering aspects of the work or terminology she wished to use. I think I felt anxious and concerned about putting her under pressure.

Jo

Jo was an in-person interview. Jo described her motivations for taking part in the study as a general wish to contribute to research and an interest in the topic: “I have noticed when people come into the service for second time round after having like a course of CBT, there's differences in how I work with them.”

Like other therapists, Jo spoke of the importance of establishing whether clients had previous CBT, their perceptions of its helpfulness and “What are their thoughts about trying it again?” This suggested to me that Jo remained alert to the possibility that some clients may not wish to access CBT again. Jo conveyed a commitment to utilising previous therapy as a resource in shaping her work with clients: "If they can remember what interventions were used, that’s been really helpful to know...to set a foundation for my treatment with them going forwards.”

Jo shared that she was most concerned with identifying any potential “engagement with therapy” issues. Jo talked of not needing to “persuade” clients who had previously found CBT helpful. This communicated to me that Jo may have at times, felt a pressure to persuade clients to “get into” CBT by attempting to problem solve difficulties. Jo shared her experience that therapy tended to work better for clients (i.e., they would “perform better”) who waited *“*a couple of years or more” before returning for further therapy. For clients who return sooner, Jo expressed concern about the fit with CBT for their needs, and Jo related this to differences in “willingness” to “put the work in, to get the results back.” Jo reflected on being less daunted by working with clients who were critical of their last therapist and saw this as an opportunity to “turn it around.”

Jo talked about her work with two clients, Chloe and Polly. Jo shared that she brought Chloe as her previous therapy experiences aided their work together. Jo worked with Chloe approximately a year ago. Jo told me that she selected Polly because it had been a contrasting challenging experience, and as they had recently completed the work together and it was “fresh in my mind.”

I appreciated the preparation Jo had put into the interview. She came with some ideas about how the previous therapy had impacted her work with the selected clients. However, I also found Jo to be thoughtful in her responses and willing to think in the interview. I noticed Jo appeared concerned about being helpful, for example, several times asking me to interject if her response had not been useful. Due to this, I considered whether Jo had been led by my probes once or twice during the analysis. I was mindful about how I used these sections of data in the analysis.

Kate

Kate had an in-person interview. Kate did not express a strong interest in previous therapy experiences, both when she described her motivations to take part in the study: "I know that it can be really difficult getting participants at times and this is one that I could contribute to quite easily" and throughout the interview. I wondered if Kate had the sense that previous therapy was not significant in its impact because of its perceived everyday-ness: "I must admit it's not uncommon for us to see people that have had therapy before."

Kate described exploring past therapy in terms of practicalities, timing, duration, focus, and client learning. Like several other participants, Kate emphasised the value of understanding clients' previous CBT experience, she appeared to assume some socialisation to the model ("then they understand the concepts"). Kate shared her belief that clients having realistic expectations of CBT would promote model adherence and positive outcomes.

Kate described some value in obtaining more information about previous therapy, such as experiences of previous intervention, if clients returned with the same difficulty. Kate reflected that aspects of previous therapy considered helpful could be utilised ("draw on that and use that to your advantage"). When clients alluded to previously struggling with elements of therapy central to CBT, Kate described offering more explanation about the rationale, "to manage any problems that might come down the line."

Kate spoke about her work with two clients, Han and Lou. Han was selected because Kate had worked with her twice and it was a piece of work that she could recollect

clearly due to the “unusual” nature of some of the experiments and their “very, very good” rapport. Kate most recently worked with Han about 18 months ago. Kate selected Lou because of her contrasting feelings about the work, stemming from a more formal dynamic in the relationship. From Lou’s initial description of previous therapy, Kate had assumed it to be counselling, however, when they started to formulate, Lou identified the most recent therapy was CBT. Lou was someone that Kate was working with at the time of the interview.

Kate appeared to take a pragmatic approach to her work and did not report any particularly difficult emotional responses. I thought Kate had some interesting things to say about clients’ previous therapy experiences. I admired her straightforwardness in expressing her scepticism regarding the significance of clients’ previous therapy experiences. When Kate shared that her position had shifted slightly by the end of the interview, I certainly had no sense that she was trying to please me. Kate shared she would still ask the same questions about previous therapy experiences but may think more deeply about client responses and their significance to her work with them.

Tania

Tania shared that she was motivated to take part in the research by curiosity and had not previously considered the impact of clients’ previous therapy experiences: “I think it's quite interesting to think about the difference in clients who are new to CBT or therapy, and never had it before, and the difference in experiences with clients who have had therapy before.”

Tania described her process for exploring previous therapy experiences as: “Maybe just briefly, what it was for and how they found it. I don’t feel like I go that much into detail.” Tania linked this to a pressure to get started with therapy (“We don't have that time to reflect”). However, in preparing for the interview, Tania shared that she had started to question this and reflect that previous experiences have “probably quite a few implications on the therapy.” Tania shared she would consider previous experience of CBT most significant to explore. Tania’s expressed intent in doing so as follows: “I wouldn't want to

run the risk of just doing the same thing again. It's interesting because now I don't know why I would not want to do the same thing."

Tania brought two clients that she had recently discharged to talk about, Gina and Amy. Tania selected Gina because she "spoke about that previous therapy on quite a few occasions during our therapy." Tania also reflected that the "whole experience" of therapy was "interesting" when understood in the context of the picture of Gina's previous therapy experiences obtained from service notes after their therapy ended. Tania shared that her reason for discussing her work with Amy was the impact Amy's previous experience with a particular intervention had on how she approached therapy.

I found Tania to be enthusiastic and positive about her work as a therapist. I experienced Tania as candid and open to questioning herself and revealing her motives. I probably asked fewer probe questions as I noticed the frame of the interview itself appeared to stimulate Tania to reflect and think more deeply about her practice.

J

J stood out as my sole male participant. He shared that his motivation for taking part in the study was having an opportunity to reflect:

> "Step back and think about clients in different ways because obviously I have supervision, but you know what supervision is like, it's quite mechanistic from CBT point of view, isn't it? So, it's always interesting to think about stuff outside of that and the influence of therapy."

J shared that his preferred way of exploring previous therapy was to speak to clients directly although he would also consult notes. J reflected that clients vary in the extent to which they remember previous therapy, contrasting clients who are a bit "perfectionist" and retain their previous materials with "some people don't, and so don't remember any of it". For J, clear client recollections of previous therapy were unusual, and when these were available, he would use them to shape his work. J talked about how he would be curious to understand the sustainability of interventions worked on in previous

therapy: “but also think about ... ‘Why they’ve come back to treatment?’ and what the limitations had been if someone had stopped. Quite often it’s people just stop doing stuff that was helpful.”

J spoke about two clients, Dee and Jac, both of whom he had discharged a few months prior to the interview. Dee was selected because J took a much less active role due to Dee's previous therapy experiences: “I didn't really have to do that much,” which he attributed to his observation that “they already have the learning there.” Jac was selected as she had regularly talked about her previous therapy, which J had perceived to be extensive.

I found J to be an engaging interviewee, he used humour occasionally during the interview which made the conversation feel more relaxed. At the same time, I wondered if this meant more vulnerable emotions were given less space to be thought about together. Although J discussed two clients, his interview was the shortest. I did notice at times my prompt questions did not yield much in the way of further reflection, and so perhaps there was a limit to depth J wished to think about his practice with me.

Jean

Jean told me that she had been motivated to take part in the study due to the resonance of the question, “I think for me it was definitely I noticed the difference between working with people who had previous therapy and people who didn't.”

Jean shared that early in the assessment, she would ascertain clients’ experience of CBT, and their perceptions of its usefulness. Similar to other therapists, in asking these questions, Jean’s intentions appeared to be personalising therapy such that valued interventions could be drawn on as a resource, and perceived unhelpful aspects of CBT could be modified “if possible”, or she could work with the client to set realistic expectations: “or if it is part of the CBT approach, at least I could re-explain why we do that, and the importance of that.”

Jean shared her sense that it was useful to go into the specifics of clients' experiences beyond the “approach”, this could be, for example, language that was used or how sessions were structured.

Jean talked about her work with clients: Sarah and Lucy, with whom she had completed therapy within the last few months. Jean told me that Sarah was selected because "She had such a brilliant experience with her past CBT therapist" that this had "put pressure on me to live up to that standard" and influenced the work as a result. Jean shared that Lucy was selected to provide a contrasting experience, to her this work seemed like "the opposite situation." Jean described that Lucy had found one aspect of the previous CBT particularly challenging and this was something she had to navigate re-introducing.

Jean appeared to be well-prepared for the interview, she had notes which she referred to, including constructively critical reflections on her practice. I found Jean to be a generous interviewee, prepared to do more thinking with me in the interview, only once or twice appearing to prevent herself from speculating on her motivations.

Table 3.2

Therapist reported client therapy history and outcome

Therapist-client dyad	Client therapy history[a] (therapy, problem focus, timeframe[c])	Problem focus and number of sessions	Outcome or anticipated outcome
Ani-Grace	CBT[b], PTSD, 3-5 years	Social anxiety, 6 sessions	Premature ending, no recovery
Bear-Suni	CBT, GAD, 1-2 years CBT, phobia, 1-2 years	Phobia, 20 sessions	Completed therapy, recovery
Bear-Cara	CBT, LSE, <1 year	LSE, full course	Completed therapy, recovery
Marley-Jules	CBT, LSE, 6-10 years CBT, GAD, 3-5 years	PTSD, 20 sessions	Completed therapy, recovery
Suzie-Bob	CBT, OCD, >10 years	Transdiagnostic, 20 sessions	Completed therapy, recovery
Lisa-Carol	CBT, GAD, >10 years CBT, GAD, 1-2 years CBT, GAD, 1-2 years	GAD, 10 sessions	In therapy, anticipates no recovery
Lisa-Tina	Specialist service, CBT, PTSD, 1-2 years	PTSD, 7 sessions	In therapy, anticipates no recovery
H-Ana	Private, counselling, >10 years Counselling, 3-5 years	PTSD, 18 sessions	In therapy, anticipates recovery
H-Bal	Private, counselling, grief, 3-5 years	PTSD, full course	Completed therapy, recovery
Anita-Tom	CBT, OCD, 3-5 years	OCD, 20 sessions	Completed therapy, recovery
Anita-Lin	Counselling, depression, 1-2 years CBT, depression, 1-2 years	Depression, 6 sessions	Premature ending, no recovery
Jo-Chloe	CBT, OCD, 3-5 years Counselling, depression, unknown	OCD, 16 sessions	Completed therapy, recovery

Jo-Polly	Group therapy, depression, unknown CBT, depression, 1-2 years	Depression, 12 sessions	Premature ending, no recovery
Cat-Han	Specialist service, eating disorder, >10 years CBT[b], panic disorder, 1-2 years	Transdiagnostic, 16 sessions	Completed therapy, recovery
Cat-Lou	Private, counselling, 3-5 years Private, CBT, <1 year	LSE, 6 sessions	In therapy, anticipates recovery
Tania-Gina	CBT, GAD, 6-10 years Private, relationships, counselling, 1-2 years	LSE, 18 sessions	Completed therapy, no recovery
Tania-Amy	Private, CBT, body image, 1-2 years	LSE, 17 sessions	Completed therapy, recovery
J-Dee	CBT, health anxiety 3-5 years	Health anxiety, 10 sessions	Completed therapy, recovery
J-Jac	Secondary care, depression, >10 years Secondary care, depression, >10 years CBT, depression, 3-5 years CBT, depression, 1-2 years	Mixed anxiety and depression, 14 sessions	Completed therapy, no recovery
Jean-Sara	CBT, depression, >10 years	Depression, 16 sessions	Completed therapy, recovery
Jean-Lucy	CBT, panic disorder, 1-2 years	Panic disorder, 12 sessions	Completed therapy, no recovery

Abbreviations: GAD generalised anxiety disorder; LSE low self-esteem; OCD obsessive compulsive disorder; PTSD post-traumatic stress disorder. [a] Therapy provider NTT unless stated; [b] indicates client's prior course of therapy was with participant; [c] for ease, the timeframe (i.e., interval between previous episodes of therapy and the subsequent course of therapy with the participant) is presented in categories < 1year; 1-2 years; 3-5 years; 5-10 years; more than 10 years; unknown.

Theme overview

To recap, this study posed following questions:

1. Do clients' previous therapy experiences affect how NHS Talking Therapies CBT therapists experience and navigate the subsequent therapy?
2. How do clients' previous experiences appear to hinder or facilitate the subsequent therapy?

The themes derived from therapists' accounts of working with therapy-experienced clients suggest that, to different degrees, and in obvious and more subtle ways, previous therapy experiences do affect how therapists experience and navigate their work with clients. Based on these therapists' accounts, clients' previous experiences appeared, at times, to have straightforward facilitatory or hindering effects on the therapy, at others, the effects appeared more complicated. **Table 3.3** summarises the contribution of each therapist participant-client dyad to the themes and subthemes.

This study reports four themes. The first theme, **Preventability of return – therapists' lenses** and its subthemes, ***A medicalised view of therapy*** and ***Working in the therapy factory*** capture therapists' assumptions about the possibility of preventing returns to therapy. It is partly through these assumptions that therapists' responses to clients' previous therapy experiences and their impact upon the work, can be understood. Hence, this has been positioned in the thematic map as a contextual theme.

There is a temporal flow to the remaining themes, starting with the second theme, **Conducting a post-mortem of previous therapy** and its subthemes ***Skimming the surface*** and ***Going deeper*** capturing a process which starts at the outset of therapy. This theme describes therapists' interest in and approach to learning about clients' previous therapy experiences, and the implicit communication to clients in this process. The picture therapists build of the previous therapy then impacts upon the third theme, **Previous therapy as a wellspring – setting the therapist's course,** and its subthemes, ***Proving therapy works – standing out from the crowd*****;** ***Proving I'm good – going down in the client's book*****;** ***Teaming up with previous therapy*** which speaks to how therapists approach

their work with clients, from the beginning into the middle stages of therapy. This theme explores how therapists' assumptions and ideas about clients' previous therapy experiences act as a wellspring, generating emotional responses which are influential in setting the course of the therapist. Therapists could be drawn into a competitive dynamic, in matching or bettering their predecessors' work, or proving therapy works and rescuing clients from repeated therapy experiences. Therapists could also be drawn into a more collaborative position with previous therapy, open to using this as a resource. The course therapists take appears to influence their responsivity to feedback about client needs. The final theme, **The big finale,** and its subthemes, ***Mission accomplished*** and ***Failed mission*** captures the ending (or anticipated ending) of the work with clients. This describes therapists' sense-making of their endings with clients and the possibility of future returns and considers how these endings may have positioned clients in their relationship with any subsequent therapy.

Figure 3.1

Thematic map outlining how clients' previous therapy experiences impact their experience and navigation of therapy

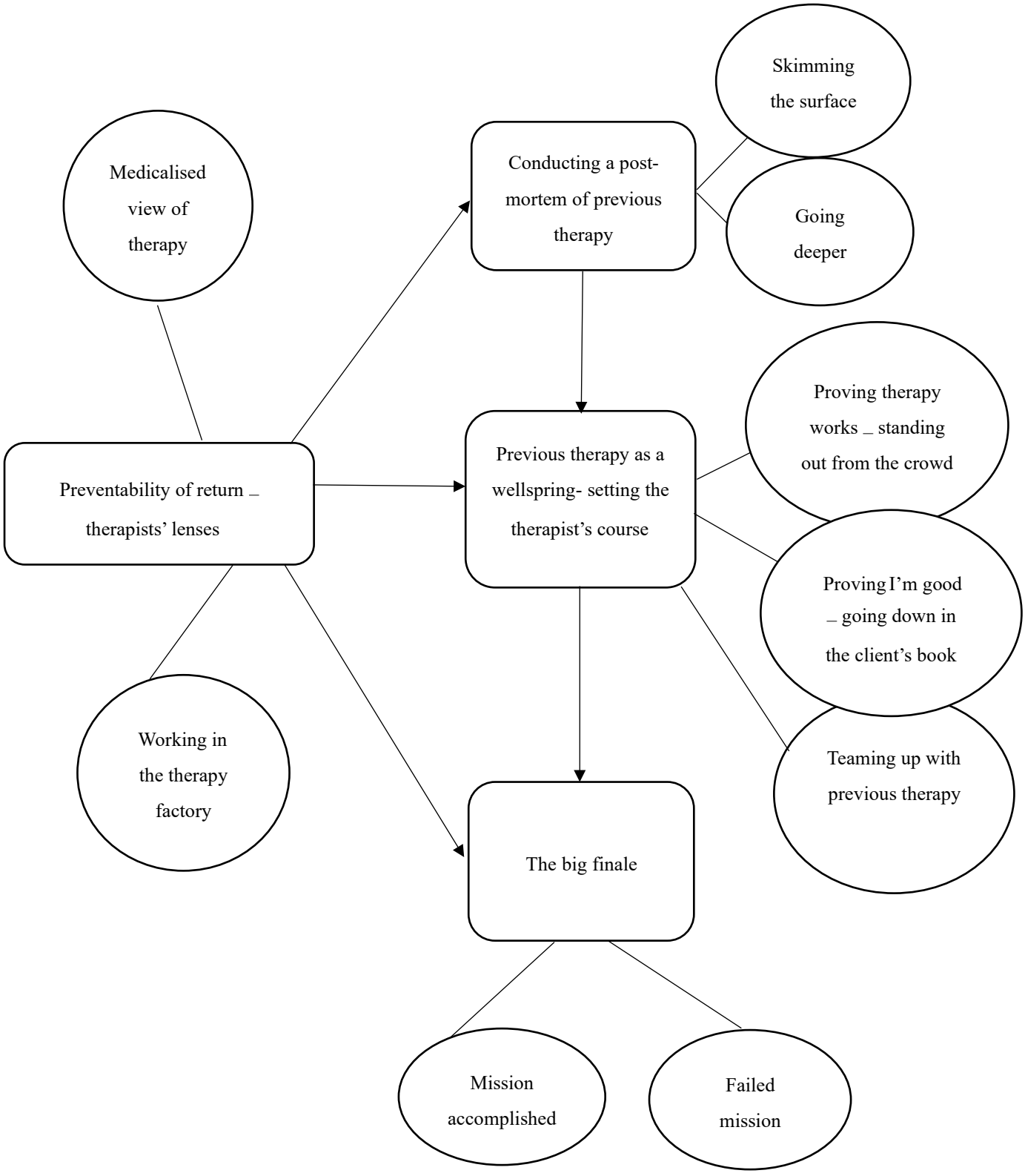


Table 3.3

Contributions of each participant to the themes and subthemes

Theme	Subtheme	Ani	Marley	Beau		Suzie	Lisa		H		Anita		Jo		Kate		Tania		J		Jean	
		Grace	Jules	Suni	Cara	Bob	Carol	Tina	Ana	Bal	Tom	Lin	Chloe	Polly	Han	Lou	Gina	Amy	Dee	Jac	Sara	Lucy
Preventability of return	A medicalised view of therapy	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
	Working in the machine	X	X	X	X	X	X	X	X		X	X	X	X	X	X	X	X	X	X	X	X
Conducting a post-mortem	Skimming the surface	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X		X	X
	Going deeper	X	X	X	X					X			X		X			X	X	X	X	X
Previous therapy as a wellspring	Proving therapy works			X		X	X	X	X		X	X	X	X		X	X					X
	Proving I am good				X		X	X	X					X						X	X	X
	Teaming up with previous therapy	X	X		X					X			X		X			X	X		X	X
The big finale	Failed mission						X	X			X	X		X			X			X		X
	Mission accomplished	X	X	X	X	X			X	X\			X		X	X		X	X		X	

Preventability of return

Therapists' ideas about how therapy works and how services work, were evident in the data. In sharing these, therapists implicitly and explicitly communicated their ideas about the preventability of clients returning for therapy. Therapists appeared to hold, to some degree, the position that when therapy is delivered correctly and the system works as intended, returning for therapy is preventable. In their experience, the reality of working in NTT services may make this endeavour difficult, threatening their sense of competence as therapists. This theme provided a contextual and cultural backdrop to the other three themes.

A medicalised view of therapy

This subtheme captures therapists' assumptions about how therapy works, and the roles and responsibilities of therapists and clients. Therapy appeared to be broadly understood within a medical model. Therapy can be expected to alleviate distress, when the correct protocol is applied to an adequate standard. Some therapists emphasised the influence of the broader context of clients' lives, appearing to offer a softer version of a medicalised approach to therapy.

Therapists were cast in a role of educator, providing the relevant knowledge and techniques according to the correct recommended evidence-based protocol for clients' difficulties, understood as disorders with characteristic symptom profiles. Adhering to a protocol was viewed as the proper way to carry out therapy and thus a means to protect the therapist from blame for poorer outcomes ("It made me more inclined to do things by the book ... I think I was more inclined to do what I'd I knew a proper CBT therapist should do" **Lisa, p10, Carol)**. Using a protocol-based approach to therapy could also be seen as a collegial act, supporting the work of subsequent therapists if clients return, as it can be assumed that a particular problem has been adequately addressed, as **Marley (p34, Jules)** reflected: "So maybe the next person who might pick her up, might be like 'Oh, but actually, there's something else going on here, PTSD has been ruled out because Marley stuck to the PTSD protocol.'" Some therapists assumed therapy-experienced clients expected protocol-

based approaches (“They’ve had the protocol therapy before and maybe I need to do that” **Anita, p17, Tom**), which could preclude more responsive ways of practising, as shared by **Lisa (p11, Carol)**:

> “I would approach it in a far more flexible way ... I don't need to immediately decide what the presentation is, and what specific protocol I'm going to follow. I think we can formulate, and then we can ... apply strategies and interventions that I know have been effective for people.”

Clients were assigned a reciprocal student role, to acquire, retain and apply the relevant knowledge to manage their distress independently according to a relapse prevention plan. The following extract from **Jean (p16, Sara)** illustrates this:

> “I think it was the right time to finish treatment ‘cos we had gone through the protocol. We had gone through all the techniques and skills. There were more behavioural experiments we could’ve set but I think she had the knowledge and skills to do those herself.”

This suggests that therapists held a sense of what a “good” client contributes to preventing returns to therapy, for the same difficulty at least (“I think it's just a shame that clients have to come back to services, especially when it's around the same thing” **Beau p12, Suni)**.

In contrast, other therapists normalised returning to therapy, suggesting their belief this was an expected outcome, as **Jo (p17, Chloe)** shared: “I always talk with every client about services that she could contact if she does need further support and that she could always come back to Talking Therapies.” These therapists posited return could be precipitated by life events or influenced by client readiness for, and desired pace of change as **H (p35, Bal)** reflected: “It put in her mind the right seeds and knowledge ... So, I think, even though it wasn’t the right time it was still something that she could use another time.” Therapists could wrestle with the idea that clients may return to therapy to have relational needs met rather than be supported to acquire knowledge or techniques. Some therapists

acknowledged the relationship provided a safe context for returning clients to use previously acquired knowledge and skills. Therapists seemed concerned about creating dependency on therapy when returning clients appeared to seek relief rather than sustainable ways of managing their distress. Consider the following extract:

> "It's almost like they want to feel less stressed, quick relief, short-term. And then they've heard me, understood it, but then they've not applied it. Then they come back to the next session seeking the same relief and nothing is changing. I've found that with a lot of clients ... particularly with clients that have had previous counselling experience." **(H, p10, Ana)**

In-line with the protocol-based approach to therapy, if both parties were perceived to have adequately played their respective roles, and distress remained or returned, therapists posited that another protocol or expert was required, perhaps implying that therapy is often the answer to alleviating distress. An example of this thinking is provided in this extract from **Jean (p15, Sara)**: "There was still a quite a challenge with her daughter and the relationship there. And we were thinking maybe a different modality might be quite helpful around that, too, just to explore that." Therapists expressed the idea that models they perceived as more comprehensive or potent in some way, such as cognitive or transdiagnostic models, could prevent relapse and further returns. This suggests that although some therapists normalised the return, they were also motivated to prevent it. In the following extract, **Jo (p9, Chloe)** shared her model selection process and how this considered the client's return:

> "'Should we just go down that route again because obviously it's worked? Should we just try it again and do a bit of a refresher?' I was also like 'Well, she's had that episode of therapy and then she's coming back. She's relapsed. So does she need something a little bit more to prevent her from relapsing in the future?' ... I personally thought that doing something different might be helpful."

Working in the therapy factory

The preventability of returns could also be understood within the context of the service delivery structures. Therapists reflected on the challenges of working within the NTT system which offers a highly proceduralised approach to alleviating distress in clients who often present with complex needs. Therapists reflected on how they responded to NTT services' emphasis on achieving recovery.

Therapists appeared to experience clients returning for therapy as a common experience ("That just happens all the time" **Lisa, p4, Carol;** "I must admit it's not uncommon for us to see people that have had therapy before" **Kate, p21, Lou).** Therapists expressed that they often felt ill-equipped to meet the needs of referred clients, suggesting they perceived a gap between their competencies and the needs of clients ("We don't get the standard IAPT clients as well" **Beau, p12, Suni).** This appeared to leave therapists with the choice of declining to provide therapy and maintaining integrity to the NTT model or plugging the perceived therapy gap by offering CBT to clients who were unlikely to recover. Consider the following extracts: first from **Suzie (p8, Bob)** who reflected on the limited number of clients they felt able to provide therapy to:

> **"**I wondered if this would be somebody who would be likely to benefit because my experience in this service is that most people are not. And I take on a lot of people and then refer them elsewhere ... because that has been the case in about 80% of patients that I pick up."

A related extract from **J (p17, Jac)** describes navigating conflict that arises from responding to a pull to provide CBT and stepping outside of service procedures or therapist competencies:

> **"**I suppose most of the people I work with now aren't suitable for the kind of CBT I was trained to provide. So, it's like you have to reconcile yourself with the fact that as long as you're in touch with it a little bit, maybe that's okay."

Within the NTT system, clients could be viewed as consumers empowered to complain ("When someone comes back, and they had a negative experience. It's like customer service, turn it around" **Ani, p19, Grace)** and make choices about the therapy they want ("I've got to do what the client wants, and what the client thinks is best for them and just deal with it. It's my job to have these difficult sessions sometimes" **Jo, p32, Polly**). The power held by clients to express their dissatisfaction appeared to deter therapists from using their own power to end therapy or impose limits. This appeared to contribute to some therapists' diminished responsivity to therapy-experienced clients. Consider this extract from **Lisa (p15, Carol):** "This is always my fear ... she'd drop out of therapy, and she'd complain about me and ... in some way I'd get some bad feedback."

