

**A QUALITATIVE ANALYSIS OF CLIENTS' EXPERIENCE OF NON-  
RESPONSE TO PSYCHOLOGICAL THERAPY**

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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:* There has been an expansion of research into psychotherapy outcomes for both clients who improve and clients who deteriorate as a result of therapy. However, those who fail to respond to therapy have been overlooked. Estimates of non-response to therapy vary from 14% to 60%, yet research with this client group is lacking. Additionally, research suggests therapists are limited in their ability to predict negative outcomes in therapy. If this is equivalent for non-response to therapy, our ability to respond appropriately to these clients may be an issue that needs addressing further. This study aims to begin to understand what sense clients make of therapy which, they feel, has brought about no change.

*Method:* Eight clients who had completed a course of therapy within psychological therapy services (6+ sessions) and subjectively felt that they had not benefitted from this were interviewed about their experience. An interpretative phenomenological analysis was employed to allow an in depth, inductive study of a new area, in order to develop a model of participants' experiences.

*Results:* Five themes emerged regarding the therapy experience; 'what I expected', 'how I found my therapist', 'what was therapy like', 'external influences' and 'what I am left with'. These were brought together into a model which allowed further meaning to be drawn from the accounts and the experience understood as a process.

*Discussion:* The analysis and model were explored in relation to the available literature. This included consideration of attachment theory in relation to managing therapy expectations, facilitating emotional expression and length of therapy required, in addition to seeking further clarity with regard to what is meant by the term 'non-response' in psychological therapy. Novel findings of this research were examined in the context of the strengths and limitations of this particular study. From this, areas of future research and potential clinical implications were considered.

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## **ABBREVIATIONS**

APA: American Psychological Association  
BDI: Beck Depression Inventory  
BPS: British Psychological Society  
CBT: Cognitive Behaviour Therapy  
CE: Corrective Experiences  
CMHT: Community Mental Health Team  
CORE: Clinical Outcomes in Routine Evaluation  
CPN: Community Psychiatric Nurse  
CTC: Client Theory of Change  
DoH: Department of Health  
ECT: Electroconvulsive Therapy  
GT: Grounded Theory  
HAM-D: Hamilton Rating Scale for Depression  
IAPT: Improving Access to Psychological Therapies  
IPA: Interpretative Phenomenological Analysis  
OQ: Outcome Questionnaire  
PDT: Psychodynamic Therapy  
PTS: Psychological Therapy Services  
PTSD: Post Traumatic Stress Disorder  
RCI: Reliable Change Index  
SRS: Session Rating Scale  
SSI: Semi-Structured Interviews  
TNR: Treatment Non-Response



## CHAPTER ONE: INTRODUCTION

Research into psychotherapy outcomes has been of increasing interest in recent years and researchers are attempting to answer questions such as how can we enhance treatment effects and what works for whom? e.g. Roth & Fonagy, 2005. There is also growing interest into the estimated 10% of clients who deteriorate as a result of therapy (Lambert & Ogles, 2004). Lists of potentially harmful treatments have been devised (Lilienfeld, 2007), changes to training strategies proposed (Castonguay, Boswell, Constantino, Goldfried, & Hill, 2010) and service-wide studies examining adverse effects of psychological therapies commissioned (Parry et al., n.d.; Shepherd, Evans, Cobb, & Ghossain, 2012). However, the group which has been overlooked in this research are those who fail to respond to therapy. Estimates of non-response to psychological therapy vary from 14% (Lorentzen, Høglend, Martinsen, & Ringdal, 2011) to 60% (Hansen, Lambert, & Forman, 2002), yet the research available is minimal.

Additionally, research suggests that therapists have limited ability in predicting negative outcomes in therapy (Hannan et al., 2005). This may be equivalent for non-response to therapy, making our ability to respond appropriately to these clients an issue which requires further exploration.

This study aims to begin to address some of these issues by exploring what sense clients make of therapy which they feel has brought about no change. This introduction will begin by considering how we understand change in therapy and some of the difficulties in defining and measuring this. It will then move on to consider the merits of studying client experience and finally will explore the literature on non-response in relation to psychological therapies.

### **Therapy and Change**

#### *Defining Therapy*

*“Psychotherapy is a primarily interpersonal treatment that is based on psychological principles and involves a trained therapist and a client who has a mental disorder, problem, or complaint; it is intended by the therapist to be remedial for the client’s disorder, problem, or complaint; and it is adapted or individualized for the particular client and his or her disorder, problem, or complaint”*

(Wampold, 2001, p.3).