Therapists seemed dependent, not only on avoiding negative client feedback to evaluate their professional worth, but also clients achieving NTT recovery. Some therapists expressed that the combination of complexity of client need, and service limitations meant they struggled to achieve the NTT recovery metric at the expected frequency. This could leave therapists feeling less confident in their role, as the quotation from **Lisa (p28, Tina)** illustrates:

> "We see people who maybe are just gonna make a really minimal improvement and so you don't get that ... feedback that you always need to keep you feeling like buoyed ... it feels like it's few and far between."

When therapists perceived they were adequately trained and competent to meet the needs of referred clients, the issue of clients presenting with multiple disorders ("People aren't just a nice neat little one thing. There's lots of things. They interact" **Marley, p33, Jules**) was described as making it challenging to meet these needs in a single episode of therapy. This difficulty was attributed to limits on the number of sessions and the need to adhere to a protocol-based approach. Consider the following extract from **Kate (p4, Han):**

> "The previous course of treatment meant that if she had come to me for the first time and hadn't had that experience, I don't think we would have got through it all

> because there were so many elements to it ... We'd have never done it all, in in our service, anyway, in the number of sessions that we had."

Therapists reflected on the limitations of their training, for example, in terms of therapy process skills, and linked this to challenges in meeting clients' needs and their subsequent return for further therapy.

> "One of the drawbacks to the training that we don't have that training in the interpersonal dynamics and understanding how to deal with that as much. That's more learnt on the job I suppose." **(Jo, p33, Polly)**

Against this background of concerns about the adequacy of their training, therapists seemed to link experience with competence. When considering the preventability of return, therapists could question their own or their predecessors' level of experience. Consider the following quotation from **Beau (p24, Cara)**:

> "I think that person was really experienced and had a lot more years' experience than me and I've not got that much ... I think they were 20 plus years' experience as a CBT therapist. And I'm not that. So, what can I offer?"

Whilst therapists appeared to ascribe to ***A medicalised view of therapy*** and see this as the correct way to carry out therapy, some therapists also perceived that personalisation could be compromised by service protocols. Therapists could feel opportunities to consider clients' relationships to previous therapy and formulate their difficulties comprehensively were restricted due to the limited time available ("Crack on 'cos you've only got 12 sessions" **Kate, p18, Lou)**. The structured nature of supervision could also curtail opportunities to reflect on the influence clients' previous therapy experiences had on their approach to therapy, as **J (p19, Jac)** shared: "It's interesting talking about people in that in that way, and your own experience of it, because I think CBT supervision, you don't tend to go into that too much."

A lack of personalising interventions to clients' needs, interests and life context or adjusting interpersonal style to the client, was seen as a factor that could contribute to

clients' needs not being met adequately ("Because the service is only allowing you an hour rather than the hour and a half this person needed" **Marley, p24, Jules)** and subsequently returning which the following quotation from **Ani (p19, Grace)** illustrates:

> "I'm sorry for saying this, but with IAPT, because it's very regimented, 'And you must do this' and sometimes because the clinician doesn't have the time or ... because the clinician is a human being having a bad day... the clinician might forget that we don't just say 'These are the rules' ... If you are like that that the person will come back. The GP will refer them back."

Some therapists described pushing back against service protocols. Consider the following extract from **Beau (p13, Suni):**

> "I think, taking it slowly, but having the time to do so, we had probably more sessions than expected ... Probably not an IAPT thing to do. It's like going back to me saying, IAPT is a machine ... if I need to have more sessions with somebody, I'll strongly push my rationale as to why."

In contrast, other therapists described a sense of disempowerment. For these therapists, pushing back against decisions made by supervisors felt difficult, impacting their work with therapy-experienced clients. Consider the following quotation from **H (p24, Ana):**

> "'I want to lay out these expectations again with the client', this was later on in sessions ... 'I'm just worried that every session we're spending a lot of time discussing and not really focusing on the CBT.' And my supervisor said, 'Let's not focus on that right now, we're already at …', whatever session, it was midway, 'Now let's keep focusing on the protocol aspect.'"

Conducting a post-mortem of previous therapy

This theme captures therapists' interest in and approach to understanding the clients' previous therapy experiences. Some therapists initially examined previous therapy in a limited way (***Skimming the surface***) and then subsequently explored things in more detail

(***Going deeper***). The approach used seemed to carry implicit communication about therapeutic process, and the degree to which clients are expected to be active and engaged participants, able to retain and recollect the experience of therapy. This theme also captures therapists' reflections on clients' contributions to the process of building a picture of previous therapy.

Skimming the surface

For most therapists, previous therapy was initially explored by looking at the previous notes, where available, which led therapists to form an impression about the quality of the previous work ("When I looked at that it didn't appear to go well for the client at that time" **Beau, p3, Suni**). The quality of notes seemed to be used as another marker of previous therapy adequacy, perhaps speaking to the thoroughness of the previous therapists, as **Anita (p17, Tom)** shared: "I just remember...the previous therapist did do some really good ERP with the client, notes were good, 'cos sometimes you do get rubbish notes." However, service records were not always consulted ("And I didn't really look at the notes through our therapy or anything" **Tania, p10, Gina)**. Therapists would also ask clients about previous therapy and form impressions based on their answers, as illustrated by **Suzie (p10, Bob**):

> "So, he didn't say lots about it. He said, 'It was really good' ... I think I remember him saying that he'd achieved things that he didn't think he could achieve ... and that he learned coping mechanisms for dealing with anxiety ... He said that the reason he was back was because he'd used those coping strategies but then become complacent. So, initially, it was a good account of therapy."

Some therapists described not exploring previous therapy in much more detail beyond those surface impressions. It seemed possible that this could communicate to clients their previous therapy experiences are not significant, and close off therapist curiosity about client attempts to instigate conversations about previous therapy, as the following extract illustrates:

> "So, therapy was referred to a lot of the time, therapy notes, therapy history was referred to, by the client, but it was never really asked about much more from my point. I felt like at the time, it felt irrelevant because I just wanted to work on what I was working on with this client" **(Tania, p15, Gina).**

The possibility that this limited curiosity about previous therapy experiences leads to a less person-centred, formulation driven approach, was highlighted in the following reflection on the interview:

> "But the more I talk to you about these things, the more it's making me realise that for whatever reason I don't spend very much time getting lots of detail about people's past experience in therapy. I know that they've had it and then I seem to quite quickly jump to a position of 'Right. Okay. Well, I either need to do the same or something different' but more based on what I think it is that they've had that's worked or that they've had." **(Lisa, p24, Tina)**

Therapists expressed concern about using too much time reviewing previous therapy experiences, as the quote from **Suzie** (**p27, Bob**) illustrates: "I think because CBT is very time limited and structured and focused. The main impact is on the time that you've got to make the best use of it." This concern about efficiency fits with therapists' experiences of the NTT context (see ***Working in the therapy factory).*** Furthermore, detailed exploration could be deemed to have limited therapeutic value and clash with a "wipe the slate clean" **(Cat, p17, Lou)** or "new chapter, like a clean slate" **(Tania, p17, Gina)** approach or could risk an anti-therapeutic experience by placing clients in touch with feelings of failure. Restricted curiosity about previous therapy experiences could also be a mechanism to protect therapists from discomfort, for example, stemming from "forcing that learning [from previous therapy] on them" **(J, p5, Dee)** or a fear of not being able to replicate the work of the previous therapist.

Therapists could experience reluctance in relation to exploring previous therapeutic relationships. Therapists appeared uncomfortable with ("I didn't think that was appropriate"

Suzie, p26, Bob) or uncertain about such enquiries ("I didn't really think to ask about the relationship, maybe I should have done" **Jo, p8, Chloe**). This could be linked to a greater valuing of therapy content. Implicitly, this may communicate to clients that the relationship is off-limits for discussion.

Restricted curiosity appeared to stem from low expectations about the depth of clients' recollections of previous therapy experiences, based on their observations "most clients' memory of it is quite poor" (**Kate, p23, Lou).** At times, these therapist expectations were defied by clients recollecting more about their experiences and understandings from previous therapy as the work unfolded. Foreclosing too quickly on this possibility may reduce opportunities for therapists to draw on this knowledge as a resource. However, remaining open to the possibility may allow existing understandings to be utilised in the therapy. Consider the following extract:

> "We were talking through it, and it's like, 'Well, there's not much'. But then, I think, as we started to do a diary, as we started to formulate...and then it was like, 'Oh, right...the reassurance seeking was a big thing that I stopped doing'" (**J, p5, Dee)**.

Therapists could also wonder about the accuracy of client accounts of previous therapy ("It's very difficult to know what it was like ... She's describing something that was 15 years ago, she's talked about it a lot, she's probably reshaped it quite a bit" **J, p16, Jac)**. Encountering generalised responses appeared to deter therapists from persisting in finding out more about previous therapy. The following extract suggests this could create a dilemma for therapists in exploring previous therapy further.

> "It looked like from that [symptom questionnaires] that she hadn't really made much progress but obviously at the time maybe I should have ... said something, but ... I had a discussion with my supervisor and said, 'This is what's being said. Shall I raise this?' and the decision was not to because ... I didn't want it to seem

> I'm...reading all her notes and disbelieving what she's saying. The best thing it felt like was to do was maybe take her experience as she ... gives it us." **(Jo, p28, Polly)**

In response to their participation in the study, therapists shared their future intentions to examine previous therapy experiences more thoroughly and persistently, going beyond the initial impressions offered by clients. This appeared to be motivated by a wish to avoid repeated patterns of limited engagement in therapy, as the following extract illustrates:

> "I want to talk about previous therapy a bit more in that first session, and maybe because I've just recognised the pitfalls it meant in that first client experience. It was really interesting to reflect on that and think it actually has such a profound impact potentially on our work together." **(Tania, p30, Amy)**

Going deeper

In contrast, some therapists expressed a keenness early in therapy to go beyond initial impressions derived from the notes and conversations with clients. Therapists appeared more interested in clients' approach to previous therapy and their learning from it, as opposed to their relational experience with the therapist.

Therapists' motivations to go deeper appeared to be linked to a desire to build on clients' previous therapy experiences, learning what worked well and less well, and anticipating any stuck points in therapy. Consider the following quote from **Jean (p18, Lucy)**:

> "She was very open and honest with her previous experience, how she found things, how she did find things helpful, and things that she didn't find helpful ... The thing she didn't find helpful was the idea of the last therapist asking her to spin around in a circle in a chair. So, I suppose I did have that conversation head on with her with this idea of 'If you think about CBT is about helping you to think differently and learn about your symptoms ... so sometimes we do ask you to bring on those symptoms so you can relate differently to them.'"

Therapists appeared frustrated by brief notes and communicated their desire for clues to enhance the therapeutic experience for clients ("You look at the notes to possibly get a connection to the client, don't you? And see what's happened previously so you can build on that therapeutic relationship" **Beau, p8, Suni)**. Notes were interrogated in detail to form grounded judgments about the adequacy of the previous work and to shape initial hypotheses about the client's return to therapy ("I do remember that there were a couple of notes I saw that made me raise eyebrows as to 'Is this PTSD?'" **Marley, p11, Jules**).

Therapists could be seen as taking a more active role in prompting recollections of previous therapy. It appeared the implicit communication in these attempts was an expectation for clients to remember and draw on aspects of previous therapy, as the following shows: "I mentioned some things like 'Did you look at hypothetical and current worries?' 'Oh no, I didn't look at them. I don't know what they are.' And then I asked about certain things within the GAD protocol, she didn't have a clue regarding what I was saying" **(Beau, p4, Suni).** Working with the same client again could lead to exploring learning from previous therapy in more depth. This seemed to be due to greater confidence that the client had retained the learning.

> "So that was drawing out the formulation and looking at that again and saying 'Does this ring a bell, and do you remember when we looked at this? And do you remember us talking about this and how these things connect?' ... just triggering those sorts of memories really of the previous work and why we did it." **(Kate, p7, Han)**

The attempt to elicit information about previous therapy was a thread that ran through the assessment, formulation and intervention phases of therapy. Therapists noticed clients remembered more as therapy proceeded, putatively due to increasing safety or exposure to cues: "She would remember stuff from previously like, 'Oh, that's that bit of it but it's coming out in this way now' and that self-discovery around it" (**Marley, p29, Jules).**

Previous therapy as a wellspring – setting the therapist's course

This theme describes the generative effects clients' previous therapy experiences could have on therapists. Therapists' perceptions and beliefs about these experiences impacted therapists' emotional responses, and their ideas and intentions about how to proceed in therapy. As a result, previous therapy could be influential in setting therapists' course in therapy, with some variation in the degree of this influence. Clients' previous therapy experiences could be experienced as something to better, replicate, or build upon. Therapists could occupy multiple positions in the therapy, striving to better the previous therapy experiences (***Proving therapy works – standing out from the crowd***), striving to prove themselves as a therapist (***Proving I'm good – going down in the client's book***) seeking to use previous therapy as a resource in the work (***Teaming up with previous therapy***). Previous therapy experiences could pose a threat to therapist self-worth or offer therapists an opportunity to bolster their sense of professional self-worth.

Proving therapy works – standing out from the crowd

Proving therapy works appeared to be a position therapists took up when they perceived clients had less successful therapy experiences in the past or had a desire to prevent further returns to therapy. Emotionally, some therapists initially felt anxious and low in hope, and proving therapy worked offered the possibility of escaping such feelings. Other therapists appeared to be fuelled by feelings of anger or a sense of injustice and a zeal to rescue, with confidence they could do better. Common to both, this therapy offered a way of bolstering therapist self-worth in relation to their role. Therapists were drawn into striving harder than usual to make the therapy work, the effects of this appeared to be varied. This could appear to pay off with positive engagement and successful outcome (see ***Mission accomplished***). Alternatively, some therapists perceived their clients' historic unhelpful patterns of relating to therapy had been replicated and therapists had failed to meet their own expectations (see ***Failed mission***).

Some therapists could initially experience feelings of insecurity and diminished hope. These feelings could stem from sensing trouble ahead, due to clients bringing feelings of dissatisfaction or low expectations from previous therapy into this therapy, and additional pressure to offer something different, and make this therapy more effective, as the following extract from **H (p10, Ana)** illustrates:

> "I felt bit of pressure to make sure that this was gonna be right because ... where someone's had therapy, and it's not giving them the result they are looking for, and this lady is in her forties. I felt the pressure to make sure that, where I know CBT does work."

In contrast, when previous therapy had gone well, feelings of security and hope could be engendered, and the drive to prove therapy works emerged when challenges were encountered in therapy ("Oh okay, this is not as straightforward" **Anita, p16, Tom)**. ***Proving therapy works*** offered the opportunity to bolster therapist confidence and escape feelings of insecurity as shared by **Lisa (p12, Carol)**:

> "I think this potentially is the impact of when you get people who've had lots of past experiences of therapy for me anyway it starts to become 'Okay, so how can I be the one who actually breaks this his cycle, and is the one who gets them better?'"

Some therapists seemed to be drawn into this competitive dynamic with the previous therapy from an unfazed, self-assured position, as **Kate (p22, Lou)** reflected:

> "So, if I know that they've had lots of treatment before that doesn't bother me, I'm not worried by that. I'm here to, 'Let's start from the beginning to look at what the problem is and put that experience to one side.'"

Therapists could experience feelings of anger directed towards previous therapists if they perceived the previous therapy to be inadequate in some way (see **Preventability of return**). Some therapists were explicitly critical of the work of the preceding therapist(s), and responsibility for the return was attributed to their shortcomings, rather than client circumstances. These ways of thinking appeared to fuel feelings of self-assurance by

differentiating the therapists from their predecessors. These therapists also appeared to welcome the opportunity to prove they could offer a better experience in their work, as the following extract illustrates: “Inwardly I felt like pleased that I could do something different with this person ... I didn’t really see it as a challenge because I thought I could do this ... I was looking forward to giving him a better experience” **(Suzie, p15, Bob)**. Other therapists’ self-assured position appeared linked their ideas about justice and a commitment to reducing the burden of client distress using CBT**.** In this way, returning clients offered therapists an opportunity to prove that CBT is effective and have this affirmed by clients: “I wanna right the wrongs, not in a, I said it earlier ‘I could do better’, but more in a ‘I wanna do it for them’. I want them to think ‘Okay, CBT is alright, it's quite good’” **(Tania, p27, Gina).**

Previous experiences of therapy that were reported as challenging by clients, or therapist judgements about the limitations of previous therapy appeared to offer a potent guide for the subsequent course of therapy. Therapists set out to remedy these limitations, for example, by including previously omitted elements, making adaptations, or helping clients better understand and tolerate interventions. Consider the following extract:

> “She had told the last therapist she was feeling better and that's why she finished treatment early, but actually, she wasn't feeling better ... So, I suppose that that then, was like, ‘Okay, I don't want that to happen again to us.’” **(Jean, p18, Lucy)**

Therapists attempted, consciously and less consciously, to ensure therapy worked in a variety of ways. Some therapists sought to reduce the perceived negative impact of previous unsuccessful therapy experiences by recognising clients’ struggles to alleviate their distress, or by nurturing hope and motivation as **Kate (p17, Lou)** illustrates:

> “I will have been and was more encouraging and hopeful so … using a few motivational techniques ‘cos if they've had two courses of treatment before that haven't gone well, it's trying to say that ‘That doesn't have any reflection on what we're doing now and we'll figure this out together and it takes as long as it takes to work it out.’”

Some therapists seemed to build client trust and engagement by subtly criticising the previous therapy and/or the previous therapist. Consider the following extract from the interview with **H (p12, Ana)**:

> "Then she'd wanna quickly go back to talking about what had happened, but then would still say that she's feeling the pain after the session ... very distraught and unwell … I tried to explain to her that counselling is not a protocol for trauma, and I think she questioned why she had it then, and why she had it for so long then."

Once their therapy was established, if clients attempted to initiate conversation about previous therapy, these therapists experienced discomfort and sought to re-direct the conversation back to the here and now.

Other ways of giving their therapy the edge included offering a new therapy model with a wider scope, incorporating more cognitive or transdiagnostic strategies, drawing on more creative ideas to target client distress and navigate barriers, or engaging in additional efforts to acquire resources to ensure the therapy was successful. Consider the following extract:

> "I wanted to make sure it was gonna work for her. So, I wanted to make sure that I had the best resources to help with that. And you'd do that for any client, however, there was something I felt I had to prove with this client to make sure that I did ... So, I was working a little bit harder to make sure that we had that." **(Beau, p16, Suni)**

Therapists perceived clients responded positively to these efforts and provided positive feedback, reinforcing this position ("He used to quite often refer back to the therapy that he'd had. And he used to compare what we were doing with that in a favourable way" **Suzie, p6, Bob)**.

Some therapists could at times appear to disempower clients, partly in view of their repeated and/or unsuccessful previous therapy experiences, as **Lisa (p24, Tina)** shared: "There was maybe just a sense there of perceiving ... she's not capable of doing this herself, and I need to help her." Taking this view, therapists could position themselves in a more

controlling, less collaborative position. In the next extract **Tania** (**p11, Gina**) responds to client hesitancy about further therapy by affirming the need for therapy and directing the focus on what she considers to be the underlying issue:

> "'I worked on worry. I'm fine now. I don't need it'... I was like, 'This person's been through a lot, and I just want to do them justice' and it felt appropriate by working on their core beliefs and low self-esteem I might do that."

As if to underline discontinuity with previous therapy experiences, some therapists could be driven to offer something different rather than be guided by the client and their formulation. Consider the following extract from **Lisa**'s interview **(p26, Tina)**:

> "I think what has happened is that I, and the same happened with Carol as well, rather than being like client-led and asking what it is that they want, I jump to a conclusion that 'Okay, this is what they've had in the past, and I need to do something different' and I'll take therapy in this particular direction."

Therapist commitment to offering something different could also seem constraining ("But I never really went over the GAD stuff with her again. I think when we did the low self-esteem model and she really connected with it, or appeared to, it just felt, 'Let's just continue going on' **Tania, p12, Gina)**. This could lead to feelings of deflation when it appeared the plan was not working: "It was more that resistance, so I think it still sticks to me because we spent a lot of time thinking about trying to help the client understand" (**Anita, p19, Lin)**. Possibly to avoid this aversive state, rather than adjusting their approach to this feedback, therapists found themselves recommitting to the plan. Therapists' difficulties navigating process issues such as potential resistance contributed to their reduced responsivity and ability to navigate therapeutic impasses, as the following extract from **Jo (p36, Polly)** illustrates: "I think at the time I was just so caught up in it and 'I want to make this intervention work for you.' I didn't realise that was an option at the time until it was too late."

Detection of reduced responsivity and the strength of the pull to prove therapy works could prompt an adjustment in approach, as **Suzie (p20, Bob)** reflected: “I think the reason I was doing that is because initially I was being more directive and answering the questions is because I really want to help him.”

The drive to prove therapy works and stand out from the crowd appeared to limit the credit that was attributed to previous therapy. In the following quote, **Kate (p20, Lou)** attributes success in therapy to new-found client hope and willingness to engage rather than familiarity with concepts gained from previous therapy, which had been alluded to earlier in the interview: “I could say it’s that there's hope ... ‘I've done it twice they've not got me anywhere and this time I'm going to crack on and really focus on these things that are really difficult for me.’” In this way, therapists could seem less collaboratively oriented and appreciative of the potential contributions made by previous therapy experiences.

Proving I’m good – going down in the client’s book

Another competitive position some therapists were drawn into was a quest to prove they were a “good therapist.” Ideas about good were based upon the clients’ previous therapy experiences. Therapists were drawn into this striving pattern when a previous therapist appeared favoured and/or clients appeared critical of previous therapists. Therapists appeared driven to avoid criticism, and be remembered well, as good and helpful in the clients’ eyes. This desire translated into doing therapy in the same way as lauded previous therapists or avoiding making therapy too hard as the criticised therapists had. This could conflict with therapists' ideas about therapist competence, and as a result, therapists could feel dissatisfied with their approach (see ***Failed mission***).

Some therapists seemed to be drawn into this position when they perceived the previous therapist had been idealised or therapy had left a particularly positive and deep imprint. Consider the following extract from **Beau (p22, Cara)** which illustrates this:

> “To be honest, it's this specific client I'm thinking about, but I know when I've had clients that it's gone really well with before, I feel a bit of the imposter syndrome of:

> ‘Oh, I'm not the best therapist ... How can I surpass that? ... How am I gonna do it to that level of before really?’”

Clients requesting to see their previous therapist appeared to induce feelings of anxiety in subsequent therapists, as **Lisa (p7, Carol)** shared: “I was aware that, not that the stakes were high, but ... they really wanted to go back to somebody that they liked.” The valuing of a previous therapist could be interpreted as a devaluation of themselves. This could suggest that therapists’ professional self-worth may be less stable when working with therapy-experienced clients.

Self-comparisons with previous therapists generated feelings of anxiety and doubts about whether they were suitably experienced or qualified to meet the client’s needs, as the extract from **Lisa (p22, Tina)** illustrates:

> “Tina had had sessions with a neuropsychologist ... I don't really know what neuropsychologists do but, in my mind, I was thinking, ‘Right. Oh gosh. Okay. They’d done some really proper stuff because this person’s got a really fancy title.’”

Hearing client criticisms of previous therapists alerted therapists to aspects of their practice to be more sensitive to (“And she said that although she got chance to talk, she didn't feel that the counsellor showed her much empathy.” **(H, p8, Ana)** and anticipation they, too, could be criticised (“That also made me think, ‘God what’s she saying about me’ ... ‘How’s she gonna be picking apart my mannerisms?’” **J, p12, Jac**). Client criticisms of previous therapists appeared to create an additional pressure to perform in-line with client expectations and avoid criticism rather than attempting to understand or formulate this client experience.

Due to their past experiences, within this dynamic, clients were positioned as experts in CBT and the wider system, as **Lisa (p11, Carol)** shared:

> “She is a bit challenging in that...she wants you to be very specific about ‘So why are we doing this?’ ... I get the sense from her that there’s an awareness of the theory behind it which it's completely reasonable. It's not a criticism of her. I don't

> necessarily get that with everybody that I see whereas ... basically she had some insight, didn't she? She'd had some past experience; she knows what a good CBT therapist looks like."

Against this background, therapists expressed a strong sense of pressure to match their predecessors' standards and style of practice, as **Beau (p27, Cara)** shared: "I think it's that doubt of ... 'Am I doing this right? Am I doing it the way that they were taught before. Am I missing anything out. Is this right?'"

Therapists' intent in seeking feedback, something they shared doing more frequently, was to ensure that they were doing therapy as well as their predecessor. Consider the following quote from **Jean (p4, Sara)**:

> "I spent a lot of time getting reassurance from her ... And I suppose that didn't come from an idea of trying to get an understanding and feedback from the client in terms of 'Is she understanding what we're doing?' I think it came from more of a place of, 'Am I living up to the expectations of what she's hoping for and this past therapist who was really life-changing for her?'"

This reassurance could also be sought from supervisors: "I was taking it to a supervision a lot more than probably I would do with other clients, just to make sure I'm doing the protocol correctly" **(Beau p23, Cara).**

Within this power dynamic, therapists seemed to use other strategies to stake a claim on their expert-status and assuage their anxiety. Therapists displayed their knowledge in a less responsive way by "over-explaining" or revisiting psychoeducation for interventions clients already understood rather than engaging in a more reciprocal dialogue, identifying areas of strength and gaps in knowledge. Therapists also engaged in additional efforts to prepare for sessions as **Lisa (p13, Carol)** shared: "I feel like I've done more reading ... I've checked up 'Am I following the right protocol?' whereas I don't always do that with other people that I see. I trust myself."

For some therapists, these fears of disappointing clients did not recede during therapy. Despite positive feedback and improvements in outcome measures, clients' ongoing references previous therapy appeared to keep therapists preoccupied with proving themselves as competent as the previous therapist, as the following extract from **Beau (p21, Cara)** suggests:

> "It went really well but I think it was more about my feelings throughout, and I don't think they changed throughout. I don't think there was a point where I didn't think I need to check in with how this is going... I think I was a little bit GAD-y myself in the sense of, 'Has this gone well? And have I done it justice?'"

When clients had successful previous experiences of therapy, doing therapy well was reduced to doing therapy in the same way as the previous therapist, possibly in-line with ideas about how therapy works and what it means to be a good therapist (see ***A medicalised view of therapy***). Therapists who were concerned with avoiding criticisms levelled at previous therapists appeared hamstrung in their attempts to expand what could be tolerated by clients. This fear of, and motivation to, avoid criticism is illustrated in the following extract from **Lisa (p21, Carol):** "I would go down in her books as being somebody that she didn't like, and somebody that hadn't helped and be put in the same category as the therapist that she hadn't liked." As such, therapists could become caught in a pattern of exercising excessive caution, by not addressing the limits of therapy with clients, and delaying or not promoting interventions clients were anticipated to find difficult again. Consider the following extract from **Jean (p19, Lucy):**

> "I used to ask every session, 'Right ... what can we do today in session that's gonna help you to learn more about your symptoms?' And it was like, 'Oh, no, I'll do this outside the session.' And then I was like, 'Okay.' And then the next week it was the same thing, 'What could we do in session?' and then it was like, 'I'll do this outside.' So, I suppose ... that reduced me in my confidence trying to aim for doing things in the session."

Accordingly, it appeared for some therapists, ***Proving I'm good*** clashed with ***Proving therapy works.*** Furthermore, for some therapists, a pressure created by ***Proving I'm good*** and their ideas about clients' previous therapy experiences led to an avoidance of eliciting expectations and having conversations about reasonable hopes for this therapy. As a result, therapists found themselves loosening boundaries and extending beyond the therapeutic hour or allocated sessions. Consider the following extracts, first from **J (p17, Jac)** who expressed his discomfort by grimacing as he described: "And then, after the blueprint, she was like, 'Oh, it feels a bit sudden. Can we have a couple more sessions? Just because I'm so used to you phoning and listening to me'. And I was like, 'Okay, yeah"'. The second is from **Jean (p11, Sara)** who talks about shaping the sessions in response to her worries:

> "Let's say we talked about something in session, but we hadn't got to formally doing a homework task, writing it, instead of me saying, 'Okay, we've ran out of time for today. How do you feel about doing that then?' I wanted to make sure that I did it properly with her, so that I gave that extra time to get that homework task done, so that she was leaving with that same experience that she had the last time ... rather than 'Jean's just letting me go and do it myself.'"

When met with difficulties in therapy, particularly those encountered in the clients' previous therapies such as limited progress or partial engagement, therapists' supervisors were positioned as potential obstructors. Discussing their work with these clients in supervision risked the therapist being instructed to stop therapy and then becoming another criticised therapist. This seemed to lead to avoidance:

> "I'd made a decision that I was going to work with this person and deliver CBT in a particular way. I think I had some fears if I bring this to supervision my supervisor might say to me 'Lisa, what's your rationale for offering another course of CBT to this person?' If they'd have said that to me, I would have struggled to have provided my rationale and then that would have put me in a position where I then would have to have had a conversation with them where I said 'I don't think it's appropriate for

> you to have more CBT ... I need to discharge you' and I don't think I could have done that, so I think I deliberately didn't bring her to supervision." **(Lisa, p20, Carol)**

Teaming up with previous therapy

Teaming up with previous therapy describes a collaborative positioning in which therapists appeared open to and engaged in drawing on clients' previous therapy experiences as a resource. Therapists' sense of the previous therapy as successful in some way, even if this was not sustained, appeared to encourage this positioning.

Some initial anxieties were experienced by therapists about how they would compare to previous therapists or if they would be able to add anything of value. However, these anxieties did not appear to persist, tempered by responses of curiosity about the previous therapy and its possible relevance to understanding clients' presenting difficulties and identifying ways forward, as the quotation from **Marley (p13, Jules)** illustrates:

> "I'm like, 'Oh that's interesting they've already had few rounds. What's going on for this person?' And yeah, I've gotta hold that ... because sometimes what they come with is nothing like what they come with before, and so ... hold it lightly and think, 'Oh, could this be another piece of this more holistic puzzle', or is it that they have just gone through something entirely different ... and we have to do a completely different piece of work for them?"

Therapists appeared struck by the resourcefulness of clients in relation to their previous therapy experiences, and this seemed to be a source of therapist hope. These impressions were grounded in observations about clients' relationships with therapy ("It's not like the five that you sometimes see. And they were quite far apart in the dates ... It's not like someone who is having back-to-back treatment, and something is clearly not working" **Marley, p14, Jules**), and engagement in previous therapy ("Well, I remember the treatment we did, and how brilliant she was ... So, I read up on what we did. She was successful very quickly" **Ani, p4, Grace**). An impression of resourcefulness could also be grounded clients'

socialisation to therapy and the knowledge they brought previous therapy, as the following extract from **Tania (p22, Amy)** illustrates: “Even in our first session, she was really socialised to the model.” Client resources from previous therapy could become apparent as therapy proceeded, as **H (p34, Bal)** reflected: “She was drawing on ... some of the things her counsellor said about moving with them in a different way.”

Therapists were complimentary of their predecessors’ work (“They’d very much stuck to the treatment model ...but not in such a way that there couldn’t be some flex in it to accommodate to the person’s needs” **Marley, p11, Jules)** and took up a non-blaming, pragmatic stance in relation to any possible weaknesses of previous therapy. This appeared to support the collaborative positioning in relation to the previous work, framing variation in therapists in terms of style rather than quality. Therapists attended to aspects of the previous therapy which they could address in their work with clients whilst holding a curious, nonjudgemental view of previous therapy. Consider the following extract from **Jo (p19, Chloe):**

> “I didn’t see any discussion about it in the previous therapy notes. I'm not sure if it was happening and it wasn't identified, or it became a problem after she finished therapy, and maybe some of the skills got a bit rusty. So, it could’ve been that she was doing it without distraction in the therapy and couple of years later it fell by the wayside.”

Consistent with the collaborative positioning, therapists appeared keen to communicate to clients the value of their previous therapy experiences as a resource to draw on in their therapy. The following extract from **J (p9, Dee)** illustrates this therapist humility well:

> “I kept saying, ‘It's like about integrating the stuff that we've done previously, that you’ve done previously, the learning you've made and really, this isn't about, like I’ve told you some great secret. It's more about learning you've made doing this stuff. In lots of ways, it feels like it's about solidifying stuff that you knew already,

thinking about how you're gonna put that into practice, and how you might deal with wobbles and setbacks and all that stuff.'"

Some therapists adopted a more idiosyncratic approach by adapting therapy based on the clients' previous therapy experiences ("There was a huge shift in my emphasis on this phase of therapy" **Tania, p23, Amy)** and therapists' understandings of why the client had returned. Consider the following extract from **J (p3, Dee):**

"They kind of basically led things. So, I strayed a little bit from the protocol just because they were coming up with all these behavioural changes that they felt like might be helpful to make. And I was like, 'Yeah, let's do that.'"

Tailoring therapy around clients' previous experiences therapists could lead therapists to deviate from service protocols or treatment manuals; by requiring more or time to formulate and intervene ensure sustained improvements. Consider the following extract from **Marley (p10, Jules)**: "We just needed to make sure, because previously she had gotten into recovery and gone up. So, 'Let's make sure that this is definitely sorted for you before we send you off for more couple's therapy.'"

When the previous course(s) of therapy had addressed specific problems, therapists opted to pick up where the previous therapy had left off, focusing on hitherto unaddressed problems or maintaining factors and consolidating the previous work. Consider the following quote from **Kate (p8, Han)**: "I knew that that it was very comorbid. So, actually, knowing that one problem had already been dealt with was good because they could really focus on what was left."

Therapists took the view that harnessing client resources to influence therapy enhanced their work by increasing their ownership: as **J (p9, Dee)** shared: "I think if people are coming up with things themselves then it's likely the therapy is gonna go well." Clients took a larger or leading role in generating treatment plans or shaping the course of therapy based on their previous therapy experiences. Consider the following extract from **Tania (p25, Amy)**: "It was a really lovely moment for us in therapy because it enabled me to make

sure I didn't make the same mistake." Therapists appeared to feel emboldened by the clients' previous experiences of successful intervention, combined with their CBT knowledge, allowed therapy to proceed at a faster pace than it might have otherwise done. Client familiarity with CBT terminology and concepts meant therapists felt freer to be more direct in how they spoke and what they proposed, as the following extract from **Kate (p8, Han**) shows:

> "Because you can say things like 'We'll do some experiments' and because they've got that prior knowledge of CBT, they know what that means, whereas if you say that to somebody who's got no knowledge of CBT, 'We're gonna do an experiment' they don't know what you're talking about, and it might frighten them as well."

Therapists who had previously worked with the same client described feeling in a unique position to draw on the depth of the relationship as a resource to have more honest dialogue, as **Ani (p5, Grace)** shared: "We looked at ... advantages and disadvantages of, 'Is this the right time? Is CBT working this time around?' So, I think our good relationship allowed this transparency … it was easier to discuss these things because we had a good therapeutic alliance."

At a more surface level ***Teaming up with previous therapy***, therapists described therapy as more efficient.

> "We didn't take as long because ... when I asked her, 'Can you summarise your understanding of what's going on? Or can you summarise the flight-fight response?' ... she was very quick with her responses explaining those things, so I suppose that made things easier." **(Jean, p22, Lucy)**

This more superficial collaborating appeared to overlap with a more competitive positioning (***Proving therapy works*** or ***Proving I'm good***). As such, willingness to use previous therapy knowledge as a resource was combined with a drive to surpass clients' previous experiences. Consider the following extract from **Jo (p16, Chloe):**

> "You need to take into account the client's past experience … because I think that if

> I'd ignored that … she might've felt a bit I suppose a bit disappointed, and not really ... taken into account as a whole person with all her experiences. It might have just been ... taking a very blinkered day-to-day view of what's going on now this episode that you've come in for now rather than 'Okay, you've had this experience in the past of therapy, I'm gonna bring that in and build on that to make things even better going forwards.'"

The big finale

This theme captures how therapists made sense of endings (or in some cases anticipated endings) in their work with returning clients, considering their previous therapy experiences. Some therapists ended therapy with the sense that they had met their own, client and service expectations for the therapy (***Mission accomplished).*** Among these therapists, some appeared satisfied their therapy was akin to a big finale to clients' therapy journeys, and providing clients continued to practise their therapy skills, they should not return. Others anticipated that, if clients were to return, it would be with positive expectations of therapy or an understanding that therapy is a journey, and each episode contributes to the bigger picture. Hence, the beginning of any future therapy in these endings was anticipated to be positive. In contrast, in other cases therapists ended therapy with the sense that they had not met their own (or service) expectations (***Failed mission)***, even if clients reported their expectations were met. These therapists reflected with concern on how these endings positioned both themselves as therapists and clients in relation to the possibility of future returns. For these therapists, the beginning of any future therapy as seen in these endings was anticipated as likely to be problematic. This theme was created to capture what therapists were left with in relation to their work with the therapy-experienced clients.

Failed mission

Some therapists adopting a competitive position in relation to previous therapy responded to the ending with feelings of disappointment due to their own unmet expectations for therapy. Therapists appeared disillusioned by the outcome, either by failing

in ***Proving therapy works*** or succeeding in ***Proving I'm good*** by avoiding criticism yet compromising their integrity in the process.

For some therapists who had set out on a course of ***Proving therapy works,*** frustration, disappointment and a sense of failure arose when they perceived their attempts to replicate successful therapy or disrupt a pattern of unsuccessful therapy had failed. For clients who had engaged, therapists appeared concerned clients had made (or were likely to make) partial improvements rather than recover. For these therapists, partial improvements were equated to failure, even when clients expressed satisfaction with their progress. Therapists expressed wishes to offer more therapy in the hope this would lead to further improvements. Consider the extract from **Jean (p24, Lucy)**:

> "I felt like we could do a good bit more. I would have been very happy to keep going ... but she was like, 'No, I think I've learned quite a lot so far, and I'd like to practice that ... I know I can come back' ... that frustration come back up of 'Oh, we could do a little bit more and it could really help', because I don't think I got that client into recovery."

For clients who were perceived to have struggled to engage with CBT, therapists appeared concerned that they had missed opportunities to name challenges in therapy or curtail therapy sooner when this did not appear to be meeting clients' needs. Therapists seemed to recognise in retrospect they had overcommitted to their plan to make the therapy work, closing off other courses of action, including helping clients reflect on their relationship with therapy. The following extract from **Tania (p15, Gina)** illustrates this:

> "I don't know why I didn't really think to change the model or think about the last therapy or discuss that. We just kept going; if I had known about that last therapy in a bit more detail ...there might have been a conversation at the review ... that could have been really useful for us as a turning point in therapy, deciding on the next steps therapy, and mainly for the client to gain more insight into how they are responding in therapy."

In making sense of this, it feels important to recognise pressures described by therapists (see ***Working in the therapy factory***) to do "something" when responding to a lack of fit between the therapy they were trained to offer and client needs.

For therapists caught in a ***Proving I'm good position***, despite avoiding client criticism in the therapy, feelings of disappointment arose when they did not realise their own hopes for the therapy. Such feelings could be present even when clients made reliable change or expressed satisfaction with their progress, for example, **Jean (p17, Sara)** shared: "Disappointed that I couldn't meet that expectation of it being life changing."

In avoiding criticism and pleasing clients, therapists perceived they had deviated from the CBT structure and their therapist role, and inadvertently maintained unhelpful patterns of engagement in therapy, such as reluctance to engage in aspects of therapy or passivity in therapy. The following extract from **J (p14, Jac)**, as he reflects on feedback from the client, illustrates this:

> "'These sessions have been really helpful, but I wonder whether because psychologists, they can really delve into your mind. I wonder whether that's what I need ... there's something they do, they see into your mind, and it just like sorts your mind.' And I was like, it feels ... it's quite a disempowering way of viewing their mental health."

Therapists reflected on how their therapy had left clients in relation to future therapy. Some therapists feared clients may be less enthusiastic about therapy in the future or deterred from returning altogether, disappointed with the return for their efforts, as **Anita (p15, Tom)** shared: "If they do come back again, how are they gonna feel about CBT?" These therapists appeared to take full responsibility for the outcome. Therapists shared that they felt that they had not challenged clients sufficiently. It seems possible this could implicitly signal to clients that increased action on their part was not viewed as necessary and impact client expectations of therapy. In contrast, therapists could be fearful that clients would continue to return for therapy which does not appear to be meeting their needs unless

these clients were helped to reflect on their way of relating to therapy. This could feel like a difficult task for some therapists in the NTT context due to a fear of evoking client dissatisfaction and negative feedback. As the following extract from **Lisa (p17, Carol)** illustrates:

> "She maybe does need somebody who is actually going to say, 'The therapy has become like one of your safety behaviours of reassurance seeking' We're all here thinking that …we're helping to solve the problem, and I suppose are to a certain degree but probably colluding a bit. So, it probably needs somebody to put stop to it and I don't know who that person is supposed to be."

Some therapists expressed concern that their work would be judged negatively by future therapists. Therapists seemed to fear that the therapy they had provided would not be remembered, or reported as CBT by clients, as **J (p16, Jac)** shared: "If she was describing therapy to someone she'd be like 'That J, I mean he was a good listener.'" Therapists also anticipated they would be criticised by clients, as the following extract from **Jean (p27, Lucy)** illustrates: "I think for me it would have been like, 'Okay, it's the same as last time, and she's gonna say to the next therapist, if she comes back, the exact same as she said to me about the last one.'"

Some therapists appeared to draw on their ideas about how therapy works to lessen their sense of failure and support a fragile sense of hope. Therapists reasoned that clients were in possession of the relevant knowledge and skills to manage their difficulties, or that another approach might be more effective. Consider the following extract from **Jo (p39, Polly):**

> "IPT therapists are skilled in working with ... those sorts of sensitivities ... so, I am hopeful that it will work. But there's also this, I don't want to be too negative about it, but this niggling doubt of, 'Is she just gonna come through again have a full course of therapy, and both her and the therapist are gonna feel deflated by the end of it?'"

Mission accomplished

Some endings were characterised by a strong confidence that clients would return if needed because their therapy experiences were perceived to be positive, as the quote from **Beau (p29, Cara)** illustrates:

> "I think for that client they probably got a positive view of therapists in general, because hopefully, they'd think first time and the second time went really well, so they got a positive view of: 'Of course I'd go back to therapy. Of course, I'd go back to NHS Talking Therapies because I've had two really good experiences.'"

Other therapists felt confident that clients would not need to return to therapy because they had now addressed all the maintaining factors, as **Kate (p14, Han)** shared: "I felt pretty confident that if they carried on with that, they would be okay" suggesting that with continued practise, cure is possible.

When ending their work with clients, some therapists shared that comparisons were drawn between the clients' experiences of therapy with them and previous therapists. Some therapists instigated comparisons, these therapists who had set out ***Proving therapy works*** or ***Proving I'm good*****,** seemed to be seeking to confirm this therapy had been more effective or that they had been as effective as their predecessor. Consider the following extract from **H (p19, Ana)**:

> "Because she has compared the two quite a lot in therapy, I think it would help draw on what she's been saying and summarising that, and then looking at why this has been helpful in more detail ... If she does need therapy again, she might focus on a CBT-based approach."

For other therapists taking up competitive positions in therapy, clients seemed to compare their therapy experiences without invitation, appearing to strongly value the subsequent therapy. Some clients expressed they hoped they would not re-return, or if they did, they would request the same therapist. These experiences were described as deeply affirming for therapists. Consider the following extract from **Suzie (p21, Bob)**:

> "When we were ending therapy, he mentioned the previous episode again ... he's gained more from this episode of therapy than previously because he's aimed higher. And again, this is where he said last time 'I just wanted to feel even 10% better' but this time he wanted to work on it all, and he felt like he had more to use for relapse prevention work as well ... previously in therapy he thought 'I can just come back to therapy' but he's not in that mindset now he's got what he needs, and he feels that this therapy is setting up for the rest of his life."

It is conceivable that explicitly or implicitly reinforcing comparisons positioning one therapy or therapist as superior to another may lead to idealising. Therapists varied in how they responded to such comparisons, for example, accepting the validation, or encouraging clients to persevere if future therapy did not live up to expectations created in this therapy. Some therapists appeared keen to explicitly credit the contribution of previous therapy to the outcome and see each course of therapy as providing an important jigsaw piece. One therapist **(Marley, p32 Jules)**, in responding to client favourably comparing their therapy as getting to the root of her difficulties, stressed therapy was part of a continuous developmental process, counter to ideas of cure:

> "'It was only because we were able to rule stuff out with that hard work that you put in previously. So, it all builds a picture, and it is all part of the journey.' I think the journey thing is quite useful thinking about not only previous therapy, but she was now going into another therapy from me. So, the fact that we'd set that up as 'It's not that you're inherently broken or you are doing things that are wrong. It's that you are doing things which are helping but they are part of a journey and a bigger picture. We've carried that forward together. And now you're carrying it even further forward.'"

Each of the therapists engaged in a ***Teaming up with previous therapy*** appeared secure in the outcome. For one therapist, this confidence was evident even when the therapy had not been successful by NTT standards. This suggests therapists' feelings about therapy

outcomes are influenced by the extent to which NTT standards are internalised to measure their worth as a therapist. Consider the following extract from **Ani (p18, Grace):**

> "She's learned as a human being, 'Sometimes I win. I crack therapy ... But this time around I wasn't ready, and that's okay ... it's okay to ... take some time out and come back when we're ready' ... I think she's learned a lot from both treatment episodes, and the way the two influenced each other, I think massively, is just 'CBT works.' That was a really good key learning from the first part."

Discussion

This chapter provides a summary of the main findings. These findings are then contextualised in the wider literature. Ideas and theories influencing the researcher are acknowledged. The clinical implications for therapists, trainers and supervisors are discussed. Finally, the strengths and weaknesses of the study, and future research directions are presented.

Summary of the main findings

The present results suggest that clients' previous therapy experiences do affect how high-intensity CBT therapists working in NTT services experience and navigate the subsequent therapy, exerting facilitative, hindering and at times more complicated effects.

The NTT context these therapists worked in appeared to shape their ideas about how therapy and services work. It was through these lenses that therapists made sense of clients returning to the service and that ideas about their role in meeting client needs were shaped. Here, two findings stand out. One, therapy could be seen as potentially curative given adequate application of the correct protocol and continued client efforts in applying their learning. Two, working in NTT led to some therapists' professional sense of worth seeming dependent on achieving recovery and avoiding complaints or negative feedback.

Therapists differed with respect to their interest in attending to previous therapy experiences. Limited curiosity about previous therapy experiences seemed to be linked to two assumptions. Firstly, low expectations regarding the richness of client recollections of previous therapy. Secondly, therapy is enhanced when it is set up as discontinuous to previous therapy ("wiping the slate clean") rendering an interest in previous therapy as irrelevant. Conversely, greater curiosity about previous therapy experiences was linked to complementary assumptions that clients will remember aspects of therapy; and engaging in therapy with therapy-experienced clients entails building upon an existing body of experiences.

Therapists' impressions of previous therapy acted as a fuel which set the course of therapy. These included impressions of how well previous therapy proceeded, the previous therapists' competence, and patterns of client engagement with therapy. Therapists were confronted with their own emotional responses to clients' previous therapy experiences and becoming successor to previous therapists. For some therapists, these impressions concretised a more competitive mindset, related to the prospect of comparisons with the previous therapy and therapist. These therapists experienced feelings of anxiety, anger, and zeal in relation to the prospect of working with these therapy-experienced clients. The NTT context in which therapists experience pressures to; (a) help clients achieve recovery; and (b) avoid negative feedback to sustain their sense of professional worth, appeared relevant to understanding these therapists' strivings. For other therapists, their positive impressions of previous therapy enabled them to enter a more collaborative mindset, reducing feelings of anxiety, which could allow a more a curious and open stance to emerge.

In setting the course of therapy, therapists appeared to occupy three positions in relation to previous therapy: ***Proving therapy works, Proving I'm good, Teaming up with previous therapy***. Some therapists seemed to move between these positions.

In ***Proving therapy works***, therapists approached their work with therapy-experienced clients from a more dominant position. Returns were understood with a more critical lens, because of service limitations, or therapists or clients not playing their expected roles adequately. These therapists seized the opportunity to differentiate their work by providing something better. Previous therapy could appear to have a hindering influence when therapists' needs were more centred in the work, as they were guided by their motivation to stand out from the crowd. In this context, therapists sought to become the hero, the one to help clients recover and stop them coming back. Some therapists shared recognising in retrospect that they had become "blinded by a mission" to prove therapy works. These therapists thought they could have curtailed therapy sooner when it did not appear to be meeting clients' needs. Some therapists ***Proving therapy works,*** appeared able to retain

focus on and responsivity to client needs, and described approaching their work more creatively, for example.

In ***Proving I'm good*** therapists appeared threatened by work that had gone well or client criticisms of previous therapists, placing them in a more submissive position. They anticipated that they may not live up to client expectations. These therapists, influenced by clients' previous experiences with therapists, experienced anxiety, and became preoccupied with avoiding criticism and negative comparisons to enable them to feel good as therapists. A wish to avoid criticism seemed to elicit two therapist responses: seeking reassurance and loosening boundaries. Attempts to replicate clients' successful experiences of therapy, potentially hindered therapists' capacity to take a person-centred approach and practise more responsively.

In ***Teaming up with previous therapy***, therapists entered a more collaborative position in which previous therapy was seen as a resource to facilitate therapy. Therapists normalised those returns, accepting they were working with fallible humans, often with complex histories, and were more appreciative of the work of previous therapists, who alongside them, had contributed to the client's therapy journey. In this context, these therapists were able to take advantage of clients' positive expectations, familiarity with therapeutic language and concepts, and existing knowledge and skills, to support change. Previous therapy experiences also shaped the direction of therapy by providing information about clients' relationships with their distress and receiving help. Therapists appeared able to effectively use this information to attend to aspects of therapy more carefully or inform how they might approach things differently.

When ending therapy (or anticipating its end) therapists seemed left either with the sense the work had been successful, and their own expectations had been met (***Mission accomplished),*** or with unmet expectations and a sense the work had been less successful (***Failed mission***). In ***Failed mission***, therapists could appear dissatisfied with their work for a variety of reasons; partial client recovery, a sense therapy had been less successful compared to previous therapy, unaddressed unhelpful patterns of client relating to therapy,

and undermined integrity due to drift or loosening boundaries. They worried about clients returning to therapy with lower expectations, repeating the same patterns, criticising them or recalling the work as something other than CBT.

In ***Mission accomplished,*** some therapists felt confident that clients would return for therapy should they need to, due to their positive experiences, regardless of whether clients had completed therapy or achieved recovery. Other therapists who had set out to prove therapy works, reflected on favourable comparisons clients had drawn between their work and previous therapy, expressing hopes of not returning to therapy or preferring to return to them if they did. This raises the possibility their determined approach could have an unintended consequence in future therapists disappointing clients, or alternatively these clients feeling disappointed in themselves, should they return.

Contextualising present findings in the wider literature

In this section, the findings from the analysis are examined in relation to the literature from the **Introduction** and the relevant wider literature.

Therapists in the present study appeared to hold a view that therapy should work by applying the correct protocol to address the person's diagnosed disorder. Some therapists were concerned that deviating from this model of therapy would attract criticism. This could be explained by system-level influences. Narrative reviews providing commentary on NTT services or organisations offering therapies in a similar proceduralised fashion, characterise therapy in a comparable way. Therapy is viewed as an instrumental endeavour involving protocol application, therapists are seen as teachers dispensing psychoeducation and techniques according to diagnosis, over a predetermined period. In these systems, therapists are closely monitored and may be overruled by service protocols or supervisors (Cushman & Gilford, 2000; Karlin, 2006; Rizq, 2012). In the present study, some therapists avoided taking therapy-experienced clients to supervision due to concerns this could interfere with their therapeutic endeavours of ***Proving therapy works*** or ***Proving I'm good***. As such,

therapists appeared not to have adequate support with the difficult feelings and challenges arising from this work.

This technical view of therapy, where therapy can be carried out correctly or incorrectly, also fits with the notion of cure. Some therapists in the present study appeared to be influenced by the narrative that correctly delivered therapy is curative and returning for further therapy for the same difficulty denotes therapy failure. Returning to therapy was normalised by some therapists to address other specific problems. These therapists were particularly critical of how previous therapy was delivered, or service limitations. As reviewed in the **Introduction**, this type of thinking is evident in the wider literature (see **Therapy failure**). Firstly, this positions therapy as the answer to distress (Clarke, 2020). Secondly, failures are linked to inadequacies in the content, timing, or delivery of therapy, incorrect diagnosis and protocol application, choice of therapy modality, or gaps in current knowledge precluding the development of therapies to meet some clients' needs (Hollon, 2010; Scott & Sembi, 2006; Sookman, 2014). Partly consistent with this view, results from an NTT service-based study examining returns suggest that the first episode of therapy is most impactful, and improvements are likely to be of a similar magnitude or diminish on subsequent re-referrals to the service, particularly for clients who complete treatment with residual symptoms (Lorimer et al., 2024). It may be that NTT therapists recognise the pattern of diminishing returns associated with repeat returns. Criticisms of service limitations or previous therapists' work may allow therapists to maintain hope that, with sufficient effort, they can alter this trajectory.