Ultimately the purpose of the psychotherapy process is that of change (Carey et al., 2007). Psychotherapy aims to offer *“an interpersonal relationship that moves through the*

*stages of engagement, pattern search, change (giving up the old pattern and maintaining a new pattern), and termination”* (Beitman, Soth, & Bumby, 2003, p.65). Beitman et al., posit that underlying therapy is an emphasis on the client’s future and ultimately how therapists can help clients *change* the way in which they perceive and understand their future. Grencavage and Norcross (1990) describe the change process as common to all therapies, i.e. the aim is some form of change, regardless of the mechanism or model which brings it about. What this change is, however, remains unclear. Wampold (2001) gives specific examples of these changes, such as bringing the unconscious to conscious awareness in psychoanalysis, altering unhelpful thinking in cognitive therapies, improving social relations in interpersonal therapies and altering family dynamics in family therapy.

Given one of the primary objectives of therapy is that of change, much research is conducted into the ‘outcome’ of psychotherapy; that being the immediate or long term *changes* that occur as a result of therapy (Hill & Lambert, 2004). It is therefore important to examine what this research can tell us and some of the difficulties in this area.

#### *Outcome Research: Efficacy and Effectiveness of Treatment*

Initially proposed by Rosenzweig, (1936) and contended by others (e.g. Eysenck, 1952; Eysenck, 1965; Smith & Glass, 1977), the equivalence of therapies, is a well-established concept. Throughout the 1990s methodologically sound meta-analyses produced sufficient evidence to conclude little, if any, difference existed in treatment efficacy of different therapeutic modalities (Wampold, 2001; Wampold et al., 1997). Since then, there has been ongoing debate as to the interpretation of these findings. Green & Latchford (2012, p.19), propose four possible hypotheses as explanations:

1. All therapies are equal as they share equivalent active ingredients, primarily the therapeutic alliance
2. All therapies are equal, but for different reasons, i.e. work to a similar extent though distinctive mechanisms
3. Therapies are not equal but research methods are not sophisticated enough to detect this as yet
4. All therapies are equal, however some therapies are more effective/quicker, but this has not been determined as yet.

These hypotheses are not necessarily mutually exclusive. It is important to bear this in mind when later considering what client experience of therapy can add to this debate.

### *Defining Change*

What is clear from the plethora of outcome research is that clients who receive psychological therapy often benefit (e.g. Smith & Glass, 1977). However, there are problems with this type of outcome research, the first of these being the complexity of defining change, which must be explored before we can begin to consider what we mean by non-response, or lack of change in therapy.

There is a general consensus that ultimately the goal of therapy is change (Miller, Duncan, & Hubble, 2005). However, the problem remains that what this change should be is often ambiguous (Wampold, 2001). Strupp and Hadley (1977) pose some interesting questions; is treating a snake phobia the same as a change in a person's self-concept? Or if someone divorces as a result of therapy is this a positive or negative change?

In an attempt to synthesise our understanding of change in psychotherapy Castonguay & Hill (2012) propose that 'corrective experiences' (CEs) provide us with a trans-theoretical understanding of the transformative process in therapy. Corrective experiences can be defined as "*ones in which a person comes to understand or experience affectively an event or relationship in a different and unexpected way*" (Goldfried, 2012, p.16). Further to this Goldfried offers the acronym STAIRCaSE, referring to when a Situation, elicits negative Thoughts and Affect in an individual, where they Intend to and are able to Respond in a way which is consistent with what they want, resulting in a positive Consequence and a positive Self-Evaluation. In this way, Goldfried (2012) proposes that CEs are both a principle of change, as well as indicating change has occurred. Although this is a trans-theoretical concept, the way CEs are clinically implemented may vary dependent on therapeutic orientation (Goldfried, 2012).

Despite this attempt to conceptualise a trans-theoretical model of therapeutic change, dependent on how outcomes are defined, what is found and the implications of these findings, will vary. Hill & Lambert (2004) highlight the example of Eysenck (1952) using a much narrower change criterion to find negative outcomes for psychotherapy, whilst Bergin (1971) found improvement in the same set of client data using different standards. Differences in outcome can come down to how change has been operationalised, rather than whether change has occurred. The conclusion is therefore that results may be an artefact of the research design, leaving us to question the validity any findings.