The finding that some therapists appeared drawn into a more striving position in therapy (***Proving therapy works*** or ***Proving I'm good***) could be understood within the broader NTT context. Therapists described regularly encountering referred clients with needs unsuitable for the therapy they felt able to provide. Concerns about achieving recovery, attaining client satisfaction, and avoiding negative feedback and criticism were also referred to as sources of pressure for therapists. These experiences of the NTT system chime with a body of qualitative research involving therapists working in these settings.

These studies highlight therapist concerns about target monitoring taking precedence over care, increasing pressures to offer therapy to clients with more complex needs, anxiety and feelings of failure linked to challenges meeting service expectations; and staff feeling seen as "work machines" by services lacking compassion for them (Broadley et al., 2023; Bruun, 2023; Harper et al., 2020; Lamph et al., 2019; Otero, 2019; Scott, 2018).

This characterisation of NTT services suggests they can be experienced as competitive environments by staff, particularly when working with therapy-experienced clients. Some therapists drew comparisons between the previous therapist and themselves. Social comparison theory (Festinger, 1950) suggests the relative cognitive efficiency of comparisons to forming an absolute view of one one's ability accounts for their ubiquity (Mussweiler & Epstude, 2009). Subsequent iterations of Festinger's ideas have differentiated motivations for social comparisons. Wills (1981) posited that to enhance one's self-view downward comparisons are sought, and to improve one's abilities, upward comparisons are sought. Evidence suggests that therapists may be more prone to making downward comparisons, as most therapists rate themselves as more able than the average therapist (Parker & Waller, 2015; Probst et al., 2022). Given that NTT may be a context ripe to experience feelings of failure, both upward and downward comparisons may appear to offer escape from such feelings by striving to improve as a therapist or drawing comfort from feeling more competent than other therapists.

In the present study, ***Working in the therapy factory*** appeared to create pressure for some therapists to strive to avoid criticism and negative comparisons to previous therapists (i.e., ***Proving I'm good***). Some therapists appeared fearful of challenging therapy-experienced clients who had criticised previous therapists, which appeared to reduce therapist ability to address unhelpful patterns of relating to therapy. One perspective suggests that the commodification of therapy, exemplified in the present study by participant use of commercial language (e.g., "client choice" and "customer service"), influences how therapists see therapy, clients, and themselves. Such commodification may increase risks of forming therapeutic relationships based on satisfaction and agreement, which limit space for

disagreement or difficult feelings, and risk therapist collusion (Cushman & Gilford, 2000; Goodman, 2016). Indeed, a seminal survey-based study exploring therapists' feelings towards clients highlighted fear was commonly experienced by therapists, including fear of client complaints (two in every three therapists) and fear of work being criticised by colleagues (four in every five therapists; Pope & Tabachnick,1993).

Some therapists' confidence was undermined by previous successful experiences leading to a pressure to prove themselves as comparatively competent. Therapists' experiences of references to previous therapists as unsettling, undermining of their sense of professional competence, mirrors findings from an interview-based study involving 18 therapists working with clients transferred from other therapists (Muller, 1985). Thériault and Gazzola's (2005) exploration of insecurity in experienced therapists distinguished more commonplace therapist feelings of inadequacy arising in the context of specific interactions with clients (e.g., doubts about doing the right thing) from a deeper level of self-doubt expressed as insecurity about the ability to meet the needs of certain clients. In-line with the current findings, experiencing this deeper level of self-doubt was linked to drawing comparisons with other therapists and questioning whether they could do a better job (Thériault & Gazzola, 2005). Some therapists in the present study appeared to respond to this self-doubt by attempting to replicate how therapy was delivered by previous therapists lauded by clients, potentially reducing their responsivity to attune to client needs and losing opportunities to explore other ways of facilitating change (e.g., could this client now learn something valuable from a therapist who encouraged more autonomy?). In support of this idea, Stiles and Hovarth (2017) contend that therapist responsivity to the emerging context in therapy created with each client accounts for therapist effects (i.e., some therapists attaining better outcomes than others).

In the present study, client accounts of previous therapy acted as an emotional fuel generating a variety of feelings including anxiety, anger, hope, zeal, security and insecurity.

Therapists' feelings appeared depend on how previous therapies and therapists were evaluated by both themselves and clients, in keeping with previous research into therapists' experiences, including therapists working with transferred clients. In these studies, like the present findings, therapist hope could be stimulated by positive descriptions of previous therapy (or conversely competitiveness when therapists felt threatened by this perceived good work), or therapists could feel contemptuous if they perceived previous therapy had been poor (Marmarosh et al. 2017; Muller, 1985; Williams & Winter, 2009). Hampton (2013) reflects on three positions therapists may take up with respect to their predecessor: (a) respect for the previous work, viewed as something to build on; (b) a neutral position, based on a limited view of previous therapy and indifference in relation to knowing more, this may be used to conceal feelings which go unvoiced and influence the therapy; and (c) disrespect for the previous work and a possible invitation to the role of idealised therapist. In the present study, although therapist feelings in relation to clients' previous therapy experiences appeared influential in setting the course of therapy, only some therapists mentioned exploring these in supervision. Some therapists shared finding the interview useful space to reflect in different ways, perhaps suggesting they experienced a greater sense of greater freedom of expression in the interview. Findings from a qualitative study interviewing NTT high-intensity CBT therapist supervisor-supervisee dyads suggested that non-disclosure, driven by a wish to preserve a supervisory relationship by avoiding challenge and conflict, is prominent in supervision (Gibson, 2024). It seems plausible such non-disclosures could negatively impact therapy and therapist wellbeing. Indeed, existing practice recommendations based on therapists' experiences suggest therapist feelings and sense-making in relation to clients' previous therapy should be explored in supervision, to reduce the risk of inadvertently repeating unhelpful client patterns in relating to therapy (McKenna, 1999; Hampton, 2013; Gloger, 2011).

The finding that some therapists were invested in understanding clients' previous therapy experiences to enhance their responsivity and guide adapting therapy to client needs is consistent with several practice-based papers and texts focused on working with therapy-

experienced clients. This body of work suggests that exploring previous therapy experiences is valuable to help understand emotional vulnerabilities and previous challenges tolerating aspects of therapy (Cloitre, 2013; DiGiuseppe, 2011; Kassinove & Tafrate, 2011; Kazantzis et al., 2017); avoid mistaken assumptions regarding therapy content or client knowledge (Cloitre, 2013; Waller & Turner, 2016); to develop hypotheses about previous premature terminations (Coyne et al., 2019; McCullough, 2000); to elicit client theories and expectations about emotional care (Chase, 2000; Kazantzis et al., 2017); and to elicit outcome expectations and credibility beliefs (Coyne et al., 2019). As such, attending to information about previous therapy experiences can aid formulation and inform strategies to calibrate the therapeutic relationship and navigate challenges (Kazantzis et al., 2017; McKenna, 1999). Underscoring the value of such adjustments, results from Werbart and colleagues' (2019) mixed methods study involving therapist-client dyads indicated that therapist perception of client relational style and subsequent adjustment to the client distinguished successful and unsuccessful therapy cases within the same therapists.

In the present study, therapists shared that some therapy-experienced clients appeared to enter therapy socialised to this way of working. Theoretically, socialisation to CBT promotes engagement with its interventions (Roos & Wearden, 2009), and empirical evidence suggests acceptance of the CBT rationale accounts for a significant proportion (8%) of variance in depression outcomes (Addis & Jacobson, 2000). Clients who have previously found this approach helpful are likely to be ready to collaborate in accordance with the CBT model and the medicalised understanding of distress it offers (Cushman & Gilford, 2000). On the other hand, therapy-experienced clients may also return to therapy with less-well matched ideas about how therapy works and struggle to take an active role in the work (Coltart et al., 1988; Szalita, 1982). This suggests that it is important to discern what clients understand about how therapy works from their previous therapy experiences.

Some therapists also described drawing on client understandings and skills derived from previous therapy to aid their work. Perhaps unsurprisingly, these therapists were working with clients who appeared to have found therapy helpful before. It is conceivable

these clients returned to therapy with a greater pool of resources to draw on. One perspective on therapeutic change suggests that therapy works by activating clients' existing resources and strengths (Gassmann & Grawe, 2006). In support of this, evidence suggests that therapy works better for more well-resourced clients. In a study involving over 200 clients accessing CBT found baseline client strengths in managing previous crises significantly predicted post-therapy symptom and functional outcomes (Schürmann-Vengels et al., 2022b). Moreover, meta-analytic evidence suggests that relative to active comparators, resource-focused therapies yield significantly better symptom and functional outcomes (Munder et al., 2019).

In the present study, due to low expectations of clients' ability to recollect previous therapy experiences, some therapists showed restricted curiosity in relation to these experiences. For these therapists, a blank slate approach to previous therapy experiences was preferred, in which they effectively approached therapy as if they were working with a novice client. The scope for therapists to draw on knowledge and skills gained from previous therapy depends on their acquisition and retention. Indeed, studies suggest that both retention of (Dong et al., 2017; Harvey et al., 2016), and independent use of CBT skills during therapy (Strunk et al., 2007), are associated with improved post-therapy outcomes, including reduced risk of relapse. Research examining client retention of therapeutic ideas and skills suggests that although some therapeutic strategies appear more difficult for clients to discern and subsequently report (Chen et al., 2017), clients recollect 30-40% of personally significant events six months post-therapy (Martin & Stelmaczonek, 1988). There may be parallels between therapist review of previous therapy experiences and therapist review of between-session work in CBT. The positive effects of therapist review in this latter context are well-documented (Ryum et al., 2023). Of interest here, is the finding that therapist review behaviours are positively associated with between-session work engagement putatively due to the positive effects on motivation and supporting the development of insight to inform future efforts (Bryant et al., 1999; Weck et al., 2013). In a

similar vein, therapist review of previous therapy experiences may convey therapy is anticipated to yield learning, and client learning from those experiences is valued. Taken together, this suggests that finding ways to; (a) support the retention of important events or learning in therapy between therapy episodes; and (b) encourage therapists to review these experiences, may facilitate therapy with returning clients.

Some therapists in this study positioned themselves as the therapist who would finally break a pattern of unsuccessful therapy or returning to therapy (see ***Proving therapy works – standing out from the crowd***). This positioning echoes findings from a qualitative study which interviewed seven therapists about unsuccessful therapies (Hopper, 2015). Therapists in Hopper's study described initially colluding with the clients' unrealistic expectations regarding therapy and strove to make the therapy work to meet their own needs to feel competent. Those therapists externalised the lack of success to clients in the end. For some therapists in the present study, the outcome of therapy was successful, and they succeeded in fulfilling their need to stand out. Other therapists felt disappointed by how they had navigated therapy and thought they could have curtailed it sooner. A pressure to stand out may be heightened in situations involving comparisons, such as working with therapy-experienced clients. Consistent with these present findings, Muller (1985) reported that therapists working with transferred clients described a pressure to offer something different to feel valued as a therapist. A sense of successful differentiation encouraged therapists, whilst attempts to rescue clients had more damaging effects on therapy due to reduced responsivity (Muller, 1985). Therapists in this study who persisted in their efforts to prove therapy works when there were signs this was not meeting the clients' needs could be seen as avoiding difficulties, and so hindering the therapy. This fits with the finding that avoiding therapeutic engagement (e.g. hoping things will improve, criticising the client, avoiding the problem) when faced with difficulties is linked to poorer therapy outcomes compared to more constructive responses (e.g. sharing the difficulty, collaborative problem-solving involving another professional; Nissen-Lie et al., 2017).

Therapists who sought to prove therapy works were at times attempting to enhance client confidence in therapy and reflected on varying experiences of success. Recent research suggests client confidence appears to be critical to understanding the influence of common factors (see **Introduction Table 1.1**) on therapy outcomes. Factor analysis of common factors suggests there are two underlying factors: confidence in therapist and their qualities to help and understand and confidence in the treatment offering a meaningful and effective approach (Finsrud et al 2022a). Both confidence in therapist and confidence in the treatment appear to have positive reciprocal effects on symptom change (Finsrud et al., 2022b). Therapists appeared particularly invested in restoring clients' confidence in therapy if clients had previous CBT experiences. An interview-based study exploring clients' experiences over multiple courses of therapy suggested that therapy episodes have different functions for clients. Discrimination episodes help the client discover a particular approach is not for them (Todd & McKenna, 1997). Given a perceived lack of alternatives, therapists may have felt a sense of pressure and cornered into providing something, overlooking previous discrimination episodes.

A return to reflexivity

In this section, the results will be considered in the context of choices made during the research process that influenced the data collected. Further to this, I will explore how my own position on therapy and ideas I am interested in may have shaped the themes and the consideration of these.

Impact of research decisions

The sampling strategy and its execution impacted on variability in the participants and their experiences. On reflection, although the intention was to create a purposive sample, as interested and willing therapists were recruited and connections to the researcher became apparent, the sampling strategy may be more accurately classified as a convenience sample. Recruiting participants as members of the public rather than via NHS services, and the use of broad exclusion and inclusion criteria meant that two participants could not consult client

notes as they were not currently working in NTT. Among therapists who could consult the service records prior to interview, it was evident that not all participants did so. It is possible this impacted the richness of the therapist accounts, as was observed to be the case for one participant.

Although participants were given an opportunity to discuss the suitability of client work for the interview, most did not, resulting in a number of unanticipated differences between the accounts.

Four pieces of client work discussed by participants were still in therapy. This meant that therapists were reflecting on anticipated outcomes and endings in the interviews, and so the data relevant to hindering or facilitatory impact of previous therapy experiences is speculative in relation to **The big finale** theme and its ***Mission accomplished*** and ***Mission failed*** subthemes.

Two pieces of client work discussed in interviews involved clients whose previous therapy experiences included working with the participant. This impacted on the contribution of these experiences to the **Previous therapy as a wellspring – setting the therapist's course** theme and both contributed data to the ***Teaming up with previous therapy*** subtheme. It is difficult to conceive how these participants would experience competitive dynamics in relation to the previous therapy. Whilst these experiences reflect the realities of clinical practice, and further, could be interpreted as suggestive of an advantage in working with previous clients, it may have constrained the ways in the data from these therapist-client dyads was made sense of and contributed to the themes.

Impact of preferred ideas and modes of practice

I am interested in ideas from systemic therapy, such as resource coordination (e.g., Burnham, 2005). Accordingly, I place a value on thinking with clients about how we might pool our resources and draw on existing client strengths, knowledge, and experiences. I, therefore, assume there is value in exploring previous therapy experiences and using this information to help understand the client better and inform how we might approach our therapy. I am also interested in understanding the client's relationship to help (e.g., Reder &

Fredman, 1996). For this reason, I am less drawn to the idea of a "blank slate" approach, unless this is led by the client and the specifics of the situation. I fear that valuable learning or insights, even from challenging experiences, would be lost, which may hinder progress. It is possible I was particularly drawn to these aspects of the data and contrasting these approaches in the themes and discussion.

Another idea which may have influenced how I approached the data is therapist responsivity (i.e., therapist behaviour driven by the emerging context) and its role in enhancing therapeutic experience for clients (e.g., Olson et al., 2022). For this reason, I was perhaps drawn to examples in the data I felt spoke to therapist responsiveness and reflected on these observations in the themes and discussion. During the analysis and write up phase of this project, I have been working with ideas from compassion-focused therapy (CFT) on placement (e.g. Gilbert, 2010). I am aware that the ideas of competitive and care-giving collaborative mentalities in CFT have influenced my thinking around the different positions therapists take in relation to therapy-experienced clients, particularly striving to avoid criticism and rejection, which from a CFT perspective can reduce capacity for cooperative, care-focused relationships.

Clinical implications

This section will outline considerations for therapists, with potential usefulness for supervision and training contexts.

Exploring clients' previous therapy experiences

Findings from this study suggest there is value in exploring previous therapy experiences in the initial assessment sessions and remaining open to exploring these experiences as therapy proceeds. This consideration for clinical practice is based upon the findings that (a) some therapists reported building on previous therapy experiences facilitated their work; and (b) the picture of previous therapy could become clearer over the course of therapy. Whilst it seems likely that many clients do initially struggle to recall what happened in previous therapy and what they learned from this, therapist assumptions that

clients have no memory of previous therapy may be inaccurate. This could mean that opportunities to build on, or be guided by previous work, are missed.

Szalita (1982) suggests asking clients questions about the previous work and current expectations in an imaginative manner to stimulate client thinking and avoid rote answers. For example, asking "If you were only able to tell me one thing about your previous therapy experience, what would be most useful for me to know?" implicitly communicates that the client remembers at least something from previous therapy and the therapist's wish to know more about this experience. Therapists could also encourage clients to share any experiences of previous therapy that come to mind as the work proceeds.

Formulating patterns of relating to therapy and therapists

Learning about clients' previous therapy experiences, including their experiences of the therapeutic relationship, can provide information to support formulations about client patterns of relating to therapy and therapists. Findings from the current study suggest that high-intensity CBT therapists feel more comfortable exploring the content of previous therapy and may not feel they are adequately trained to explore these types of relational patterns. This may lead to overlooking of important patterns, such as difficulties giving therapists feedback, or challenges completing between-session work, which subsequently go unaddressed in therapy.

In practical terms, questions could be used to explore client experiences from a more relational perspective. Examples could include questions such as: "How would you describe your relationship with between-session work from previous therapy?"; "Could you describe your relationship with your last therapist in three words?"; and "What could your last therapist have done to help you feel more comfortable?" Such exploration could then yield information about resources to build on, challenges to problem solve, and unfulfilled wishes to name and understand.

Openness with clients about limitations of therapy

In the present study, some therapists had the view that clients should not return to therapy. Understanding of common mental health problems, the focus of NTT services, as long-term recurrent conditions, in view of high rates of relapse following intervention (Ali et al., 2017) could encourage therapists to move away from notions of cure.

Clinical considerations for training and supervision contexts are for therapists to hold knowledge about the likelihood of partial or temporary improvements, rather than cure, and client return to therapy. Holding this position could help to avoid blaming the client or previous therapist for non-curative outcomes. Encouraging a view of therapy as a learning process, to which clients may come back to and discover more in the future could cultivate more realistic expectations and reduce feelings of failure in clients and therapists.

Information handover with future therapy in mind

In the present study, therapists emphasised the value of detailed therapy notes, formulations and end of therapy blueprints in building a picture of clients' previous therapy experiences. Consistent with this, research on working with transferred clients suggests the quality of information handover can facilitate the beginning of therapy for new therapists (Marmarosh et al. 2017). Trainers and supervisors may wish to encourage more thought regarding information that could support the work of future therapists. This might include, for example, observations and feedback on the therapeutic relationship and responses to therapeutic ideas and interventions. When ending therapy, given the likelihood of return, therapists could record some considerations for future therapists. Therapists could encourage clients to use therapy documents to relay their experiences to future therapists should they return. End of therapy blueprints co-created with clients could be expanded to offer an opportunity to reflect on what the experience of therapy has been like for the client. This could support clients to identify and retain key learning about their relationship with therapy and therapist and allow them to hold responsibility for sharing this with future therapists.

Using supervision to cultivate therapist humility

Caplan (2014) suggests new therapists' feelings towards the previous therapy and therapists should be greeted by supervisors as a valuable source of information for formulation and therapist development. In the present study, some therapists had strong feelings about the clients' return to therapy yet did not always explore these in supervision. The NTT Manual (2024) stresses the importance of discussing all clients in supervision. It is possible that there were missed opportunities to formulate alternatives to the striving positions therapists sometimes took up.

Striving may reduce therapist humility by centring therapists' needs. Therapist humility is characterised by a focus on the client, appreciation of therapist skills and limitations, recognition of therapist contributions to difficulties in therapy, and eschewing therapist feelings of inferiority and superiority (Sandage et al. 2016). Its value in clinical practice is supported by findings suggesting that compared to low professional self-doubt, high professional self-doubt combined with a positive self-affiliation is associated with improved outcomes. It is hypothesised this advantage is due to a willingness to work with challenge and uncertainty in therapy without blame or shame (Nissen-Lie et al., 2017). Similarly, therapist humility is theorised to enhance supervisory practice (Watkins & Mosher, 2020).

In supervision, disclosure and exploration of therapists' feelings into relation to previous therapy, their ideas about what happened in previous therapy, and positions they feel pulled towards, could help to reduce the risk of these unduly influencing the course of therapy. Such conversations could help therapists to; (a) reflect on the impact taking up striving positions (e.g. stepping into the hero role, crossing boundaries by loosening the frame of therapy) has on clients and future therapists; and (b) generate ways of keeping the focus on the client (Reynolds, 2019). For example, in ***Proving therapy works***, some therapists made decisions independently about how to proceed in view of clients' previous experiences. This appeared to reduce their responsivity to client need and opportunities for

collaboration. To counteract this, therapists could share their dilemmas in clinical reasoning with clients.

Strengths and weaknesses

This study addresses a research question which has important practical implications. Given NTT is now a well-established model for delivering psychological interventions, it is useful to think about how therapists respond to returning clients. No other research has examined this within the NTT context despite the apparent frequency of repeat referrals and knowledge that therapists can experience working in this system as challenging.

In executing the study, the hoped for number of participants were recruited. Interviews were of adequate quality to yield data rich enough to create themes to help understand the complexities of therapists' diverse experiences working with therapy-experienced clients in a simple process-focused model. Results from the only previous research exploring therapists' experiences with therapy-experienced clients were presented as topic summaries (McKenna, 1999), rendering it more difficult to discern the patterning. The present study builds on and extends this existing work.

Therapists were invited to discuss experiences of previous therapy having a facilitative or hindering effect on therapy. Therapists talked about a variety of outcomes and experiences, including work that had felt challenging with poorer outcomes and work that had gone smoothly with more positive outcomes. Most participants appeared able to talk about more vulnerable emotions and critically evaluate their work. Accounts of researcher reflexivity were included to help the reader assess how researcher subjectivity influenced the research process and themes produced.

Some limitations relate to the study design and sample. Although talking to a therapist-researcher with a background in NTT services, whom participants were professionally aware of, may have assisted in building rapport, it is possible for that some participants experienced a heightened fear of judgment. It is also conceivable that professional connections may have led some participants to provide friendly data, elevating

the importance of previous therapy experiences in influencing therapeutic process. Counter to this some participants were open about their scepticism or disinterest in previous therapy experiences. The interviews invited therapists to centre the importance of clients' previous therapy experiences and their own reactions to it, whereas research suggests that the clients' contribution to therapy outcome is greater (Norcross & Lambert, 2011). It is possible that these findings exaggerate the significance of previous therapy experiences. As such the findings should be considered tentatively, with an awareness that therapists, clients, and the contexts in which they live and work in interact in complex ways to shape therapy experiences.

Future research

There are several possible directions for future research. The current findings suggest that clients' previous therapy experiences do impact how high-intensity CBT therapists working in NTT services experience and navigate therapy. Using a quantitative approach such as a survey informed by the present themes could help to understand how widespread these experiences are (e.g., avoiding discussing their work with therapy-experienced clients in supervision). A free-text response option could be used to explore therapist, client, and service-related contextual factors encouraging more collaborative and more competitive positioning.

From a staff wellbeing perspective, the present study's results suggest there is unlikely to be a linear relationship between burnout and caseload proportion of therapy-experienced clients. Some therapists appeared to have positive experiences with therapy-experienced clients, whilst others reported persistent anxiety in their work. Some of these therapists appeared to be drawn into a pattern of enmeshment with clients (e.g., hero positioning, going the extra mile; Reynolds, 2019). Level of stressful involvement in therapy (e.g., in-session anxiety) has been associated with emotional exhaustion and depersonalisation, dimensions of burnout in NTT therapists (Steel et al., 2015; Turnpenny,

2017). A survey could be used to explore the relationship between therapists positioning (e.g., competitive or collaborative) with therapy-experienced clients and burnout.

The present study's attempt to identify the facilitative or hindering effects of clients' previous therapy experiences was limited by the absence of client accounts. This research could be extended by interviewing both parties in the therapy-experienced client-therapist dyad about their experiences. This would permit an understanding of client perspectives on how subsequent therapy was facilitated or hindered by the ways therapists responded to their previous therapy experiences.

Conclusion

This study sought understand whether clients' previous therapy experiences influenced how high-intensity CBT therapists experienced and navigated therapy. These results suggested that therapists could both position themselves as collaborators, curious about previous therapy experiences, willing to use this as a resource, and competitors with something to prove. Approaching therapy with something to prove could deter therapists from challenging clients, leading to boundary violations, and reduce therapist responsivity, leading to less satisfactory endings for therapists. Conversely, therapists could take risks of value, such as increased creativity when problem solving blocks in therapy. Holding a view that returns to therapy were understandable or maintaining a focus on client needs seemed to lead to more satisfactory endings for therapists, irrespective of how they had positioned themselves in therapy.

References

Adatto, C. P. (1995). The "interminable" analysis (excerpts). *Journal of Clinical Psychoanalysis*, 4(2), 139–148.

Addis, M. E., & Jacobson, N. S. (2000). A closer look at the treatment rationale and homework compliance in cognitive therapy for depression. *Cognitive Therapy and Research*, 24, 313-326. https://doi.org/10.1023/A:1005563304265

Ali, S., Rhodes, L., Moreea, O., McMillan, D., Gilbody, S., Leach, C., Lucock, M., Lutz, W., & Delgadillo, J. (2017). How durable is the effect of low intensity CBT for depression and anxiety? Remission and relapse in a longitudinal cohort study. *Behaviour Research and Therapy*, 94, 1–8. https://doi.org/10.1016/j.brat.2017.04.006

Altmann, U., Thielemann, D., Zimmermann, A., Steffanowski, A., Bruckmeier, E., Pfaffinger, I., Fembacher, A., & Strauß, B. (2018). Outpatient psychotherapy improves symptoms and reduces health care costs in regularly and prematurely terminated therapies. *Frontiers in Psychology*, 9, 748-748. https://doi.org/10.3389/fpsyg.2018.00748

Anderson, K.N. (2016). *Premature termination of outpatient psychotherapy: predictors, reasons, and outcomes.* [Unpublished doctoral dissertation] University of Nebraska. https://digitalcommons.unl.edu/cgi/viewcontent.cgi?article=1074&context=psychdiss

Anderson, T., Patterson, C. L., McClintock, A. S., & Song, X. (2013). Factorial and predictive validity of the Expectations About Counseling-Brief (EAC-B) with clients seeking counseling. *Journal of Counseling Psychology*, 60(4), 496–507. https://doi.org/10.1037/a0034222

Archer, M., Decoteau, C., Gorski, P., Little, D., & Porpora, D. (23 December 2016) *What is critical realism?* American Sociology Association. http://www.asatheory.org/current-newsletter-online/what-is-critical-realism

Arnkoff, D. B., Glass, C. R., & Shapiro, S. J. (2002). Expectations and preferences. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients* (pp. 335–356). Oxford University Press.

Asay, T. P., & Lambert, M. J. (1999). The empirical case for the common factors in therapy: Quantitative findings. In M. A. Hubble, B. L. Duncan, & S. D. Miller (Eds.), *The heart and soul of change: What works in therapy* (pp. 23–55). American Psychological Association. https://doi.org/10.1037/11132-001

Barkham, M., Rees, A., Stiles, W. B., Shapiro, D. A., Hardy, G. E., & Reynolds, S. (1996). Dose-effect relations in time-limited psychotherapy for depression. *Journal of Consulting and Clinical psychology*, 64(5), 927–935. https://doi.org/10.1037/0022006X.64.5.927

Baker, C. (13 January 2020). *Mental health statistics for England: prevalence, services, and funding*. House of Commons. Briefing paper 6988. https://dera.ioe.ac.uk/34934/1/SN06988%20(redacted).pdf

Barry, D., Nordberg, S. S., & Stevens, F. L. (2020). Termination in integrated primary care behavioral health. *Psychotherapy*, 57(4), 521-530. https://doi.org/https://dx.doi.org/10.1037/pst0000299

Bartholomew, T. T., Gundel, B. E., Li, H., Joy, E. E., Kang, E. & Scheel, M. J. (2019). The meaning of therapists' hope for their clients. *Journal of Counseling Psychology*, 66 (4), 496-507. doi:10.1037/cou0000328.

Bartholomew, T.T., Gundel, B. E., Scheel, M. J., Kang, E., Joy, E. E., & Li, H. (2020). Development and initial validation of the Therapist Hope for Clients Scale. *The Counseling Psychologist*, 48(2), 191–222. https://doi.org/10.1177/0011000019886428

Beaton, J., & Thielking, M. (2020). Chronic mistrust and complex trauma: Australian psychologists' perspectives on the treatment of young women with a history of childhood maltreatment. *Australian Psychologist*, 55(3), 230-243. https://doi.org/https://dx.doi.org/10.1111/ap.12430

Beitman, B.D. (1991). *The Structure of Individual Psychotherapy.* Guildford Press.

Bell, E., Marcus, D.K., & Goodlad, J. K. (2013). Are the parts as good as the whole? a meta-analysis of component treatment studies. *Journal of Consulting and Clinical Psychology*, 81(4), 722–736. https://doi.org/10.1037/a0033004

Bennett, M.J, & Feldstein, M.L. (1986). Correlates of Patient Satisfaction with Mental Health Services in a Health Maintenance Organization. *American Journal of Preventive Medicine*, 2, 3, 155-162.

Bhaskar, R. (1978). *A realist theory of science*. Harvester Wheatsheaf.

Bleyen, K., Vertommen, H., Vander Steene, G., & van Audenhove, C. (2001). Psychometric properties of the Psychotherapy Expectancy Inventory-Revised (PEI-R). *Psychotherapy Research*, 11(1), 69–83. https://doi.org/10.1080/713663853

Boerema, A. M., Cuijpers, P., Beekman, A. T. F., Hellenthal, A., Voorrips, L., & van Straten, A. (2016). Is duration of psychological treatment for depression related to return into treatment? *Social Psychiatry and Psychiatric Epidemiology: The International Journal for Research in Social and Genetic Epidemiology and Mental Health Services*, 51(11), 1495-1507. https://doi.org/https://dx.doi.org/10.1007/s00127-016-1267-7

Boswell, J. F., McAleavey, A. A., Castonguay, L. G., Hayes, J. A., & Locke, B. D. (2012). Previous mental health service utilization and change in clients' depressive symptoms. *Journal of Counseling Psychology*, 59(3), 368-378. https://doi.org/https://dx.doi.org/10.1037/a0028078

Braun, V., & Clarke, V. (2013). *Successful qualitative research: A practical guide for beginners*. SAGE.

Braun, V., & Clarke, V. (2022). *Thematic analysis: A practical guide*. SAGE.

British Association for Cognitive and Behavioural Psychotherapists. (2022, December 5). *BABCP Standards of conduct, performance and ethics*. https://babcp.com/Standards

Broadley, L. E., Burton, A. E., & Mistry, D. K. (2023). "Sharing in people's pain is not an easy thing to do": Cognitive behavioural therapists' understandings of compassion in the workplace. *Counselling and Psychotherapy Research*, 23(4), 1028–1039. https://doi.org/10.1002/capr.12614

Bruun, M. K. (2023). 'A factory of therapy': accountability and the monitoring of psychological therapy in IAPT. *Anthropology & Medicine*, 30(4), 313-329. https://doi.org/10.1080/13648470.2023.2217773

Bryant, M.J., Simons, A.D. & Thase, M.E. (1999). Therapist skill and patient variables in homework compliance: Controlling an uncontrolled variable in cognitive therapy outcome research. *Cognitive Therapy and Research,* 23, 381–399. https://doi.org/10.1023/A:1018703901116

Buchholz, K. R., Bohnert, K. M., Pfeiffer, P. N., Valenstein, M., Ganoczy, D., Anderson, R. E., & Sripada, R. K. (2017). Reengagement in PTSD psychotherapy: A case-control study. *General Hospital Psychiatry*, 48, 20-24. https://doi.org/10.1016/j.genhosppsych.2017.06.009

Budman, S.H., & Gurman, A. S. (1988). *Theory and practice of brief therapy*. Hutchinson Education.

Bugatti, M., & Boswell, J. F. (2016). Clinical errors as a lack of context responsiveness. *Psychotherapy*, 53(3), 262-267. https://doi.org/https://dx.doi.org/10.1037/pst0000080

Burnham, J. (2005). Relational reflexivity: A tool for socially constructing therapeutic relationships. In C. Flaskas, B. Mason, & A. Perlesz (Eds.), *The space between: Experience, content, and process in the therapeutic relationship* (pp. 1-18). Karnac.

Cairns, M. (2014). Patients who come back: Clinical characteristics and service outcome for patients re-referred to an IAPT service. *Counselling and Psychotherapy Research*, 14(1), 48-55. https://doi.org/10.1080/14733145.2013.770895

Callahan, J., Gustafson, S. A., Misner, J. B., Paprocki, C. M., Sauer, E. M., Saules, K. K., Schwartz, J. L., Swift, J. K., Whiteside, D. M., Wierda, K. E., & Wise, E. H. (2014). Introducing the Association of Psychology Training Clinics' Collaborative Research Network: A study on client expectancies. *Training and Education in Professional Psychology*, 8(2), 95–104. https://doi.org/10.1037/tep0000047

Cameron, S. K., Rodgers, J., & Dagnan, D. (2018). The relationship between the therapeutic alliance and clinical outcomes in cognitive behaviour therapy for adults with depression: A meta-analytic review. *Clinical Psychology and Psychotherapy*, 25(3), 446-456. https://doi.org/10.1002/cpp.2180

Caplan, R. (2014). Supervising the intern who inherits a case: Making the most of the change. *The Clinical Supervisor*, 33(2), 243–255. https://doi.org/10.1080/07325223.2014.992291

Castonguay, L. G., Goldfried, M. R., Wiser, S., Raue, P. J., & Hayes, A. M. (1996). Predicting the effect of cognitive therapy for depression: A study of unique and common factors. *Journal of Consulting and Clinical Psychology*, 64(3), 497–504. https://doi.org/10.1037/0022-006X.64.3.497

Castonguay, L. G., & Beutler, L. E. (2006). Principles of therapeutic change: a task force on participants, relationships, and techniques factors. *Journal of Clinical Psychology*, 62(6), 631–638. https://doi.org/10.1002/jclp.20256

Chase, K.A., (2000). The Integrative Stage Model approach to the case of Katrina. *Cognitive and Behavioral Practice*, 7 (4), 489-497. https://doi.org/10.1016/S10777229(00)80063-2

Chen, T.-R., Huang, H.-C., Hsu, J.-H., Ouyang, W.-C., & Lin, K.-C. (2019). Pharmacological and psychological interventions for generalized anxiety disorder in adults: A network meta-analysis. *Journal of Psychiatric Research*, 118, 73-83. https://doi.org/10.1016/j.jpsychires.2019.08.014

Chen, Y., Boswell, J. F., Schwartzman, C. M., & Iles, B. R. (2017). Psychotherapy clients' recalled treatment experiences: A survey of perceived evidence-based practice elements. *Journal of Clinical Psychology*, *73*(11), 1534–1542. https://doi.org/10.1002/jclp.22526

Cicone, M.C. (2003). *Hope and optimism: Impact on burnout, satisfaction with life and psychological well-being in psychotherapists*. [Doctoral dissertation, Alliant International University] ProQuest Dissertations and Theses.

Clark D. M. (2018). Realizing the mass public benefit of evidence-based psychological therapies: The IAPT program. *Annual Review of Clinical Psychology*, 14, 159–183. https://doi.org/10.1146/annurev-clinpsy-050817-084833

Clark, D. M., Canvin, L., Green, J., Layard, R., Pilling, S., & Janecka, M. (2018). Transparency about the outcomes of mental health services (IAPT approach): an analysis of public data. *The Lancet*, 391(10121), 679-686. https://doi.org/10.1016/S0140-6736(17)32133-5

Clarke, J. (2020). If not a Tsunami of CBT, then What? The Debate About NHS Psychotherapy Services in the Age of Mc-IAPT. *British Journal of Psychotherapy*, 36(2), 323–333. https://doi.org/10.1111/bjp.12550

Clemens, N. A. (2004). A really, really long-term follow-up. *Journal of Psychiatric Practice*, 10(4), 255-257. https://doi.org/https://dx.doi.org/10.1097/00131746200407000-00007

Clemmens, E. R. (1992). A case report: I. *The American Journal of Psychoanalysis*, 52(1), 51-65. https://doi.org/https://dx.doi.org/10.1007/BF01253443

Cloitre, M. (2013). The Case: Treating Jared through STAIR narrative therapy. *Journal of Clinical Psychology*, 69(5), 482–484. https://doi.org/10.1002/jclp.21982

Coltart, I., Covington, C., Hobdell, R., & Sherman, A. (1988). The lost ones. *British Journal of Psychotherapy*, 4(4), 380-392. https://doi.org/https://dx.doi.org/10.1111/j.17520118.1988.tb01040.x

Constantino, M. J., Arnkoff, D. B., Glass, C. R., Ametrano, R. M., & Smith, J. Z. (2011). Expectations. *Journal of Clinical Psychology*, 67(2), 184–192. https://doi.org/10.1002/jclp.20754

Constantino, M.J., Coyne, A. E., McVicar, E. L., & Ametrano, R. M. (2017). The relative association between individual difference variables and general psychotherapy outcome expectation in socially anxious individuals. *Psychotherapy Research*, 27(5), 583–594. https://doi.org/10.1080/10503307.2016.1138336

Constantino, M. J., Coyne, A. E., Boswell, J. F., Iles, B. R. & Vîslă, A. (2018). A meta-analysis of the association between patients' early perception of treatment credibility and their posttreatment outcomes. *Psychotherapy*, 55 (4), 486-495. doi: 10.1037/pst0000168.

Constantino, M. J., Vîslă, A., Coyne, A. E. & Boswell, J. F. (2018). A meta-analysis of the association between patients' early treatment outcome expectation and their posttreatment outcomes. *Psychotherapy, 55* (4), 473-485. doi:10.1037/pst0000169.

Coppock, T.E., Owen, J. J., Zagarskas, E., & Schmidt, M. (2010). The relationship between therapist and client hope with therapy outcomes. *Psychotherapy Research*, 20(6), 619–626. https://doi.org/10.1080/10503307.2010.497508

Cotton, E. (28 November 2019). *IAPT revolving door data casts doubt on recovery rate*. CBT Watch. http://www.cbtwatch.com/iapt-revolving-door-data-casts-doubt-onrecovery-rate/

Coyne, A. E., Constantino, M. J., & Muir, H. J. (2019). Therapist Responsivity to Patients' Early Treatment Beliefs and Psychotherapy Process. *Psychotherapy*, 56(1), 11-15. https://doi.org/10.1037/pst0000200

Creswell, J. W., & Poth, C.N. (2018). Q*ualitative inquiry and research design: Choosing among five approaches (Fourth Edition. International Student edition)*. SAGE Publications

Crawford, M., Thana, L., Farquharson, L., Palmer, L., Hancock, E., Bassett, P., Clarke, J., & Parry, G. (2016). Patient experience of negative effects of psychological treatment: Results of a national survey. *The British Journal of Psychiatry, 208*(3), 260-265. doi:10.1192/bjp.bp.114.162628

Cristea, I. A., Kok, R. N., & Cuijpers, P. (2015). Efficacy of cognitive bias modification interventions in anxiety and depression: meta-analysis. *The British Journal of Psychiatry*, 206(1), 7–16. https://doi.org/10.1192/bjp.bp.114.146761

Cuijpers, P., Driessen, E., Hollon, S. D., van Oppen, P., Barth, J., & Andersson, G. (2012). The efficacy of non-directive supportive therapy for adult depression: A meta-analysis. *Clinical Psychology Review*, 32(4), 280–291. https://doi.org/10.1016/j.cpr.2012.01.003

Cuijpers, P., Berking, M., Andersson, G., Quigley, L., Kleiboer, A., & Dobson, K. S. (2013). A meta-analysis of cognitive-behavioural therapy for adult depression, alone and in comparison with other treatments. *Canadian Journal of Psychiatry*, 58(7), 376-385. https://doi.org/10.1177/070674371305800702

Cuijpers, P., Cristea, I. A., Karyotaki, E., Reijnders, M., & Huibers, M. J. H. (2016). How effective are cognitive behavior therapies for major depression and anxiety disorders?: A meta-analytic update of the evidence. *World Psychiatry*, 15(3), 245-258. https://doi.org/10.1002/wps.20346

Cuijpers, P., Reijnders, M., & Huibers, M. J. H. (2019). The role of common factors in psychotherapy outcomes. *Annual Review of Clinical Psychology*, 15, 207–231. https://doi.org/10.1146/annurev-clinpsy-050718-095424

Cuijpers, P., Karyotaki, E., Ciharova, M., Miguel, C., Noma, H., & Furukawa, T. A. (2021). The effects of psychotherapies for depression on response, remission, reliable change, and deterioration: A meta-analysis. *Acta Psychiatrica Scandinavica*, 144(3), 288-299. https://doi.org/10.1111/acps.13335

Cushman, P., & Gilford, P. (2000). Will managed care change our way of being? *The American Psychologist*, 55(9), 985–996. https://doi.org/10.1037/0003066X.55.9.985

Delgadillo, J., Asaria, M., Ali, S., & Gilbody, S. (2016). On poverty, politics and psychology: the socioeconomic gradient of mental healthcare utilisation and outcomes. *The British Journal of Psychiatry*, 209(5), 429–430. https://doi.org/10.1192/bjp.bp.115.171017

Delgadillo, J., Saxon, D., & Barkham, M. (2018). Associations between therapists' occupational burnout and their patients' depression and anxiety treatment outcomes. *Depression and Anxiety*, 35(9), 844–850. https://doi.org/10.1002/da.22766

Del Re, A.C., Flückiger, C., Horvath, A. O., Symonds, D., & Wampold, B. E. (2012). Therapist effects in the therapeutic alliance–outcome relationship: A restricted maximum likelihood meta-analysis. *Clinical Psychology Review*, 32(7), 642–649. https://doi.org/10.1016/j.cpr.2012.07.002

Delsignore, A. (2008) Does prior psychotherapy experience affect the course of cognitive behavioural group therapy for social anxiety disorder? *The Canadian Journal of Psychiatry*. 2008;53(8):509-516. doi:10.1177/070674370805300805

DiGiuseppe, R. (2011). A comprehensive treatment program for a case of disturbed anger. *Cognitive and Behavioral Practice*, 18(2), 235–240. https://doi.org/10.1016/j.cbpra.2009.10.009

Dobson, K. S. (2022). Therapeutic Relationship. *Cognitive and Behavioral Practice*, 29(3), 541. https://doi.org/10.1016/j.cbpra.2022.02.006

Doidge, N., Simon, B., Brauer, L., Grant, D. C., First, M., Brunshaw, J., Lancee, W. J., Stevens, A., Oldham, J. M., & Mosher, P. (2002). Psychoanalytic patients in the U.S., Canada, and Australia: I. DSM-III-R disorders, indications, previous treatment, medications, and length of treatment. *Journal of the American Psychoanalytic Association*, 50(2), 575-614. https://doi.org/https://dx.doi.org/10.1177/00030651020500021201

Dong, L., Lee, J. Y., & Harvey, A. G. (2017). Do improved patient recall and the provision of memory support enhance treatment adherence? *Journal of Behavior Therapy and Experimental Psychiatry*, 54, 219–228. https://doi.org/10.1016/j.jbtep.2016.08.017

Drew, P., Irvine, A., Barkham, M., Faija, C., Gellatly, J., Ardern, K., Armitage, J. C., Brooks, H., Rushton, K., Welsh, C., Bower, P., & Bee, P. (2021). Telephone delivery of psychological interventions: Balancing protocol with patient-centred care. *Social Science & Medicine*, 277, 113818–113818. https://doi.org/10.1016/j.socscimed.2021.113818

Elliott, R., Fischer, C. T., & Rennie, D. L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology, 38*(3), 215-229. https://doi.org/10.1348/014466599162782

Elliott, R., Bohart, A. C., Watson, J. C. & Murphy, D. (2018). Therapist empathy and client outcome. *Psychotherapy, 55* (4), 399-410. doi: 10.1037/pst0000175.

Eubanks, C. F., Muran, J. C., & Safran, J. D. (2018). Alliance rupture repair. *Psychotherapy*, 55 (4), 508-519. doi: 10.1037/pst0000185.

Farber, B. A. & Doolin, E. M. (2011). Positive regard. *Psychotherapy*, 48 (1), 58-64. doi: 10.1037/a0022141.

Fenger, M., Mortensen, E. L., Poulsen, S., & Lau, M. (2014). A register-based study of long-term healthcare use before and after psychotherapy. *Nordic Journal of Psychiatry*, 68(7), 450-459. https://doi.org/10.3109/08039488.2013.855255

Festinger, L. (1950). Informal social communication. *Psychological Review*, 57 (5), 271-282. https://doi.org/10.1037/h0056932

Finsrud, I., Nissen-Lie, H. A., Vrabel, K., Høstmælingen, A., Wampold, B. E., & Ulvenes, P. G. (2022a). It's the therapist and the treatment: The structure of common therapeutic relationship factors. *Psychotherapy Research*, 32(2), 139-150. https://doi.org/10.1080/10503307.2021.1916640

Finsrud, I., Nissen-Lie, H. A., Ulvenes, P., Melsom, L., Vrabel, K., & Wampold, B. (2022b). Confidence in the therapist and confidence in the treatment predict symptomatic improvement week by week in therapy: A latent curve modeling approach. *Journal of Counseling Psychology*, 69(6), 823–834. https://doi.org/10.1037/cou0000640

Firestein, S.K., (1982). Termination of psychoanalysis: Theoretical, clinical, and pedagogic considerations. *Psychoanalytic Inquiry*, 2(3), 473–497. https://doi.org/10.1080/07351698209533465

Flaskerud, J. H. (1986). The effects of culture-compatible intervention on the utilization of mental health services by minority clients. *Community Mental Health Journal*, 22(2), 127–141. https://doi.org/10.1007/BF00754551

Fleishman-Pogach, L., (2008). *College students' attitudes toward seeking professional psychological help.* [Doctoral dissertation, Chestnut Hill College]. ProQuest Dissertations and Theses.

Fleming, C. J. E., Kholodkov, T., Dillon, K. H., Belvet, B., & Crawford, E. F. (2018). Actuarial prediction of psychotherapy retention among Iraq-Afghanistan veterans with posttraumatic stress disorder. *Psychological Services*, 15(2), 172-180. https://doi.org/10.1037/ser0000139

Fletcher, A. J. (2017). Applying critical realism in qualitative research: Methodology meets method. *International Journal of Social Research Methodology: Theory & Practice*, 20(2), 181–194. https://doi.org/10.1080/13645579.2016.1144401

Flückiger, C., Caspar, F., Holtforth, M. G., & Willutzki, U. (2009). Working with patients' strengths: A microprocess approach. *Psychotherapy Research*, 19(2), 213-223. https://doi.org/10.1080/10503300902755300

Flückiger, C., Del Re, A. C., Wampold, B. E. & Horvath, A. O. (2018). The alliance in adult psychotherapy. *Psychotherapy, 55* (4), 316-340. doi: 10.1037/pst0000172.

Flückiger, C., Rubel, J., Del Re, A. C., Horvath, A. O., Wampold, B. E., Crits-Christoph, P., Atzil-Slonim, D., Compare, A., Falkenström, F., Ekeblad, A., Errázuriz, P., Fisher, H., Hoffart, A., Huppert, J. D., Kivity, Y., Kumar, M., Lutz, W., Muran, J. C., Strunk, D. R., Tasca, G.A, Vîslã, A., Voderholzer, U, Webb, C.A., Xu, H., Zilcha-Mano, S., Barber, J. P. (2020). The reciprocal relationship between alliance and early treatment symptoms: A two-stage individual participant data meta-analysis. *Journal of Consulting and Clinical Psychology*, 88(9), 829-843. https://doi.org/10.1037/ccp0000594

Frank, J.D., (1961). *Persuasion and healing: a comparative study of psychotherapy*. Oxford University Press.

Freud, S. (1937). Analysis terminable and interminable. *International Journal of Psychoanalysis*, 18, 373–405.

Fryer, T. (2020, October 30) *A beginner's guide to critical realism*. Critical Realism Network. https://criticalrealismnetwork.org/2020/10/30/a-beginners-guide-tocritical-realism/

Fryer, T., (2022). A critical realist approach to thematic analysis: producing causal explanations. *Journal of Critical Realism*, 21(4), 365–384. https://doi.org/10.1080/14767430.2022.2076776

Furukawa, T. A., Noma, H., Caldwell, D. M., Honyashiki, M., Shinohara, K., Imai, H., Chen, P., Hunot, V., & Churchill, R. (2014). Waiting list may be a nocebo condition in psychotherapy trials: a contribution from network meta-analysis. *Acta Psychiatrica Scandinavica*, 130(3), 181–192. https://doi.org/10.1111/acps.12275

Garibaldi, P. M., Abel, M. R., Snow, R. L., & Schleider, J. L. (2020). Does failure help or harm? Linking parents' treatment histories, views of failure, and expectancies for child psychotherapy. *Child & Youth Care Forum*, 49(1), 151-169. https://doi.org/https://dx.doi.org/10.1007/s10566-019-09523-7

Gassmann, D., & Grawe, K. (2006). General change mechanisms: the relation between problem activation and resource activation in successful and unsuccessful therapeutic interactions. *Clinical Psychology and Psychotherapy*, 13(1), 1–11. https://doi.org/10.1002/cpp.442

Gelso, C., & Johnson, D. H. (1983). *Explorations in time-limited counseling and psychotherapy*. Teachers College Press.

Gerke, L., Meyrose, A. K., Ladwig, I., Rief, W., & Nestoriuc, Y. (2020). Frequencies and predictors of negative effects in routine inpatient and outpatient psychotherapy: Two observational studies. *Frontiers in psychology*, 11, Article 2144. https://doi.org/10.3389/fpsyg.2020.02144

Giacomini, M. (2010). Theory matters in qualitative health research. In I. Bourgeault, R. Dingwall, & R. de Vries (Eds.), *The Sage handbook of qualitative methods in health research* (pp. 125–156). Sage.

Gibson, B. (2024). "*There's a six-foot monkey that's not being talked about" Improving Access to Psychological Therapies (IAPT): Cognitive behavioural supervisors' and supervisees' experiences of interpersonal processes in the supervisory relationship. An interpretative phenomenological analysis*. [Doctoral dissertation, University of Derby. University of Derby Repository. https://doi.org/10.48773/q5y75

Gilbert, P. (2010). *The compassionate mind*. Constable.

Glass, C.R., Arnkoff, D. B., & Shapiro, S. J. (2001). Expectations and preferences. *Psychotherapy*, 38(4), 455–461. https://doi.org/10.1037/0033-3204.38.4.455

Gloger, E. R. (2011). Breakdown and development – A clinical case study. *Psychoanalytic Psychotherapy*, 25(2), 157–175. https://doi.org/10.1080/02668734.2011.576495

Goddard, E., Wingrove, J., & Moran, P. (2015). The impact of comorbid personality difficulties on response to IAPT treatment for depression and anxiety. *Behaviour research and therapy*, 73, 1–7. https://doi.org/10.1016/j.brat.2015.07.006

Goh, M., Xie, B., Wahl, K. H., Zhong, G., Lian, F., & Romano, J. L. (2007). Chinese students' attitudes toward seeking professional psychological help. *International Journal for the advancement of counselling*, 29(3-4), 187-202. https://doi.org/https://dx.doi.org/10.1007/s10447-007-9038-5

Goodman, D. M. (2016). The McDonaldization of psychotherapy: Processed foods, processed therapies, and economic class. *Theory & Psychology*, 26(1), 77–95. https://doi.org/10.1177/0959354315619708

Grawe, K. (1997). Research-informed psychotherapy. *Psychotherapy Research*, 7(1), 1-19. https://doi.org/10.1080/10503309712331331843

Grawe, K. (2004). *Psychological therapy*. Hogrefe & Huber Publishers.

Grenyer, B. F. S., Deane, F. P., & Lewis, K. L. (2008). Treatment history and its relationship to outcome in psychotherapy for depression. *Australian counselling and psychotherapy research*, 8(1), 21-27. https://doi.org/https://dx.doi.org/10.1080/14733140801889055

Hampton, C. (2013). Experiences of following on from a previous therapist. *Psychodynamic Practice: Individuals, Groups and Organisations*, 19(1), 73-80. https://doi.org/https://dx.doi.org/10.1080/14753634.2013.750096 (Psychodynamic Counselling)

Hanna, F. (2002). *Therapy with difficult clients: Using the precursors model to awaken change (First edition)*. American Psychological Association.

Hardy, G. E., Bishop-Edwards, L., Chambers, E., Connell, J., Dent-Brown, K., Kothari, G., O'Hara, R., & Parry, G. D. (2019). Risk factors for negative experiences during psychotherapy. *Psychotherapy Research*, 29(3), 403-414. https://doi.org/10.1080/10503307.2017.1393575

Harper, K., Bhutani, G., Saleem Rao, A., & Clarke, J. (2020). Wellbeing matters in IAPT practitioners: Identity vs system. *International Journal of Stress Prevention and Wellbeing*, 4, 4. https://www.stressprevention.net/volume/volume-4-2020/volume-4article-4/

Hartlaub, G. H., Martin, G. C., & Rhine, M. W. (1986). Recontact with the analyst following termination: a survey of seventy-one cases. *Journal of the American Psychoanalytic Association*, 34(1986), 895-910.