This definitional problem is further complicated by the methodological difficulties of measuring change. Without a single definition of what constitutes change in therapy, it is practically impossible to reconcile the vast amount of data on the subject. This problem is

highlighted by Froyd, Lambert, and Froyd (1996) who reviewed 1430 outcome measures, from 348 outcome studies in 20 journals over five years. They found as many as 840 different measures were used only once and many of these were not standardised. This highlights the abundance of means by which to measure and define change within the psychotherapy literature. This is in part a result of the complex and multifaceted nature of psychotherapy, but is also due to lack of consistency throughout the psychotherapy outcome research.

In addition to the overabundance of outcome measures, there are further methodological issues in measuring change, for instance whether to use multi-trait scales such as the Clinical Outcomes in Routine Evaluation (CORE; Evans et al., 2000) to assess multiple symptoms, or mono-trait scales to measure a single trait such as the Beck Depression Inventory (BDI; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961). Although psychometrically sound, such measures have been described as ‘arbitrary metrics’ (Blanton & Jaccard, 2006) and may not necessarily translate to a client’s real world functioning (Kazdin, 2001).

It is possible that idiosyncratic measures may be more useful, as each client is unique and brings their own distinctive set of difficulties. However, these also have methodological issues, summarised in Hill and Lambert (2004). Hill and Lambert assert that in order to address some of these difficulties in measuring outcomes there are a number of recommended practices to bear in mind:

1. Allow replication by clearly specifying what is measured
2. Measure change from multiple perspectives
3. Use symptom based atheoretical measures
4. Examine patterns of change over time

(Hill & Lambert, 2004, p.107)

In order to find a universal understanding of change, the literature must find a means by which to unite and refine these outcomes.

### *Clinically Significant Change*

In relation to the above, one such attempt to reconcile this difference and ambiguity is through the concept of clinically significant change. Clinical significance is defined as a return to normal functioning (Jacobson, Roberts, Berns, & McGlinchey, 1999) and aims to quantitatively encompass what we mean when we say a client has improved.

Additionally, according to the definition of psychotherapy set out at the beginning (Wampold, 2001), a client comes to therapy with a mental health problem, which the client and therapist work together to alleviate. It seems reasonable then that a return to normal functioning outlined by clinical significance definitions, would be the desired change. However, this definition fails to take into account the magnitude of change, and whether this change may simply be the result of chance or measurement error (Jacobson et al., 1999).

Reliable change is therefore another criterion to take into account when considering change measurement. Initially proposed by Payne and Jones (1957), Jacobson and Truax (1991) developed the statistically derived Reliable Change Index (RCI) to indicate when a change was reliable, i.e. to rule out change being an artefact of the unreliability in the measuring instrument. In addition to clinical change this is often the means by which change is defined in the outcome research literature (e.g. Hansen et al., 2002; Whipple & Lambert, 2011). Nonetheless, there are a number of difficulties with the concepts of reliable and clinically significant change.

For clinical significance to be achieved, the client must initially fall within the 'clinical' population, which is not always the case. Research suggests that there are a significant number of 'sub-syndromal' individuals who do not have sufficient symptoms to warrant diagnosis, but nonetheless have impairment and prognoses equivalent to those who do meet diagnostic criteria. For example, Lewinsohn, Solomon, Seeley, and Zeiss (2000) found the diagnostic threshold for major depression did not necessarily need to be crossed for depressive symptoms to be of significance to an individual.

In addition, some clients may never return to within the non-clinical population cut-off due to the chronicity of their difficulties, despite making meaningful change for themselves (Hansen et al., 2002). In conditions such as Tourettes' and Autistic Spectrum Conditions (Kazdin, 2001) meaningful change may be achieved without the removal of all clinical symptoms. Furthermore, Kazdin, (2001) highlights the need for more research into the connections between constructs and the specific measures used to capture these. Anecdotally, we may be able to bring to mind clients whose outcomes show no clinically significant change, yet outside the clinic room report a meaningful difference in their everyday life. Conversely, clients who have achieved clinically significant change on a measure, may or may not have made meaningful change in their everyday functioning.

Although reliable and clinically significant change has become one of the primary approaches to defining change in the literature, there are other examples of defining change. For example, Mohr et al. (1990) define a positive response to therapy as more than one

standard error of measurement on the BDI, while non-response is defined as a change less than 25% on the Hamilton Rating Scale for Depression (HAM-D-17) in another (Van, Dekker, Peen, van Aalst, & Schoevers, 2008). This again underlines the arbitrary nature of defining change in outcome literature.