Harvey, A. G., Lee, J., Smith, R. L., Gumport, N. B., Hollon, S. D., Rabe-Hesketh, S., Hein, K., Dolsen, E. A., Haman, K. L., Kanady, J. C., Thompson, M. A., & Abrons, D. (2016). Improving outcome for mental disorders by enhancing memory for treatment. *Behaviour Research and Therapy*, *81*, 35–46. https://doi.org/10.1016/j.brat.2016.03.007

Hepgul, N., King, S., Amarasinghe, M., Breen, G., Grant, N., Grey, N., Hotopf, M., Moran, P., Pariante, C. M., Tylee, A., Wingrove, J., Young, A. H., & Cleare, A. J. (2016). Clinical characteristics of patients assessed within an Improving Access to Psychological Therapies (IAPT) service: results from a naturalistic cohort study (Predicting Outcome Following Psychological Therapy; PROMPT). *BMC Psychiatry*, 16(49), 52-52. https://doi.org/10.1186/s12888-016-0736-6

Hill, C. E. (1995). What are the mechanisms of change in the common factors? *Clinical Psychology Research and Practice*, 2 (1), 87-89. https://doi.org/10.1111/j.14682850.1995.tb00029.x

Hill, C. E. (2005). Therapist techniques, client involvement, and the therapeutic relationship. *Psychotherapy: Theory, Research, Practice, Training*, 42 (4), 431442.

Hollon, S. (2010). Foreword and preface. In D. McKay, J.S. Abramowitz, & S. Taylor, S. (Eds.). *Cognitive-behavioral therapy for refractory cases: Turning failure into success*. (pp xiii-xxiii). American Psychological Association. https://doi.org/10.1037/12070-000

Hopper, S.R. (2015). *The therapist experience of client non-response.* [Doctoral dissertation, University of Leeds]. White Rose eTheses Online. etheses.whiterose.ac.uk/10725

Horn, A. (2002). *A longitudinal evaluation of an intermittent model of psychotherapy.* [Doctoral dissertation, Northwestern University]. ProQuest Dissertations & Theses.

Howard, K.I., Lueger, R. J., Maling, M. S., & Martinovich, Z. (1993). A phase model of psychotherapy outcome: Causal mediation of change. *Journal of Consulting and Clinical Psychology*, 61(4), 678–685. https://doi.org/10.1037/0022-006X.61.4.678

Hundt, N. E., Mott, J. M., Miles, S. R., Arney, J., Cully, J. A., & Stanley, M. A. (2015). Veterans' perspectives on initiating evidence-based psychotherapy for posttraumatic stress disorder. *Psychological Trauma*, 7(6), 539-546. https://doi.org/10.1037/tra0000035

Hutten, R. (2018). *The making of psychological therapists: Towards a psychosocial understanding of IAPT training, culture and practices*. [Doctoral thesis, University of Sheffield].

Impala, T., Dobson, K. S., & Kazantzis, N. (2022). Does the working alliance mediate the therapist competence-outcome relationship in cognitive behavior therapy for depression? *Psychotherapy Research*, 32(1), 126-138. https://doi.org/10.1080/10503307.2021.1946195

Karlin, R. A. (2006). Two cases, one good therapist. *Pragmatic Case Studies in Psychotherapy*, 2(2). https://doi.org/10.14713/pcsp.v2i2.874

Kassinove, H., & Tafrate, R. C. (2011). Application of a flexible, clinically driven approach for anger reduction in the case of Mr. P. *Cognitive and Behavioral Practice*, 18(2), 222–234. https://doi.org/10.1016/j.cbpra.2009.08.008

Kazantzis, N., Dattillio, F.M., & Dobson, K. S. (2017). *The therapeutic relationship in cognitive-behavioural therapy: A clinician's guide*. The Guilford Press

Kazantzis, N., & Dobson, K. S. (2022). Therapeutic relationships in cognitive behavioral therapy: Theory and recent research. *Psychotherapy Research*, 1-3. https://doi.org/10.1080/10503307.2022.2124047

Kazantzis, N., Luong, H. K., Usatoff, A. S., Impala, T., Yew, R. Y., & Hofmann, S. G. (2018). The processes of cognitive behavioral therapy: A review of meta-analyses. *Cognitive Therapy and Research*, 42(4), 349–357. https://doi.org/10.1007/s10608018-9920-y

Kazdin A. E. (2009). Understanding how and why psychotherapy leads to change. *Psychotherapy research: Journal of the Society for Psychotherapy Research*, 19(4-5), 418–428. https://doi.org/10.1080/10503300802448899

Kennerley, H., Westbrook, D., & Kirk, J. (2017). *An Introduction to cognitive behaviour therapy: Skills and applications* (Third edition.). SAGE.

Kilcullen, J. R., Castonguay, L. G., Janis, R. A., Hallquist, M. N., Hayes, J. A., & Locke, B. D. (2020). Predicting future courses of psychotherapy within a grouped lasso framework. *Psychotherapy Research*, 31, 1, 63-77. https://doi.org/https://dx.doi.org/10.1080/10503307.2020.1762948

Knight, C., Russo, D., Stochl, J., Croudace, T., Fowler, D., Grey, N., Reeve, N., Jones, P. B., & Perez, J. (2020). Prevalence of and recovery from common mental disorder including psychotic experiences in the UK Primary Care Improving Access to Psychological Therapies (IAPT) Programme. *Journal of Affective Disorders*, 272, 84-90. https://doi.org/https://dx.doi.org/10.1016/j.jad.2020.04.015

Knox, S., Miller, C., Twidwell, R. E., & Knowlton, G. (2022). Client perspectives on psychotherapy failure. *Psychotherapy Research*, 1-18. https://doi.org/10.1080/10503307.2022.2110020

Kolden, G. G., Wang, C., Austin, S. B., Chang, Y. & Klein, M. H. (2018). Congruence/Genuineness. *Psychotherapy, 55* (4), 424-433. doi: 10.1037/pst0000162.

Kostaki, E. (2018). *The association between work-related potential stressors, selfcompassion and perceived stress in IAPT therapists*. [Doctoral dissertation, University of Essex]. https://repository.essex.ac.uk/22914/

Krebs, G., Isomura, K., Lang, K., Jassi, A., Heyman, I., Diamond, H., Advani, J., Turner, C., & Mataix-Cols, D. (2015). How resistant is 'treatment-resistant' obsessive compulsive disorder in youth? *British Journal of Clinical Psychology*, 54(1), 63-75. https://doi.org/https://dx.doi.org/10.1111/bjc.12061

Lambert, M. J., & Shimokawa, K. (2011). Collecting client feedback. *Psychotherapy*, 48 (1), 72-79. doi: 10.1037/a0022238.

Lamph, G., Baker, J., Dickinson, T., & Lovell, K. (2019). Personality disorder co-morbidity in primary care 'Improving Access to Psychological Therapy' services: A qualitative study exploring professionals' perspectives of working with this patient group. *Personality and Mental Health*, 13 (3), 168-179. https://doi.org/10.1002/pmh.1454

Lauzier-Jobin, F., Brunson, L., & Olson, B. (2022). Introduction to the special issue on critical realism. *Journal of Community Psychology*. https://doi.org/10.1002/jcop.22981

Layard, R., Clark, D., Knapp, M., & Mayraz, G. (2007). *Cost-benefit analysis of psychological therapy*. Centre for Economic Performance.

Lazar, A., Sandell, R., & Grant, J. (2006). Do psychoanalytic treatments have positive effects on health and health care utilization? Further findings of the Stockholm Outcome of Psychotherapy and Psychoanalysis Project (STOPPP). *Psychotherapy Research*, 16(1), 51-66. https://doi.org/10.1080/10503300500268094

Leeds Mental Wellbeing Service (18 August 2022). *Eligibility and Criteria Principles*. Leeds Community Healthcare NHS Trust.

Leonidaki, V. (2021). Moving beyond a single-model philosophy: Integrating relational therapies in front-line psychological therapy services in England. *Journal of Psychotherapy Integration*, 31(1), 70-85. https://doi.org/10.1037/int0000192

Levy, H.C., O'Bryan, E.M., & Tolin, D.F. (2021). A meta-analysis of relapse rates in cognitive-behavioral therapy for anxiety disorders. *Journal of Anxiety Disorders*, 81, 102407. https://doi.org/10.1016/j.janxdis.2021.102407

Linehan, M. M., Cochran, B. N., Mar, C. M., Levensky, E. R., & Comtois, K. A. (2000). Therapeutic burnout among borderline personality disordered clients and their therapists: Development and evaluation of two adaptations of the Maslach burnout inventory. *Cognitive and Behavioral Practice*, *7*(3), 329-337. https://doi.org/10.1016/S1077-7229(00)80091-7

Liness, S., Beale, S., Lea, S., Byrne, S., Hirsch, C. R., & Clark, D. M. (2019). The sustained effects of CBT training on therapist competence and patient outcomes. *Cognitive*

Therapy and Research, 43(3), 631-641. https://doi.org/https://dx.doi.org/10.1007/s10608-018-9987-5

Lorenzo-Luaces, L., DeRubeis, R. J., & Webb, C. A. (2014). Client characteristics as moderators of the relation between the therapeutic alliance and outcome in cognitive therapy for depression. *Journal of Consulting and Clinical Psychology*, *82*(2), 368–373. https://doi.org/10.1037/a0035994

Lorenzo-Luaces, L., Driessen, E., DeRubeis, R. J., Van, H. L., Keefe, J. R., Hendriksen, M., & Dekker, J. (2016). Moderation of the alliance-outcome association by prior depressive episodes: Differential effects in cognitive-behavioral therapy and short-term psychodynamic supportive psychotherapy. *Behavior Therapy*, 48(5), 581-595. https://doi.org/10.1016/j.beth.2016.11.011

Lorimer, B., Kellett, S., Nye, A., & Delgadillo, J. (2021). Predictors of relapse and recurrence following cognitive behavioural therapy for anxiety-related disorders: a systematic review. *Cognitive Behaviour Therapy*, 50(1), 1–18. https://doi.org/10.1080/16506073.2020.1812709

Lorimer, B., Kellett, S., Giesemann, J., Lutz, W., & Delgadillo, J. (2024). An investigation of treatment return after psychological therapy for depression and anxiety. *Behavioural and Cognitive Psychotherapy*, 52(2), 149–162. https://doi.org/10.1017/S1352465823000322

Loumidis, K. S., & Shropshire, J. M. (1997). Effects of waiting time on appointment attendance with clinical psychologists and length of treatment. *Irish Journal of Psychological Medicine*, 14(2), 49–54. https://doi.org/10.1017/S0790966700002986

Luong, H. K., Drummond, S. P. A., & Norton, P. J. (2020). Elements of the therapeutic relationship in CBT for anxiety disorders: A systematic review. *Journal of Anxiety Disorders*, 76, 102322-102322. https://doi.org/10.1016/j.janxdis.2020.102322

Lutz, W., Martinovich, Z., & Howard, K. I. (1999). Patient profiling: An application of random coefficient regression models to depicting the response of a patient to outpatient psychotherapy. *Journal of Consulting and Clinical Psychology*, 67(4), 571-577.

Maass, U., Kuhne, F., Maas, J., Unverdross, M., & Weck, F. (2020). Psychological interventions for health anxiety and somatic symptoms: A systematic review and meta-analysis. *Special Issue: Medically Unexplained Symptoms and Bodily Distress*, 228(2), 68-80. https://doi.org/https://dx.doi.org/10.1027/21512604/a000400

Malin, N.R. (1990). Returning to psychotherapy with the same therapist: A self-psychological perspective. *Clinical Social Work Journal*, 18(2), 115–129. https://doi.org/10.1007/BF00756473

Malterud, K., Siersma, V. D., & Guassora, A. D. (2016). Sample size in qualitative interview studies: Guided by information power. *Qualitative Health Research*, 26(13), 1753–1760. https://doi.org/10.1177/1049732315617444

Marmarosh, C. L., Thompson, B., Hill, C., Hollman, S., & Megivern, M. (2017). Therapists in-training experiences of working with transfer clients: One relationship terminates and another begins. *Psychotherapy*, 54(1), 102–113. https://doi.org/10.1037/pst0000095

Marsden, T.E. (2014). *Client expectations and pretreatment attrition at a community mental health center.* [Doctoral dissertation, University of Central Arkansas]. ProQuest Dissertations and Theses.

Marshall, D., Quinn, C., Child, S., Shenton, D., Pooler, J., Forber, S., & Byng, R. (2016). What IAPT services can learn from those who do not attend. *Journal of Mental Health*, 25(5), 410- 415. http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med13&NEWS=N&AN=26635236

Martin, C., Iqbal, Z., Airey, N. D., & Marks, L. (2022). Improving Access to Psychological Therapies (IAPT) has potential but is not sufficient: How can it better meet the range of primary care mental health needs? *The British Journal of Clinical Psychology*, 61(1), 157–174. https://doi.org/10.1111/bjc.12314

Martin, J., & Stelmaczonek, K. (1988). Participants' identification and recall of important events in counseling. *Journal of Counseling Psychology*, *35*(4), 385–390. https://doi.org/10.1037/0022-0167.35.4.385

Maxwell, J.A., (1992). Understanding and validity in qualitative research. *Harvard Educational Review*, 62(3), 279–300. https://doi.org/10.17763/haer.62.3.8323320856251826

Mayo-Wilson, E., Dias, S., Mavranezouli, I., Kew, K., Clark, D. M., Ades, A. E., & Pilling, S. (2014). Psychological and pharmacological interventions for social anxiety disorder in adults: A systematic review and network meta-analysis. *The Lancet Psychiatry*, 1(5), 368-376. http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=psyc11&NEWS=N&AN=2015-57504-023

Mazzetti, M. (2010). Analyzing the impact of prior psychotherapy on a patient's script. *Transactional Analysis Journal*, 40(1), 23-31. https://doi.org/https://dx.doi.org/10.1177/036215371004000104

Mazzotti, E., & Barbaranelli, C. (2012). Dropping out of psychiatric treatment: a methodological contribution. *Acta Psychiatrica Scandinavica*, 126, 6, 426-433. https://doi.org/10.1111/j.1600-0447.2012.01872.x

McCausland, J., Paparo, J., & Wootton, B. M. (2021). Treatment barriers, preferences and histories of individuals with symptoms of body dysmorphic disorder. *Behavioural and Cognitive Psychotherapy*, 49(5), 582-595. https://doi.org/https://dx.doi.org/10.1017/S1352465820000843

McCrone, P. (2013). IAPT is probably not cost-effective. *British Journal of Psychiatry*, 202(5), 383-383. https://doi.org/10.1192/bjp.202.5.383

McCullough, J. P. (2000). The case of Katrina: Skating on thin ice. *Cognitive and Behavioral Practice*, 7(4), 510–514. https://doi.org/10.1016/S1077-7229(00)80067X

McKenna, P. A. (1999). *Clinician perspectives on psychodynamic psychotherapy with experienced clients.* [Doctoral dissertation, University of Massachusetts]. ProQuest Dissertations and Theses.

McKenna, P., & Todd, D. (1997). Longitudinal utilization of mental health services: A timeline method, nine retrospective accounts, and a preliminary conceptualization.

Psychotherapy Research, 7(4), 383-395. https://doi.org/10.1080/10503309712331332093

Menaker, W. (1997). *Congruence of patient and therapist conceptions of psychotherapy and its impact on treatment.* [Doctoral dissertation, Northwestern University]. ProQuest Dissertations and Theses.

Mendenhall, S., (2009). From termination to the evolution of a relationship: A new understanding. *Psychoanalytic Inquiry*, 29(2), 117–135. https://doi.org/10.1080/07351690802274835

Morris, E. (2019). *Burnout within healthcare workers: The role of self-compassion, job demands and empathy.* [Doctoral dissertation, University of Liverpool]. University of Liverpool Repository. https://livrepository.liverpool.ac.uk/3054489/1/201227107_Jun2019.pdf

Motherwell, L., Houde, S.A., & Rutan, S.J. (2004). Patients who return to group therapy. *Group*, 28(1), 1–14.

Mukuria, C., Brazier, J., Barkham, M., Connell, J., Hardy, G., Hutten, R., Saxon, D., Dent-Brown, K., & Parry, G. (2013). Cost-effectiveness of an Improving Access to Psychological Therapies service. *British Journal of Psychiatry*, 202(3), 220-227. https://doi.org/10.1192/bjp.bp.111.107888

Muller, R. (1985). *The therapist-in-training and the transfer case: Beyond the transfer triangle*. [Doctoral dissertation, University of Massachusetts Amherst] ScholarWorks@UMass Amherst. https://doi.org/10.7275/d4zt-tk57

Munder, T., Karcher, A., Yadikar, Ö., Szeles, T., & Gumz, A. (2019). focusing on patients' existing resources and strengths in cognitive-behavioral therapy and psychodynamic therapy: a systematic review and meta-analysis. *Zeitschrift Für Psychosomatische Medizin Und Psychotherapie*, 65(2), 144–161. https://doi.org/10.13109/zptm.2019.65.2.144

Mussweiler, T., & Epstude, K. (2009). Relatively fast! Efficiency advantages of comparative thinking. *Journal of Experimental Psychology*. 138(1), 1–21. https://doi.org/10.1037/a0014374

National Institute for Health and Care Excellence. (2005). *Obsessive-compulsive disorder and body dysmorphic disorder: Treatment [NICE Guideline No. 31].* https://www.nice.org.uk/guidance/ng31

National Institute for Health and Care Excellence. (2013). *Social anxiety disorder: recognition, assessment and treatment [NICE Guideline No. 159]*. https://www.nice.org.uk/guidance/ng159

National Institute for Health and Care Excellence. (2018). *Post-traumatic stress disorder [NICE Guideline No. 116]*. https://www.nice.org.uk/guidance/ng116

National Institute for Health and Care Excellence. (2020). *Generalised anxiety disorder and panic disorder in adults: management [NICE Guideline No. 113]*. https://www.nice.org.uk/guidance/ng113/history

National Institute for Health and Care Excellence. (2022). *Depression in adults: treatment and management [NICE Guideline No. 222]*. https://www.nice.org.uk/guidance/ng222/history

Natterson, I. (1993). Turning points and intersubjectivity. *Clinical Social Work Journal*, 21(1), 45-56. https://doi.org/https://dx.doi.org/10.1007/BF00754911

Neill, S. J. (2001). *Female psychotherapists' views of managed mental health car*e. [Doctoral dissertation, University of Minnesota]. ProQuest Dissertations and Theses.

NHS Digital (2021). *Psychological therapies. Annual report on the use of IAPT services 2020-21*. Retrieved from https://digital.nhs.uk/data-and-information/publications/statistical/psychological-therapies-annual-reports-on-theuse-of-iapt-services/annual-report-2020-21

NHS Digital (2022). *Psychological therapies. Annual report on the use of IAPT services 2021-22*. Retrieved from https://digital.nhs.uk/data-and-information/publications/statistical/psychological-therapies-annual-reports-on-theuse-of-iapt-services/annual-report-2021-22

NHS Talking Therapies (2024). *NHS Talking Therapies for anxiety and depression manual (Version 7)*. National Collaborating Centre for Mental Health. https://www.england.nhs.uk/wp-content/uploads/2018/06/NHS-talking-therapiesmanual-v7-1.pdf

Nissen-Lie, H. A., Rønnestad, M. H., Høglend, P. A., Havik, O. E., Solbakken, O. A., Stiles, T. C., & Monsen, J. T. (2017). Love yourself as a person, doubt yourself as a therapist? *Clinical Psychology and Psychotherapy*, 24(1), 48–60. https://doi.org/10.1002/cpp.1977

Norcross, J. C. & Lambert, M. J. (2011). Psychotherapy relationships that work II. *Psychotherapy*, 48 (1), 4-8. doi: 10.1037/a0022180.

Norcross, J. C., & Lambert, M. J. (2018). Psychotherapy relationships that work III. *Psychotherapy*, 55(4), 303–315. https://doi.org/10.1037/pst0000193

Ogden, J., & Cornwell, D. (2010). The role of topic, interviewee and question in predicting rich interview data in the field of health research. *Sociology of Health & Illness*, 32(7), 1059–1071. https://doi.org/10.1111/j.1467-9566.2010.01272.x

Oliver, J. M., Searight, H. R., & Lightfoot, S. (1988). Client characteristics as determinants of intervention modality and therapy progress. *American Journal of Orthopsychiatry*, 58(4), 543-551. https://doi.org/https://dx.doi.org/10.1111/j.19390025.1988.tb01618.x

Olson, D. A., Westra, H. A., Shukla, S., & Di Bartolomeo, A. A. (2023). Therapist responsivity during disagreement in psychotherapy. *Counselling and Psychotherapy Research*, 23(3), 837–849. https://doi.org/10.1002/capr.12583

Omylinska-Thurston, J., McMeekin, A., Walton, P., & Proctor, G. (2019). Clients' perceptions of unhelpful factors in CBT in IAPT serving a deprived area of the UK. *Counselling and Psychotherapy Research*, 19(4), 455-464. https://doi.org/10.1002/capr.12249

Orgel, S. (2013). A patient returns. *Journal of the American Psychoanalytic Association*, 61(5), 935-946. https://doi.org/https://dx.doi.org/10.1177/0003065113507482

Otero, P. (2019). *Psychological therapists' wellbeing in the context of IAPT-NHS: A Foucauldian discourse analysis*. [Doctoral dissertation, University of East London]. University of East London Repository. https://doi.org/10.15123/uel.874y0

Ouellette, J. A., & Wood, W. (1998). Habit and intention in everyday life: The multiple processes by which past behavior predicts future behavior. *Psychological Bulletin*, 124(1), 54–74. https://doi.org/10.1037/0033-2909.124.1.54

Painter, A. (2018). *Processing people! The purpose and pitfalls of case management supervision provided for psychological wellbeing practitioners, working within Improving Access to Psychological Therapies (IAPT) Services: A thematic analysis.* [Doctoral dissertation, University of West England]. University of West England Repository. https://uwe-repository.worktribe.com/output/859047

Pamukcu, B., & Meydan, B. (2019). Turkish university students' expectations about counseling. *International Journal for the Advancement of Counselling*, 41(4), 544-560. https://doi.org/https://dx.doi.org/10.1007/s10447-019-09378-6

Papola, D., Ostuzzi, G., Tedeschi, F., Gastaldon, C., Purgato, M., Del Giovane, C., Pompoli, A., Pauley, D., Karyotaki, E., Sijbrandij, M., Furukawa, T. A., Cuijpers, P., & Barbui, C. (2022). Comparative efficacy and acceptability of psychotherapies for panic disorder with or without agoraphobia: Systematic review and network meta-analysis of randomised controlled trials. *The British Journal of Psychiatry*, 221(3), 507-519. https://doi.org/https://dx.doi.org/10.1192/bjp.2021.148

Parker, Z.J. and Waller, G. (2014) Factors related to psychotherapists' self-assessment when treating anxiety and other disorders. *Behaviour Research and Therapy*, 66. 1-7. https://doi.org/10.1016/j.brat.2014.12.010

Patterson, C., Uhlin, B., & Anderson, T. (2008). Clients' pretreatment counseling expectations as predictors of the Working Alliance. *Journal of Counseling Psychology*, 55(4), 528–534. https://doi.org/10.1037/a0013289

Patterson, V., Levene, H., & Breger, L. (1977). A one-year follow-up of two forms of brief psychotherapy. *American Journal of Psychotherapy*, 31(1), 76-82. http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=psyc2&NEWS=N&AN=1977-29869-001

Perfect, D., Jackson, C., Pybis, J. & Hill, A. (2016). *Choice of therapies in IAPT: An overview of the availability and client profile of step 3 therapies*. British Association for Counselling and Psychotherapy.

Pickersgill, M. (2019). Access, accountability, and the proliferation of psychological therapy: On the introduction of the IAPT initiative and the transformation of mental healthcare. *Social Studies of Science*, 49(4), 627-650. https://doi.org/https://dx.doi.org/10.1177/0306312719834070

Pope, K. S., & Tabachnick, B. G. (1993). Therapists' anger, hate, fear, and sexual feelings: national survey of therapist responses, client characteristics, critical events, formal complaints, and training. *Professional Psychology, Research and Practice*, 24(2), 142–152. https://doi.org/10.1037/0735-7028.24.2.142

Probst, T., Humer, E., Jesser, A., & Pieh, C. (2022). Attitudes of psychotherapists towards their own performance and the role of the social comparison group: The self-assessment bias in psychodynamic, humanistic, systemic, and behavioral therapists. *Frontiers in Psychology*, 13, 966947–966947. https://doi.org/10.3389/fpsyg.2022.966947

Quigley, L., Dozois, D. J. A., Bagby, R. M., Lobo, D. S. S., Ravindran, L., & Quilty, L. C. (2019). Cognitive change in cognitive-behavioural therapy v. pharmacotherapy for adult depression: a longitudinal mediation analysis. *Psychological Medicine*,

49(15), 2626-2634. https://doi.org/10.1017/S0033291718003653

Radcliffe, K., Masterson, C., & Martin, C. (2018). Clients' experience of non-response to psychological therapy: A qualitative analysis. *Counselling and Psychotherapy Research*, 18(2), 220–229. https://doi.org/10.1002/capr.12161

Radhakrishnan, M., Hammond, G., Jones, P. B., Watson, A., McMillan-Shields, F., & Lafortune, L. (2013). Cost of improving Access to Psychological Therapies (IAPT) Programme: an analysis of cost of session, treatment and recovery in selected primary care trusts in the East of England region. *Behaviour Research and Therapy*, 51(1), 37–45. https://doi.org/10.1016/j.brat.2012.10.001

Reder, P., & G., Fredman (1996). The relationship to help: Interacting beliefs about the treatment process. *Clinical Child Psychology & Psychiatry*, 1 (3), 457-467.

Reynolds, V. (2019). The Zone of Fabulousness: Resisting vicarious trauma with connection, collective care and justice-doing in ways that centre the people we work alongside. *Context*. 164, 36-39.

Rizq, R. (2012). The perversion of care: Psychological therapies in a time of IAPT. *Psychodynamic Practice*, 18(1), 7–24. https://doi.org/10.1080/14753634.2012.640161

Rodgers, B. (2003). An exploration into the client at the heart of therapy: A qualitative perspective. *Person-Centered & Experiential Psychotherapies*, 2(1), 19–30. https://doi.org/10.1080/14779757.2003.9688290

Rollwage M, Habicht J, Juechems K, Carrington B, Viswanathan S, Stylianou M, Hauser TU, Harper R. (2023). Using conversational AI to facilitate mental health assessments and improve clinical efficiency within psychotherapy services: Real-world observational study. JMIR AI 2023;2:e44358. https://doi: 10.2196/44358

Roos, J., & Wearden, A. (2009). What do we mean by "socialization to the model"? A Delphi Study. *Behavioural and Cognitive Psychotherapy*, 37(3), 341–345. https://doi.org/10.1017/S1352465809005281

Roscoe, J. (2019) Has IAPT become a bit like Frankenstein's monster? *CBT Today*, 47 (1), 16-17. https://issuu.com/babcpcomms/docs/cbt_today_feb_2019_final

Rosengarten, S. (2009). Myra's story: A life narrative as it unfolds in the treatment and journey of an adopted woman. *Psychoanalytic Inquiry*, 30:1, 54-62, DOI: 10.1080/07351690903200150

Rubel, J. A., Zilcha-Mano, S., Feils-Klaus, V., & Lutz, W. (2018). Session-to-session effects of alliance ruptures in outpatient CBT: Within- and between-patient associations. *Journal of Consulting and Clinical Psychology*, 86(4), 354-366. https://doi.org/10.1037/ccp0000286

Ryum, T., Bennion, M. & Kazantzis, N. (2023). Integrating between-session homework in psychotherapy. *Psychotherapy*, 60 (3), 306-319. doi: 10.1037/pst0000488.

Sandage, S. J., Rupert, D., Paine, D. R., Bronstein, M., & O'Rourke, C. G. (2016). Humility in psychotherapy. In E.L.,Worthington, D.E., Davis, & J.N., Hook (Eds.), *Handbook of humility: Theory, Research, and Applications* (pp. 317-331). Routledge.

Sandell, R., Clinton, D., Frovenholt, J., & Bragesjo, M. (2011). Credibility clusters, preferences, and helpfulness beliefs for specific forms of psychotherapy. *Psychology and Psychotherapy: Theory, Research and Practice*, 84(4), 425-441.

https://doi.org/10.1111/j.2044-8341.2010.02010.x

Santoft, F., Axelsson, E., Ost, L.-G., Hedman-Lagerlof, M., Fust, J., & Hedman-Lagerlof, E. (2019). Cognitive behavioural therapy for depression in primary care: Systematic review and meta-analysis. *Psychological Medicine*, 49(8), 1266-1274. https://doi.org/https://dx.doi.org/10.1017/S0033291718004208

Schürmann-Vengels, J., Appelbaum, S., Apel, M.-K., Trimpop, L., Muermans, M. M., Ostermann, T., Teismann, T., & Willutzki, U. (2022a). Association of patients' pretherapy strengths and alliance in outpatient psychotherapy: A multilevel growth curve analysis. *Psychotherapy Research*, 1-15. https://doi.org/10.1080/10503307.2022.2146543

Schürmann-Vengels, J., Teismann, T., Margraf, J., & Willutzki, U. (2022b). Patients' self-perceived strengths increase during treatment and predict outcome in outpatient cognitive behavioral therapy. *Journal of Clinical Psychology*, 78(12), 2427-2445. https://doi.org/10.1002/jclp.23352

Scott, C. (2018). *An exploration of burnout in Improving Access to Psychological Therapy (IAPT) services: An interpretative phenomenological analysis*. [Doctoral dissertation, University of West England]. https://uwerepository.worktribe.com/output/858514/

Scott, M. J., & Sembi, S. (2006). Cognitive behaviour therapy treatment failures in practice: The neglected role of diagnostic inaccuracy. *Behavioural and Cognitive Psychotherapy*, *34*(4), 491–495. doi:10.1017/S1352465806003055

Scott, S. (2006). The medicalisation of shyness: from social misfits to social fitness. *Sociology of Health & Illness*, 28(2), 133–153. https://doi.org/10.1111/j.14679566.2006.00485.x

Seidler, Z. E., Rice, S. M., Kealy, D., Oliffe, J. L., & Ogrodniczuk, J. S. (2020). Once bitten, twice shy: Dissatisfaction with previous therapy and its implication for future help-seeking among men. *International Journal of Psychiatry in Medicine*, 55(4), 255-263. https://doi.org/https://dx.doi.org/10.1177/0091217420905182

Shaw, S. C. (2003). *The client's helical path: A grounded theory of unsuccessful therapy experiences*. [Doctoral dissertation, University of Saskatchewan]. ProQuest Dissertations & Theses.

Sheeran, P., Aubrey, R., & Kellett, S. (2007). Increasing attendance for psychotherapy: Implementation intentions and the self-regulation of attendance-related negative affect. *Journal of Consulting and Clinical Psychology*, 75(6), 853–863. https://doi.org/10.1037/0022-006X.75.6.853

Siddall, L. B., Haffey, N. A., & Feinman, J. A. (1988). Intermittent brief psychotherapy in an HMO setting. *American Journal of Psychotherapy*, 42(1), 96-106. http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=psyc3&NEWS=N&AN=1988-20796-001

Sookman, D.L. (2014). Introduction. In D.L. Sookman & R.L. Leahy (Eds.). *Treatment resistant anxiety disorders: Resolving impasses to symptom remission* (pp xi-xviii). Routledge.

Snyder, C.R. (2002). Hope theory: Rainbows in the mind. *Psychological Inquiry*, 13(4), 249–275. https://doi.org/10.1207/S15327965PLI1304_01

Spear, A.M. (2018). *Impact of adolescent beliefs and past treatment experiences on an online depression prevention program.* [Doctoral dissertation, University of Palo Alto]. ProQuest Dissertations & Theses.

Steel, C., Macdonald, J., Schröder, T., & Mellor-Clark, J. (2015). Exhausted but not cynical: burnout in therapists working within Improving Access to Psychological Therapy Services. *Journal of Mental Health*, 24(1), 33–37. https://doi.org/10.3109/09638237.2014.971145

Steen, S. (2020). A cost-benefit analysis of the Improving Access to Psychological Therapies programme using its key defining outcomes. *Journal of Health Psychology*, 25(13-14), 2487-2498. https://doi.org/10.1177/1359105318803751

Stern, D.N., (1998). *The motherhood constellation: a unified view of parent-infant psychotherapy*. Karnac Books.

Stige, S. H., Binder, P.-E., Stiegler, J. R., Schanche, E., Hummelslund, D. A., & Hjeltnes, A. (2021). Clients' perspective on predetermined time limits for therapy in the context of the Norwegian welfare system. *SAGE Open*, 11(2). https://doi.org/10.1177/21582440211009506

Stiles, W. B., & Horvath, A. O. (2017). Appropriate responsiveness as a contribution to therapist effects. In L. Castonguay & C. E. Hill (Eds.), *How and why are some therapists better than others? Understanding therapist effects* (pp. 71–84). APA Books.

Stobie, B., Taylor, T., Quigley, A., Ewing, S., & Salkovskis, P. M. (2007). "Contents may vary": A pilot study of treatment histories of OCD patients. *Behavioural and Cognitive Psychotherapy*, 35(3), 273-282. https://doi.org/https://dx.doi.org/10.1017/S135246580700358X

Strauss, A. Y., Huppert, J. D., Simpson, H. B., & Foa, E. B. (2018). What matters more? Common or specific factors in cognitive behavioral therapy for OCD: Therapeutic alliance and expectations as predictors of treatment outcome. *Behaviour Research and Therapy*, 105, 43–51. https://doi.org/10.1016/j.brat.2018.03.007

Strauss, B., Gawlytta, R., Schleu, A., & Frenzl, D. (2021). Negative effects of psychotherapy: estimating the prevalence in a random national sample. *BJPsych Open*, 7(6), Article e186. https://doi.org/10.1192/bjo.2021.1025

Strunk, D. R., DeRubeis, R. J., Chiu, A. W., & Alvarez, J. (2007). Patients' competence in and performance of cognitive therapy skills: Relation to the reduction of relapse risk following treatment for depression. *Journal of Consulting and Clinical Psychology*, 75(4), 523–530. https://doi.org/10.1037/0022-006X.75.4.523

Stulz, N., & Lutz, W. (2007). Multidimensional patterns of change in outpatient psychotherapy: The phase model revisited. *Journal of Clinical Psychology*, 63(9), 817-833. https://doi.org/10.1002/jclp.20397

Swift, J. K. & Derthick, A. O. (2013). Increasing hope by addressing clients' outcome expectations. *Psychotherapy*, 50 (3), 284-287. doi: 10.1037/a0031941.

Swift, J.K., Whipple, J. L., & Sandberg, P. (2012). A Prediction of initial appointment attendance and initial outcome expectations. *Psychotherapy*, 49(4), 549–556. https://doi.org/10.1037/a0029441

Szalita, A. B. (1982). Further thoughts on reanalysis. *Contemporary Psychoanalysis*,

18(3), 327-348. https://doi.org/10.1080/00107530.1982.10745689

Tallis, F. (2020). *The act of living: What the great psychologists can teach us about surviving discontent in an age of anxiety*. Little Brown.

Thériault, A., & Gazzola, N. (2005). Feelings of inadequacy, insecurity, and incompetence among experienced therapists. *Counselling and Psychotherapy Research*, *5*(1), 11–18. https://doi.org/10.1080/14733140512331343840

Thornicroft, G. (2018). Improving Access to Psychological Therapies in England. *The Lancet*, 391(10121), 636-637. https://doi.org/10.1016/S0140-6736(17)32158-X

Tryon, G. S., Birch, S. E. & Verkuilen, J. (2018). Meta-analyses of the relation of goal consensus and collaboration to psychotherapy outcome. *Psychotherapy, 55* (4), 372383. doi: 10.1037/pst0000170.

Tschacher, W., Junghan, U. M., & Pfammatter, M. (2014). Towards a taxonomy of common factors in psychotherapy: Results of an expert survey. *Clinical Psychology and Psychotherapy*, 21(1), 82–96. https://doi.org/10.1002/cpp.1822

Turnpenny, L. (2019). *An investigation into predictors of Maslach's three dimensions of burnout in mental health staff*. [Doctoral dissertation, University of Southampton]. University of Southampton Research Repository. https://eprints.soton.ac.uk/431110

Tzur Bitan, D., & Abayed, S. (2020). Process expectations: Differences between therapists, patients, and lay individuals in their views of what works in psychotherapy. *Journal of Clinical Psychology*, 76(1), 20–30. https://doi.org/10.1002/jclp.22872

Waller, G., & Turner, H. (2016). Therapist drift redux: Why well-meaning clinicians fail to deliver evidence-based therapy, and how to get back on track. *Behaviour Research and Therapy*, 77, 129–137. https://doi.org/10.1016/j.brat.2015.12.005

Wampold, B. E. (2015). How important are the common factors in psychotherapy? An update. *World Psychiatry*, 14(3), 270–277. https://doi.org/10.1002/wps.20238

Watkins, C. E., & Mosher, D. K. (2020). Psychotherapy trainee humility and its impact: Conceptual and practical considerations. *Journal of Contemporary Psychotherapy*, 50(3), 187–195. https://doi.org/10.1007/s10879-020-09454-8

Watson, H. J., Levine, M. D., Zerwas, S. C., Hamer, R. M., Crosby, R. D., Sprecher, C. S., O'Brien, A., Zimmer, B., Hofmeier, S. M., Kordy, H., Moessner, M., Peat, C. M., Runfola, C. D., Marcus, M. D., & Bulik, C. M. (2017). Predictors of dropout in face-to-face and internet-based cognitive-behavioral therapy for bulimia nervosa in a randomized controlled trial. *International Journal of Eating Disorders*, 50(5), 569-577. https://doi.org/https://dx.doi.org/10.1002/eat.22644

Weck, F., Richtberg, S., Esch, S., Höfling, V., & Stangier, U. (2013). The relationship between therapist competence and homework compliance in maintenance cognitive therapy for recurrent depression: Secondary analysis of a randomized trial. *Behavior Therapy*, 44(1), 162–172. https://doi.org/10.1016/j.beth.2012.09.004

Weingarten, K. (2010). Reasonable hope: Construct, clinical applications, and supports. *Family Process*, 49(1), 5–25. https://doi.org/10.1111/j.1545-5300.2010.01305.x

Werbart, A., Annevall, A., & Hillblom, J. (2019). Successful and less successful psychotherapies compared: Three therapists and their six contrasting cases. *Frontiers in Psychology*, 10, 816–816. https://doi.org/10.3389/fpsyg.2019.00816

Werbart, A., von Below, C., Brun, J., & Gunnarsdottir, H. (2015). "Spinning one's wheels": Nonimproved patients view their psychotherapy. *Psychotherapy Research*, 25(5), 546-564. https://doi.org/10.1080/10503307.2014.989291

Werman, D. S. (1989). Early transferences and transference-like reactions. *The Hillside Journal of Clinical Psychiatry*, 11(1), 55-68. http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med3&NEWS=N&AN=2613187

Werner-Wilson, R. J., & Winter, A. (2010). What factors influence therapy drop out? *Contemporary Family Therapy: An International Journal*, 32(4), 375–382. https://doi.org/10.1007/s10591-010-9131-5

Westen, D., & Morrison, K. (2001). A multidimensional meta-analysis of treatments for depression, panic, and generalized anxiety disorder: an empirical examination of the status of empirically supported therapies. *Journal of Consulting and Clinical Psychology*, 69(6), 875–913. https://doi.org/10.1037//0022-006X.69.6.875

Westra, H. A., Dozois, D. J. A., & Marcus, M. (2007). Expectancy, homework compliance, and initial change in cognitive-behavioral therapy for anxiety. *Journal of Consulting and Clinical Psychology*, 75(3), 363–373. https://doi.org/10.1037/0022006X.75.3.363

Wakefield, S., Kellett, S., Simmonds-Buckley, M., Stockton, D., Bradbury, A., & Delgadillo, J. (2021). Improving Access to Psychological Therapies (IAPT) in the United Kingdom: A systematic review and meta-analysis of 10-years of practice-based evidence. *British Journal of Clinical Psychology*, 60(1), 1-37. https://doi.org/10.1111/bjc.12259

Williams, L., & Winter, H. (2009). guidelines for an effective transfer of cases: the needs of the transfer triad. *The American Journal of Family Therapy*, 37(2), 146–158. https://doi.org/10.1080/01926180801960583

Willig, C., (2013). *Introducing qualitative research in psychology*: *Third edition*. McGraw Hill Education.

Willis, M. E. H. (2023). Critical realism and qualitative research in psychology. *Qualitative Research in Psychology*, 20(2), 265–288. https://doi.org/10.1080/14780887.2022.2157782

Wills, T. A. (1981). Downward comparison principles in social psychology. *Psychological Bulletin*, 90(2), 245–271. https://doi.org/10.1037/0033-2909.90.2.245

Wilson, M., & Sperlinger, D. (2004). Dropping out or dropping in? A re-examination of the concepts of dropouts using qualitative methodology. *Psychoanalytic Psychotherapy*, 18(2), 220–237. https://doi.org/10.1080/14749730410001700705

Wojnarowski, C., Firth, N., Finegan, M., & Delgadillo, J. (2019). Predictors of depression relapse and recurrence after cognitive behavioural therapy: A systematic review and meta-analysis. *Behavioural and Cognitive Psychotherapy*, 47(5), 514–529. https://doi.org/10.1017/S1352465819000080

VanDyke, M. M., & Pollard, C. A. (2005). Treatment of refractory obsessive-compulsive disorder: The St. Louis model. *Cognitive and Behavioral Practice*, 12(1), 30-39. https://doi.org/10.1016/S1077-7229(05)80037-9

Verbist, I. L., Allsopp, K., Huey, D., & Varese, F. (2021). Frequency and impact of childhood sexual and physical abuse on people using IAPT services. *British Journal of Clinical Psychology*, 60(4), 504-512. https://doi.org/https://dx.doi.org/10.1111/bjc.12310

Verbist, I., Huey, D., & Bennett, H. (2022). Predicting treatment outcomes in improving access to psychological therapy (IAPT) services. *Mental Health Review Journal*, 27(1), 114-131. https://doi.org/https://dx.doi.org/10.1108/MHRJ-04-2021-0037

Vittengl, J. R., Clark, L. A., Dunn, T. W., & Jarrett, R. B. (2007). Reducing relapse and recurrence in unipolar depression: a comparative meta-analysis of cognitive behavioral therapy's effects. *Journal of Consulting and Clinical Psychology*, 75(3), 475–488. https://doi.org/10.1037/0022-006X.75.3.475

Zhang, A., Franklin, C., Jing, S., Bornheimer, L. A., Hai, A. H., Himle, J. A., Kong, D., & Ji, Q. (2019). The effectiveness of four empirically supported psychotherapies for primary care depression and anxiety: A systematic review and meta-analysis. *Journal of Affective Disorders*, 245, 1168-1186. https://doi.org/https://dx.doi.org/10.1016/j.jad.2018.12.008

List of Abbreviations

CBT Cognitive behavioural therapy

GAD-7 Generalised Anxiety Disorder-7 (symptom measure for generalised anxiety)

IAPT Improving Access to Psychological Therapies

NNT NHS Talking Therapies for depression and anxiety

NICE National Institute of Health and Clinical Excellence

PHQ-9 Patient Health Questionnaire-9 (symptom measure for depression)

RCT Randomised controlled trial

WSAS Work and social adjustment scale (measure of functional impairment)

Appendix A Literature searching strategy

A scoping search of literature pertaining directly to the main research question was carried out. Please see **Table A1** for details of the search terms used in the Ovid MEDLINE (from 1946) and PsycINFO (from 1806). The selected search terms were deliberately inclusive to ensure that no relevant papers were overlooked as initial searches indicated the literature pertaining to this topic were scant.

Table A1

Search terms used in PsycINFO and MEDLINE

Phenomenon of interest		**Perspective**
Multiple referrals Re-refer* Rerefer* Repeat* referral$ Help-seeking histor* Help seeking histor* Past help-seeking Past help seeking Previous help-seeking Previous help seeking Prior help seeking Prior help-seeking Previous therap* Past therap* Previous psychotherap* Past psychotherap* Prior psychotherap* Prior therap* Multi* courses Multi*episode* Treatment histor* Return* to therapy Return* to treatment Returnee$ Revolving door Past CBT Previous CBT Prior CBT Previous cognitive behavio$r* therap* Past cognitive behavio$r* therap* Prior cognitive behavio$r* therap* Previous cognitive therap* Prior cognitive therap* Past cognitive therap* Intermittent therap* Intermittent courses Intermittent episodes Exp Treatment Resistant Disorders	Psych* therap* Psych* treatment? Counsel?ing Talking therap* Cognitive behavio?ral therap* Psychotherap* Therap* MeSH Exp Cognitive Behavior Therapy/ Exp Counseling Exp Psychotherapy/	Therapist* experience* Counsel?or* experience* Psychologist* experience* Psychotherapist* experience* Clinician* experience* Therapist* perspective* Counsel?or perspective* Psychologist* perspective* Psychotherapist* perspective* Clinician* perspective* Therapist* view* Counsel?or view* Psychologist* view* Psychotherapist* view* Clinician* view* MeSH Exp Therapists/ Exp Psychologists/ Exp Counselors Exp Psychotherapists/ Exp psychotherapeutic processes/ Exp therapeutic processes/ Exp therapist attitudes

All literature searches were carried out between November and December 2022. PsycINFO, MEDLINE, EBSCO (CINAHL and Social Work Abstracts), and Web of Science. EndNote was used to store references and identify and remove duplicates. Inclusion and exclusion criteria were used when screening and assessing papers for eligibility (see **Table A2**).

Table A.2

Study inclusion and exclusion criteria

Inclusion	**Exclusion**
Clients from any client group (child, adult, specific populations) who have previously been in psychotherapy or counselling.	Therapy-experienced clients who were accessing group therapy, occupational therapy, computerised therapy.
Clients who accessed any type of individual psychotherapy or counselling subsequently.	The provision of assessment, consultation, or adjunctive therapy only.
Focused on therapeutic process.	Interruptions in therapy (e.g., transferring therapists).
Focused on therapist experiences of therapy.	

The searches of three of these four databases were repeated in July 2024 to ensure no relevant papers published since the study was conceived were overlooked. PsycINFO yielded 65 records to review; MEDLINE 25 records; and EBSCO 16 records. No relevant articles were identified. Additional, more informal searching was used to gather literature to contextualise the current study.

Appendix B Participant information sheet

How do CBT therapists in NHS Talking Therapies Services experience and navigate work with therapy-experienced service users?

Can you help our research? (Version 3 09.07.2023)

We are seeking to recruit qualified CBT therapists, currently or recently working in NHS Talking Therapies (previously known as IAPT) services. We would like to interview therapists to hear their accounts of how service users' previous therapy experiences appeared to hinder or help their work together. This excludes work with service users who have solely accessed Step 2 interventions previously. Therapists will be invited to discuss one or two specific pieces of work with service users in some detail.

Our aim is to understand, from CBT therapists' perspectives, whether and how service users' previous therapy experiences impact their therapeutic work with service users. We think this is important due to findings from practice-based studies suggesting; 1) service users with previous NHS Talking Therapies referrals have poorer outcomes; 2) therapists can find working with returning NHS Talking Therapies service users stressful.

We hope the results of this study will provide valuable insights for NHS Talking Therapies therapists, supervisors, trainers, and service providers. If you are interested in hearing more about this study, on the next page you will find our Participant Information Sheet (Version 3 09.07.2023). We expect this will take a few minutes to read.

Who is conducting this research?

The Lead Researcher for this project is Laura Edmeade, Psychologist in Clinical Training, University of Leeds. This research is being carried out as part of the academic requirements for the Doctoral Programme in Clinical Psychology. This research is being supervised by Dr Ciara Masterson and Dr David Turgoose, who both serve as academic members of staff on the Doctoral Programme in Clinical Psychology, University of Leeds.

What is the purpose of this research?

Surprisingly little research has examined how therapists experience and navigate therapy with service users who have accessed prior courses of therapy. Addressing this gap in the research literature is particularly pertinent for NHS Talking Therapies services. Findings from NHS Talking Therapies-based studies indicate; 1) around a third of all referrals to these services are re-referrals; 2) service users with previous NHS Talking Therapies referrals have poorer outcomes, even when symptom severity, functional impairment, chronicity, and motivation to change are controlled for; and 3) clinicians can find working with returning service users stressful. The present study is examining, from the perspectives of CBT therapists working in NHS Talking Therapies services, whether and how service users' previous therapy experiences impact subsequent therapy.

Why have I been invited to take part?

We would like to interview qualified CBT therapists, currently or recently working in NHS Talking Therapies services, who see service users for individual therapy. To help answer the study questions, we need to speak to therapists who feel able to reflect, in some detail, on their experiences working with service users who have attended previous courses of therapy.

Do I have to take part?

No. Your participation is entirely voluntary.

If you decide to take part, then you will be asked to provide consent and complete some pre-interview participant background questions. After you provide consent, you can still change

your mind and withdraw consent without giving any reason up to one week after the interview has taken place. After one week, interview transcription and analysis will commence, and withdrawal will no longer be possible.

At the point of completing the pre-interview questions, you can withdraw consent by closing the page. Once you submit your responses, you can withdraw consent by emailing the Lead Researcher at psc4ler@leeds.ac.uk to request that your responses be deleted.

During the interview, you can ask for it to be stopped and the interview recording deleted at any point. Up to one week after the interview is completed, you can withdraw your interview data by emailing the Lead Researcher at psc4ler@leeds.ac.uk to request that your data be deleted in full or part.

What will I be asked to do?

If you would like to take part, you will be asked to provide your contact details so the Lead Researcher can discuss the study with you, either by email or phone. The Lead Researcher will attempt to contact you by email up to three times to arrange this. If you are happy to take part and arrange an interview, you will be asked to complete a consent form and some pre-interview questions online.

The pre-interview questions will provide some background information about you (e.g., demographics, years qualified as a CBT therapist).

Interviews will be conducted by the Lead Researcher. Interviews will take place either in person at the University of Leeds or remotely using Zoom. All interviews will be recorded using Zoom. Interviews will take approximately 60-90 minutes.

The subject and focus of the interview will be:

1. Your general experiences working with service users who have attended previous courses of therapy.

2. One or two examples of your work with service users whose previous therapy experiences appeared to impact your work together, either helpfully or unhelpfully.

This excludes work with service users whose previous therapy experiences were exclusively Step 2 interventions.

During the interview, you will be asked to use refrain from using service users' names. You will be asked to select pseudonyms for yourself and the service users you discuss. If any personally identifiable information is disclosed, it will be removed from the interview transcripts to ensure that your data are fully anonymised prior to analysis.

What are the possible advantages of taking part?

There may not be any immediate direct benefits to you from taking part in the study. It is possible some participants will find reflecting on their work with therapy-experienced service users useful for their personal and professional development.

It is hoped that, once disseminated, the results of this study will provide valuable information for therapists, supervisors, and services to inform practices to reduce therapist burnout and improve service user experience.

What are the possible disadvantages of taking part?

We do not foresee or anticipate any significant risks to you from taking part in this study. It is possible that reflecting on pieces of work that may have been personally and professionally challenging in the interview will evoke feelings of distress. If participants become distressed in the interview, the interview will be paused so that these feelings can be attended to. Participants will be asked if they feel okay to continue and reminded that the interview can

be stopped at any time if required. After the interview, participants who have felt distressed will be encouraged to engage in their own self-care practices or seek support.

What will happen to my information?

All the information we receive from you will be treated in the strictest confidence. Your name and contact details will be stored separately from both your pre-interview question responses and interview data. Participants will be assigned a number so that responses can be linked if required (e.g., if a participant requests to withdraw their data from the study). The pre-interview question responses are anonymous and will be kept confidential. All interview data provided will be kept confidential and anonymised at the point of transcription. The interviews will be transcribed by the Lead Researcher or a university-approved transcription service who are required to sign a confidentiality agreement and use an encrypted drive to share recordings and transcripts.

The only circumstance in which we may not be able to keep your information confidential is in the unlikely event gross professional misconduct is disclosed. In such an event, the research supervisors will be consulted for advice, and following this, if appropriate, the relevant professional body (i.e., BABCP) representing participants informed of the disclosure. In this eventuality, participants would be informed of any steps undertaken by email.

Your anonymised data will be analysed together with other interview data, and we will ensure that there is no possibility you are identifiable from this point. Participant contact details, consent forms and interview audio recordings will be securely deleted after the project is successfully completed.