There is also the issue that clinically significant change only captures those changes which move from a negative to neutral or positive position, a particularly pathological and disease focused model of change. The emergent positive psychology literature begins to address this by aiming to move from a preoccupation with repairing what is wrong, to beginning to consider how we build on more positive qualities (Seligman & Csikszentmihalyi, 2000). However, if clinically significant change is not an appropriate outcome measure for positive psychology, we are left with the dilemma of how to integrate outcomes from this area of research into the current outcome data.

#### *Law of Averages*

Howard et al. (1996) highlight three questions that can be asked of outcome data. Firstly, does this treatment work in experimental conditions? Secondly, does this work in routine practice? And finally, does this work for this particular client? The major challenge with the current outcome literature is that for the most part research focuses on the first two questions. As a result we know only whether the treatment works on average. This research simply tells us that most people benefitted, rather than saying anything about those who did not change. These treatment-focused studies fail to examine which patient variables contribute to the distribution of outcome scores (Lorentzen et al., 2011). This means of measurement is of course valuable for gaining information on the efficacy and effectiveness of treatments, but it is not always practically useful, as clinical decisions have to be made on a case by case basis (Lutz, Böhnke, & Köck, 2011).

In order to address this, Howard et al. (1996) introduced the concept of patient-focused research, research which is carried out in everyday clinical settings with individual clients, to improve the treatments we provide (e.g. Lambert, Hansen, & Finch, 2001). This research aims to answer the question “*does this treatment work for this particular patient?*” (Lutz et al., 2011, p.311).

Studies have also begun to explore the effect of client feedback on outcomes with the aim of removing the emphasis from the therapist as ‘in charge’ and to give the client a voice in their treatment (Miller et al., 2005). This research has led to the development of feedback tools such as the Session Rating Scale (SRS; Duncan et al., 2003). This brief self-

report scale requires clients to mark their ratings of four aspects of the therapy session; the relationship, the goals and topics discussed, the approach and method employed, and the session overall. Dependent on ratings, these facets can be discussed at the time of completing the measure, i.e. during the therapy session.

In support of the usefulness of tools such as the SRS, there has been much research to suggest that feedback from clients can enhance treatment outcomes. For example, Whipple et al. (2003) found that clients whose therapists were provided feedback on their progress (and were given additional support tools) had superior outcomes, with almost twice as many of those in the feedback group achieving clinically significant change, in comparison to those whose therapists did not receive feedback.

Following this, Lambert and colleagues (Lambert, 2007) developed a feedback system alerting practitioners to the development of individual cases in accordance with pre-programmed algorithms of expected therapy progress. This progress was dependent on initial disturbance levels and ratings on a purpose devised questionnaire, after one or more sessions. Using this, Lambert (2007) was able to predict approximately 88% of deterioration cases correctly. The team then developed a clinical support tool which improved the course of 53% of those expected to deteriorate (Whipple & Lambert, 2011).

### **Client Experience**

Hubble, Duncan, and Miller (1999), estimate that around 40% of variance in final outcomes could be attributed to client and extra-therapeutic factors, in contrast to the 30% attributable to the therapeutic relationship and less than 15% credited to the model, technique and placebo factors. Client experience may therefore be an important means by which to advance our understanding of the mediational processes involved in therapeutic change (Elliott & James, 1989). Clients have privileged access to information (Paulson, Everall, & Stuart, 2001). As surmised in George Kelly's first principle of Personal Construct Theory; if you want to know what's wrong with a person, why not ask them? (Kelly, 1955). Before embarking on a study which examines client experience of therapy, it is important to review the client experience literature and understand why client perspectives are an important standpoint from which to continue to research.

Client experience literature dates back over sixty years, beginning with the study of client experience in person-centred therapy (Lipkin, 1948; as cited in Elliott, 2008). However, prior to the last 20 years, research in this domain was somewhat limited. Influences from behavioural, positivist and psychoanalytic stances led to a devaluing of

verbally reported conscious experience (Rennie, 1994). In addition, there were beliefs in clients' inability to suitably articulate difficulties and to make accurate judgements, as well as questions regarding the accuracy of client's recall (Hodgetts & Wright, 2007; Macran, Ross, Hardy, & Shapiro, 1999), which contributed to a paucity of research. However, more recently interest has grown, and the value of client experience is now recognised (Elliott, 2008).