Anonymised pre-interview question responses and interview transcripts may be stored for a minimum of 10 years in the University's Research Data Leeds Repository to allow other researchers access to the data. If the data are not required by the Repository, they will still be held as separate files on a secure database by the University of Leeds for up to three years after the project is successfully completed. Retention of these files will allow the research to be written up and submitted for publication. After this time, these files will be permanently and securely deleted.

A pen portrait of each therapist participant will be included in the study report. Pen portraits will consist of some demographic and work-related information, in addition to general reflections on the interview process. For further details of rights in relation to your data, please see the University's Research Participant Privacy Notice.

Privacy Notice for Research

Where will the results of the research be published?

A report will be written containing the research findings. This report will be made publicly available on the White Rose eTheses Online open-access repository. It is possible the research may be written up for publication in a peer-reviewed journal and presented at conferences. Anonymous and non-identifying direct quotes may be used for publication and presentation purposes. An electronic copy of the report can be made available to research participants on request.

Who has granted ethical approval for this research?

The project has been reviewed and approved by School of Medicine University of Leeds Research Ethics Committee. Any comments, questions or complaints about the ethical conduct of this study can be addressed to the School of Medicine Research Ethics Committee, University of Leeds at FMHuniEthics@leeds.ac.uk.

What if something goes wrong?

Concerns about any aspect of this study can be addressed to the Research Supervisors, Dr Ciara Masterson and Dr David Turgoose, at the University of Leeds by contacting meddclin@leeds.ac.uk or calling the Doctoral Programme in Clinical Psychology office on 0113 3430815.

What if I have more questions or something does not seem clear?

If you have any questions or would like more information or clarification about any aspect of this study at any point, please contact Laura Edmeade, Lead Researcher at psc4ler@leeds.ac.uk.

What happens next? If you are interested in taking part, please provide your preferred contact details below and we will be in touch to discuss the study further, answer any questions, and guide you through the consent process.

Please enter your full name and preferred contact details (email or phone number) below.

Appendix C Consent form and pre-interview questions

How do CBT therapists in NHS Talking Therapies Services experience and navigate work with therapy-experienced service users?

Consent form and pre-interview questions. Study consent form (Version 3 09.07.2023)

Please add your Participant Number

1. I confirm that I have read the Participant Information Sheet (Version 3, 09.07.2023). I have had the opportunity to consider the information, ask any questions, and decide whether I wish to participate. I can confirm that I am happy to answer some pre-interview questions and be interviewed. Yes No
2. I understand that my participation is voluntary, and I am free to withdraw without giving a reason. In addition, should I wish not to answer any question, I am free to decline.

   Yes No
3. I understand that I am free to withdraw from the study. I can request that some or all of my pre-interview and interview data is deleted and withdrawn from the study up to a week after the interview has taken place. After this time, interview transcription and data analysis will commence and withdrawal will no longer be possible.

   Yes No
4. I understand an audio recording of the interview will be downloaded and held on a secure University of Leeds password protected folder. A transcript will be created using this recording. A university-approved transcription service will be used. I understand that all personally identifiable information will be removed from the interview transcript. The interview recording will be stored on a secure University of Leeds password protected folder until the study is completed, upon which it will be permanently and securely deleted.

   Yes No
5. I understand that members of the study team will have access to the anonymised interview transcripts. I give permission to these individuals to access my data.

   Yes No
6. I understand that auditors from the University of Leeds may look at relevant sections of my data collected during the study. I give permission for these individuals to access my interview data.

   Yes No
7. I understand I will not be identified or identifiable in the study report or any other publications. A participant pen portrait will be included, which will contain broad demographic and work-related information, as well as reflections from the interview. I will not be identifiable from the portrait. Direct quotations from the interview will also be used. As a result of the interview transcript anonymisation process, in which all person-identifiable information is removed prior to data analysis, I will not be identifiable.

   Yes No
8. I understand that all my responses will be kept strictly confidential unless I disclose practice indicative of gross professional misconduct. In this eventuality, any disclosures are first discussed with research supervisors, and if appropriate, shared

with the relevant professional body (i.e., BABCP). I would be informed of any steps taken by email.

Yes No

9. I understand that my name and contact details, my consent form, pre-interview question responses, interview audio recording and interview transcript data will be separately and securely stored in password-protected University of Leeds folders. My name and contact details, consent form and interview audio recording will be permanently and securely deleted after study completion. My anonymised pre-interview question responses and anonymised interview transcripts will be offered to the University data repository to be held for a minimum of 10 years for use by other researchers. If the study data are not required by the repository, they will be held by the University's Programme of Clinical Psychology for up to three years following study completion for the purposes of writing up the study for publication.

Yes No

Pre-interview questions (Version 3 09.07.2023)

1. Which age group do you belong to?

   18-24 years old 25-34 years old 35-44 years old 45-54 years old

   55-64 years old Over 65 years old

2. How would you describe your gender identity? You may select more than one option.

   Woman Man Cis-gender Transgender Non-binary Gender fluid Other

3. How would you describe your ethnicity?

4. How long have you worked in NHS Talking Therapies or IAPT services for? Less than 5 years 5-10 years More than 10 years

5. How long have you been qualified as a CBT therapist?

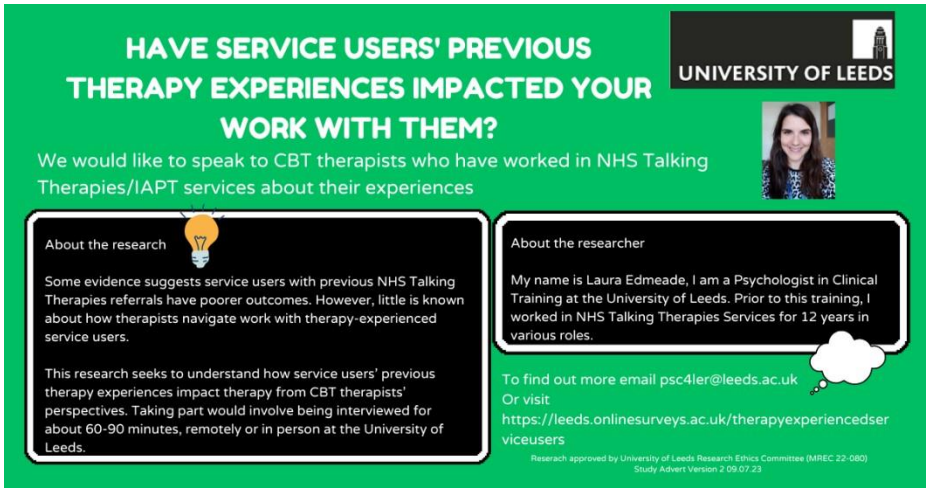
   Less than 5 years 5-10 years More than 10 years

Appendix D Recruitment materials

D.1 Advert used for Instagram and LinkedIn platforms



D.2 Advert used for Facebook and X platforms



Appendix E Email confirmation of ethical approval

From: Medicine and Health Univ Ethics Review <FMHUniEthics@leeds.ac.uk>

Sent: 10 July 2023 10:01

To: Laura Elizabeth Edmeade [psc4ler] <psc4ler@leeds.ac.uk>; Ciara Masterson <C.Masterson@leeds.ac.uk>

Subject: RE: MREC 22-080 - Conditional Study Approval Confirmation

Dear Laura

Thank you for the revised documents. I can confirm receipt and have filed these for our records. I can also confirm that the documents received fulfil the conditions of the approval.

Hope the study goes well.

Kind regards.
Sou

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Sou Sit Chung, Research Ethics Administrator, The Secretariat, University of Leeds, LS2 9NL,

[redacted]

Please note my working hours are Monday to Friday 9am – 12.30pm
~~~~~~

Appendix F Interview topic guide

General questions

1. What interested you in taking part in this study?
2. How and to what extent do you gather information about clients' past therapy experiences?
3. Could you tell me what information about clients' past therapy experiences is particularly significant to you and what follows from knowing this information?

Case examples

In this part of the interview, I'd like to invite you to talk in more detail about pieces of work with clients whose previous therapy experiences appeared to impact your work together, either facilitating or hindering it.

4. What prompted you to bring this client? What do you know about their previous therapy(ies) generally, and their history with NHS Talking Therapies specifically?
5. Can you tell me about your work with this client, starting from the point they were assigned to your caseload to the conclusion of therapy? For context it would be helpful to know how long ago you worked with this client.

Repeat questions 4 and 5 if participants have a second piece of work which they would like to talk about.

Checking out

6. Was there anything else you did not get the chance to say or share?
   10. How did you find the interview?

Revisit consent and one-week time limit to amend anything from the interview or withdraw consent.

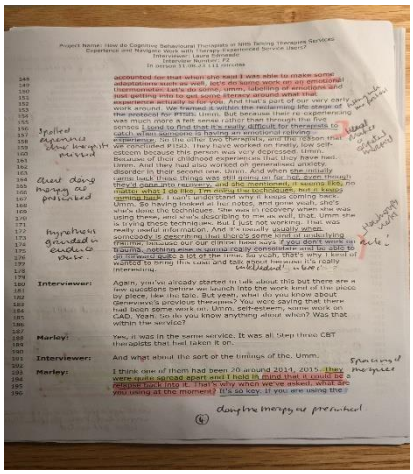
Appendix G Phases in thematic analysis

G.1 Familiarisation

This involved preparing the transcripts. As transcribing was a resource heavy process, after transcribing half of one interview, to increase efficiency, digitally produced transcripts were used. The accuracy of digitally produced transcripts was checked against the interview recordings. Significant editing was required which facilitated my close engagement with the data. Nine interviews were transcribed using Braun and Clarke's (2013) notation system. This captured features such as overlapping speech, pauses, laughter. Due to time constraints, this system was not used for the three remaining transcripts. Although non-verbal communication in participants' speech was not documented, interview notes had some information about these aspects. Once prepared, these were read and re-read these as paper transcripts. Initial observations and ideas about codes were recorded in the margins (see **Figure G.1** for sample of annotated transcript).

Figure G.1

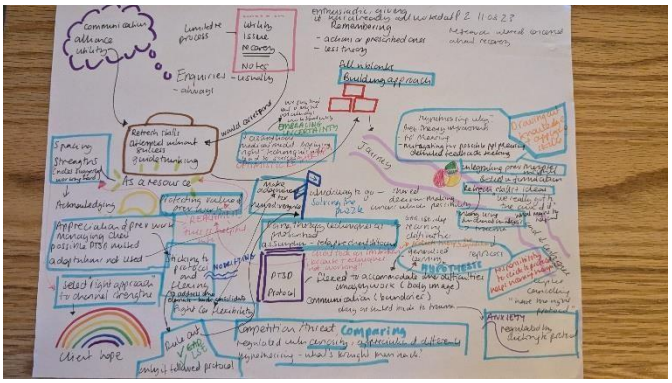
Sample of annotated transcript



A summary of the familiarisation notes was created in the form of a mind map (see **Figure G.2** for a sample mind map), for each interview and across all interviews to help to inform the next coding.

Figure G.2

Sample mind map



G.2 Coding

Transcripts were coded line-by-line to record features of the dataset salient to the study's aims. The Comments feature on Microsoft Word was used to log the code label alongside the relevant data. A list of code labels for each participant was created with the transcript page number to identify the location of the accompanying data (see **Figure G.3** for a sample of some participant codes). The transcripts were coded twice in a different order on each run. An estimated couple of hundred codes were initially created due to a sharpened approach, and so codes were expanded to better capture repeated patterns, whilst still allowing finer details to be represented. An Excel spreadsheet was used to collate the codes and accompanying data.

Figure G.3

Sample of some codes for one participant



What you start with
- Process information is what counts in understanding what happened previously
- Process info could support therapy adaptations
- Preferred therapist more likeable p11
- Critical of past therapist p3, 22

Chasing success/Righting the wrongs
- coming to the rescue (move out of powerless victim position?) p7, p11p8
- Blinded by the mission? If I keep working hard enough it will come good? P8
- It's my responsibility to prove therapy works p23

Not offering what is needed
- More effective to be like the disliked therapist p3
- Need to challenge returning client - more CBT will not be helpful p3
- Working differently/less responsively - driven by own need p11
- Fear of being seen as disliked, unhelpful therapist p19
- Delaying therapy due to previous experience of therapy as harmful p22

Defensive practice/avoiding responsibility
- can't risk not following protocol, if I follow protocol then it's not my fault? P8
- Defensive practice, following evidence not client (semantic) p8

Pressure/therapist anxiety
- Client expressed preference to see previous therapist p7
- Anticipating therapy would be hard work p8
- Pressure to stick to protocol p8, 11
- Pressure to win client over (like preferred therapist) p8
- Pressure to perform as a "good therapist" = being nice and following protocol ("able to read in a textbook") p10, p11
- Perceive client as critical of therapists p11
- Confronting clients with limitations of therapy risks a rupture p14

Power relations
- client scrutinising therapy, questioning therapist based on previous experiences p11
- Therapy consumers unhappy with service constraints (limit therapy and limit return p16
- Previous experiences of not being helped by therapy - view of client as not resourceful p22
- Doing to - repeating experiences with other professionals (semantic) p22
- Difficulty challenging suitability decisions p27

Making it different (how/content)
- using a different conceptualisation p.7
- Exploring earlier trauma p22

Making it different (process)
- Not eliciting client ideas about how to shape therapy p24

Difference doesn't fit
- Revert to previous conceptualisation - new one did not fit p7
- Revert to original focus p22

Quest to be well-remembered?
- Prioritised being remembered as a good therapist over client need p11

Threat to therapist identity
- Need to match previous therapist p13

Managing threat to therapist identity
- Be the one who sorts it out p8

Competing
- additional reading/checking protocol p13

G.3 Theme creation

Codes were collated into potential themes patterns of meaning underpinned by a shared concept or idea (see **Figure G.4** for a sample of some initial theme ideas). The coded data was then collated under each theme using an Excel spreadsheet worksheet for each theme (see **Figure G.5** for a sample of collated data for the **Conducting a post-mortem of previous therapy** theme).

Figure G.4

Initial theme creation: Collated codes

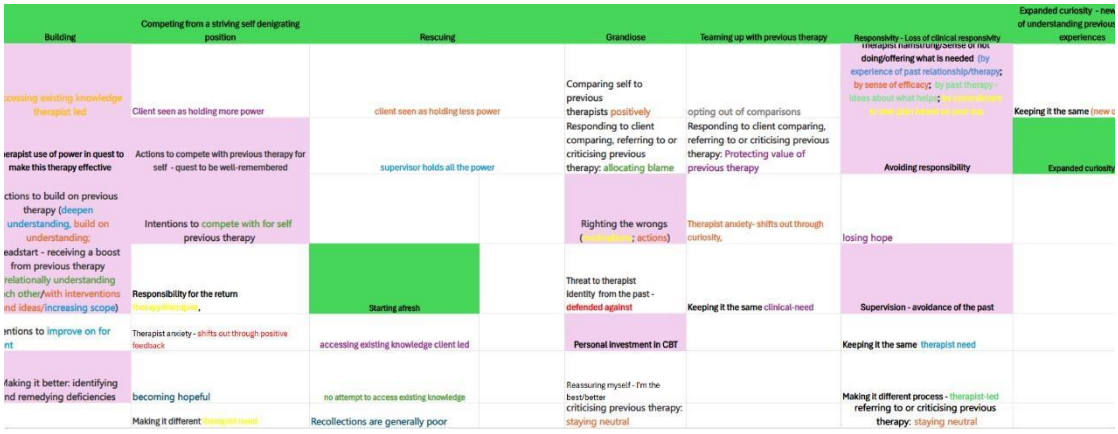


Figure G.5

Initial theme creation: Collated data

therapist discomfort in exploring therapy	P	Restricted curiosity in relation to previous therapy (action, assumption, context)	P	Starting from scratch (why, when, how, impact)	P
No, he didn't say anything really about this therapist. It was about just about the therapy, yeah. And I didn't. I didn't really kind of try and explore that or anything. And I didn't. Yeah, I didn't think that was appropriate. Just if it came up, I did ask a bit more about his experience of the therapy, but yeah, never the therapist.	P4, p26	but I didn't actually I didn't. I hadn't spent time. I didn't talk to the past therapist about their past work and I didn't particularly pour over their notes and what they'd done and tried to do that; She basically talked about doing this kind of exposure stuff and found that really difficult, and when she and that she did some breathing exercises, and she found the breathing exercises kind of really triggering but then I didn't get any more detail from her than that that's down to me that's down to me not asking as opposed to her not being able to tell me or not forthcoming; But then also the same problem was there, and it was interesting that I, although we unpicked the worries together, I never had a really big conversation about her last therapy with her. We didn't really address it after that first session; I didn't ask if she'd ever addressed these things before. It felt like it was all new.	P5, p14, p25; P10, p9, p23	However, that's partly because when I work with someone who's had therapy before, I do generally start from a clean slate. So previously I would say to somebody like, you know, do you remember doing this from your previous therapy? And can you tell me about it? So, a bit quite Socratic of an approach. I, I stopped doing that because I found that with previous patients how therapists do things is just not the same at all. And sometimes another therapist might have explained something in a completely different way to the way that I would do it in my work.	P4 p15
I didn't really, you know, I didn't really think to ask about the relationship maybe I should have done; It was more of, "Okay, is this the same way that they did it beforehand? 'cause she found it useful beforehand.	P8, p8; P13, p7	I kind of know that they've had it and then I seem to kind of think quite quickly jump to a position of like erm 'Right. OK. Well, I either need to do the same or something different' but but more based on what I think it is that they've had that's worked or that they've had	P5, p24;	sometimes I would be quite explicit about that with people. So I would say, "I know you've had therapy before, but I'm just gonna start afresh with you, if that's OK, because sometimes it can be unhelpful to refer back to that it might conflict with what we're doing now. It might not be exactly the same". Umm, I didn't do that with him, and I can't remember why. It just mustn't have felt needed. Maybe it was because it was so long ago and he couldn't remember it, that I didn't have that conversation. But yeah, I didn't feel like we were building on anything. I just basically felt like we were starting from scratch, but that is partly because that's the way that I find it more helpful to to do it.	P4 p15

G.4 Theme review

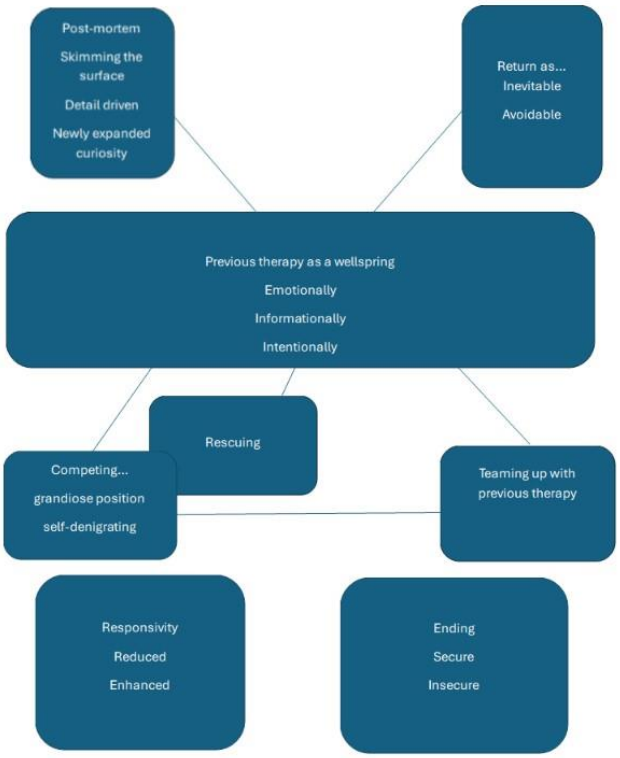
Themes were reviewed to assess their coherence with associated codes. The validity of themes was then reviewed in relation the entire database by re-reading the transcripts.

G.5 Theme definition and naming

Themes were defined so that the meaning of each theme was made apparent, an attempt was made to use participants words where this fitted. A short summary of each theme was written. Themes were considered in relation to other themes to produce a thematic map (see **Figure G.6** for an earlier thematic map). These theme ideas were discussed in supervision to help clarify my thinking about the themes and relationships between them.

Figure G.6

Earlier iteration of thematic map



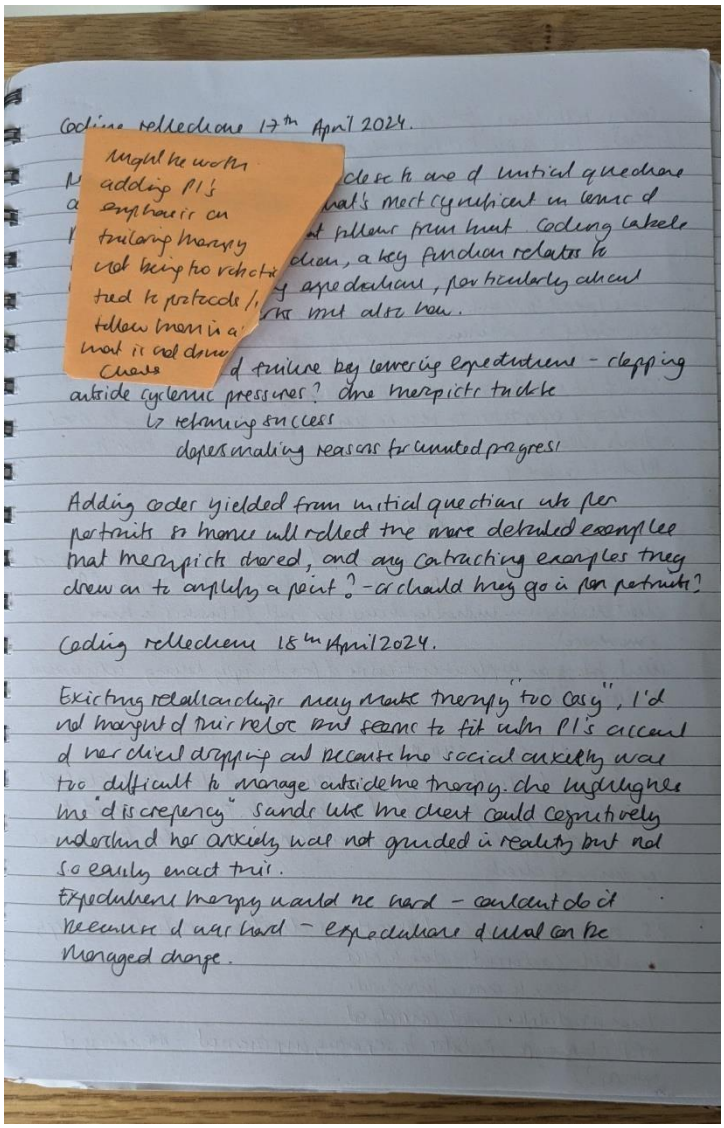
G.6 Write up

Themes were described and explained to provide a concise, coherent account of the narrative pertaining to the research aims. Illustrative quotes were selected for each theme.

Filler and repeated words were removed from the quotes for readability purposes. The write up went through three drafts.

The writing process resulted in the incorporation of ideas for themes, for example, responsivity and its subthemes reduced and enhanced (see **Figure G.6**), into **Previous therapy as a wellspring**, to help enrich this theme. An example of a subtheme which was eliminated was ***How do I know I am competent?*** This was originally included as a contextual subtheme however conversations in supervision helped me to appreciate that this overlapped with ***Proving I'm good*** subtheme.

Appendix H Reflexive journal extract



Coding reflections 17th April 2024.

Might be worth adding PI's emphasis on tailoring therapy not being too rebotte tied to protocols / ...

...d failure by lowering expectations - stepping outside cyclonic pressures? Some therapists tackle by retaining success

does making reasons for limited progress!

Adding codes yielded from initial questions who per portraits so those will rolled the more detailed examples that therapists shared, and any contrasting examples they drew on to explain a point? - or should they go in per portraits?

Coding reflections 18th April 2024.

Existing relationships may make therapy "too easy", I'd not thought of this before but seems to fit with PI's account of her clinical dropping out because the social anxiety was too difficult to manage outside the therapy. She highlights the "discrepancy" sounds like the client could cognitively understand her anxiety was not grounded in reality but not so easily enact this.

Expectations therapy would be hard - couldn't do it because it was hard - expectations of what can be managed change.

Appendix I RTA quality checklist

Taken from Braun & Clarke (2022)

Process	No.	Criteria	Evaluation
Transcription	**1**	The data have been transcribed to an appropriate level of detail, and the transcripts have been checked against the tapes for 'accuracy'	Yes, see **Appendix G** for a description of the process used.
Coding	**2**	Each data item has been given equal attention in the coding process.	All participant responses in the interview pertaining to the case examples were considered in the coding process.
	3	Themes have not been generated from a few vivid examples (an anecdotal approach), but instead the coding process has been thorough, inclusive and comprehensive	Each theme and subtheme is based on codes contributed by multiple participants. See **Table 3.3** for each participant's contribution to subthemes and themes.
	4	All relevant extracts for all each theme have been collated.	Yes, see **Appendix G** for a description of the process used.
	5	Themes have been checked against coded data and back to the original data set.	Yes, see **Appendix G** for a description of the process used.
	6	Themes are internally coherent, consistent, and distinctive; each theme contains a well-defined central organising concept; any subthemes share the central organising concept of the theme.	Yes, see **Appendix G** for a description of the process used to achieve this.
Analysis	**7**	Data have been analysed-interpreted, made sense of- rather than just paraphrased or described.	Yes, see **Results**, there has been interpretation of emotional and behavioural responses described by participants.
	8	Analysis and data match each other- the extracts illustrate the analytic claims.	Yes, see **Results.**

	9	Analysis tells a convincing and well organised story about the data and topic.	Yes, see **Results**. The themes have been organised into a temporal sequence with a broader contextual theme providing a backdrop through which to understand participants experiences working with this client group.
	10	An appropriate balance between analytical narrative and illustrative extracts is provided.	Yes, there is roughly a 40:60 split between data extracts and analytic narrative.
Overall	**11**	Enough time has been allocated to complete all phases of the analysis adequately, without rushing a phase or giving it a once-over lightly.	Yes, the analysis was carried out over seven months.
Written report	**12**	The specific approach to thematic analysis, and particulars of the approach including theoretical positions and assumptions, are clearly explicated.	Yes, see **Reflexive TA (Methods)** which includes an account of approach to RTA including the philosophical framework, positioning of orientation to data, focus on meaning and qualitative framework.
	13	There is good fit between what was claimed, and what was done - i.e. the described method and reported analysis are consistent.	Yes. I have been held to account in supervision throughout the research process including analysis.
	14	The language and concepts used in the report are consistent with the epistemological position of the analysis.	Yes. I have been held to account in supervision throughout the research process including analysis.
	15	The researcher is positioned as active in the research process; themes do not just ‘emerge’.	I have acknowledged my active role and the influence of my positioning throughout.