Elliott and James (1989) conducted a meta-synthesis of client experience literature and defined client experience as "*clients' sensations, perceptions, thoughts, and feelings during therapy, and with reference to, therapy sessions*" (p. 444). This comprises a variety of experience including meanings, memories, both conscious and unconscious experience, along with extra-therapy reflections, or reactions to therapy. They argued it is important to study this, as establishing a better understanding of the experience clients have in therapy can lead practitioners and researchers to an enhanced understanding of how and why therapy works in terms of the mediational process in therapy. Being aware of these perspectives should allow clinicians to remain open minded. Client experience therefore becomes a fundamental aspect of our perception of therapy.

The attention to client experience is reinforced by the emergent service-user movement and emphasis within the NHS for client choice. This was popularised during 1980s with the publication of 'The Griffiths Report' (NHS Management Inquiry, 1993), highlighting the importance of the needs and approval of the consumer. Today, satisfaction remains a major component of the NHS ethos, illustrated in the Department of Health (DoH) paper, 'The NHS Plan' (DoH, 2004). Since publication, the NHS has "*increasingly listened to the patient voice in designing services*" and "*NHS Trusts are now required to collect feedback from service-users on a regular and ongoing basis*" (DoH, 2004, p. 22). This has since been consolidated with 'Creating a Patient-led NHS' (DoH, 2005) in which client choice and decision making are further advocated.

Furthermore, in traditional research methods, fuelled by deductive reasoning and positivism, the client is often perceived as a passive recipient of therapy (Macran et al., 1999), placing the therapist in the expert role (Gordon, 2000). Not only is this an artificial depiction of the therapy process, but may also sit uncomfortably with those who work within a collaborative framework, using shared decision making, aimed at minimising the power imbalance. Understanding of the client's experience of therapy therefore comes from a professional's perspective as opposed to how clients themselves would describe experiencing it.



### *Client Theory of Change*

One such way to amalgamate client experience and change within therapy is the concept of ‘client theory of change’ (CTC: Robinson, 2009). Robinson argues that, in contrast to formal theories of change often held in the mind of professionals, the client also has an informal theory of how change may come about. This encompasses the client’s perception of their problem and how it may be resolved and although this is often not a fully formed or articulated idea, it is ultimately the process by which the client experiences change (Robinson, 2009).

Knight, Richert, and Brownfield (2012) raise the question ‘does each client have their own highly individual understanding of change, or are there common ways in which change is conceived?’ In order to answer this, they conducted a grounded theory analysis on interviews with eighteen individuals across the life span, who were not in therapy. They asked participants to reflect on episodes of change within their lives and how they felt they had brought about the change. In terms of clinical implications, the authors concluded that clients do not necessarily have a well-formed narrative about how change may come about. The authors describe that a ‘co-authorship’ is required, whereby the client contributes to the narrative, but there remains a dialogue between the therapist and client to allow the continued development of the CTC (Knight et al., 2012).

Literature pertaining to client experience of change is scant. Knight et al. (2012) reviewed the literature on client experience of change and highlight that much of this focuses on helpful and hindering aspects of therapy, some with categories predetermined by the researchers, others with a more open stance (e.g. Grafanaki & McLeod, 1999; Orford et al., 2006). Timulak, (2007) used a novel approach by applying meta-analytic techniques to qualitative research exploring helpful aspects of therapy. The study identifies nine ‘categories of impact’ which are; awareness/insight/self-understanding, behavioural change/problem solution, feeling understood, empowerment, relief, exploring feelings/emotional experiencing, client involvement, reassurance/support/safety and personal contact (p.311). It may be possible that some of these aspects of therapy may have been absent from their experience for clients who feel they have not responded to therapy. The study does have some methodological issues, such as lack of detail of procedures in original studies, echoing the difficulties found in quantitative analyses.

Knight et al. (2012) also note that it is important to bear in mind that the majority of these studies are retrospective accounts and so the CTC cannot be assumed to be uncontaminated by the therapist’s influence within the therapy. This is an important point to

keep in mind when considering what each the client and therapist may have brought to the understanding.

#### *Client Experience as a Predictor of Outcome*

Beyond policy and ethical motives for studying client experience, there is research to suggest client perspectives are the strongest predictors of outcome, over that of therapists or outside observers (Lambert, 1992). A review of the patient preference literature (Mauksch, 2000) reported that focusing on patient preference in primary care can improve patient outcomes, from patients feeling their concerns were heard, through to involvement in decision making processes (Williams, Frankel, Campbell, & Deci, 2000). Client assessment of the relationship is also consistently superior in predicting the outcome of therapy (Miller et al., 2005), while client subjective experience of meaningful change in the first few visits also predicts successful outcome (Haas, Hill, Lambert, & Morrell, 2002).

Client perception of helpfulness of therapy has also been indicated as a predictor of outcome (Addis & Jacobson, 1996). Here, clients were assigned to a twenty week course of either behavioural activation or cognitive therapy. Those who by the second session of behavioural activation group felt the treatment was helpful had positive outcomes. A similarly positive, but non-significant finding was found for the cognitive therapy group. Similarly, client ratings of the 'real' relationship within therapy (i.e. degree to which client and therapist are genuine with each other), have been found to be predictive of outcome, while therapist ratings were not (Gelso et al., 2012).

These findings indicate the importance of positioning the client "*in the driver's seat of their therapy*" (Miller et al., 2005, p.87). Collectively, this research reiterates that clients' views are at the very least valid, if not an indispensable method of evaluating and gaining insight into the therapeutic process.

#### *The Client-Therapist Gap*

In addition to the evidence that client experience is a key perspective to consider in therapy outcome research, there is also evidence that therapists have limited ability in predicting negative outcomes in therapy (Hannan et al., 2005). As non-response is a relatively under researched area, we do not know whether the same holds true in non-response.

Lambert (2007) asserts that to reduce negative effects in therapy, we must first be capable of predicting them. Preliminary findings underpinning this research observed that

clinicians have limited abilities in predicting deterioration in clients. For example, Hannan et al. (2005) developed a set of laboratory tests to predict treatment failures, using various outcome measures and treatment predictors. Over three weeks, 26 (of 332) clients deteriorated. The tests correctly identified 20 (77%) of the 26 who deteriorated, whereas therapists only identified five, suggesting therapists require independent data to help them to identify clients that are likely to deteriorate. Hatfield, McCullough, Frantz, and Krieger (2010) also examined therapists' awareness of client deterioration. They used outcome measures to identify sessions in which client's symptoms significantly worsened. This was then compared with therapists' progress notes to examine whether the therapist had noted this deterioration. The results found that therapists detected deterioration in only 15 (21.4%) of the 70 cases where deterioration had been identified from outcome scores. The authors note the limitations with this design, for example it would be good clinical practice for therapists to record deterioration in progress notes, but this does not mean that it necessarily happened in every case.

Furthermore, research has consistently found discrepancies between client and practitioner perceptions (Hodgetts & Wright, 2007; Llewellyn, 1988), particularly when client views of therapy are negative (Below & Werbart, 2012). A number of studies identified that when therapists of clients who are deteriorating are interviewed, most attributed the deterioration to the client (e.g. Shepherd et al., 2012). Further to this, therapists were generally more satisfied with the therapy than their clients (Below & Werbart, 2012). This may stem in part from individuals, including health professionals, overestimating their capabilities (Tracey, Arroll, Barham, & Richmond, 1997; Woolliscroft, Tenhaken, Smith, & Calhoun, 1993). Therefore, when presented with information suggesting client deterioration, therapists tend to attribute this either to the client (Shepherd et al., 2012) or downplay the deterioration (Below & Werbart, 2012; Whipple & Lambert, 2011).

One study has also identified this discrepancy with clients who fail to respond to therapy. Coffman, Martell, Dimidjian, Gallop, and Hollon (2007), report on a subset of clients who describe 'extreme non-response' to cognitive therapy with regard to their self-reported depression. This self-evaluation of depression did not correspond with equivalent therapist ratings. The authors suggest that although this may be an anomalous result, it may equally be an outcome that the therapists did not detect, or alternatively the client may not have valued any improvement that had been made. Although this is a single study, when

taken together with the literature on failure to detect deterioration, this is an area which warrants further attention.

## **Non-Response**

### *Defining Non-Response in Therapy*

As discussed, change is a primary aim of therapy and much of the time this is achieved. Nonetheless, a significant minority of cases either deteriorate or fail to respond. Figures range from between 14% of non-response in small studies (Lorentzen et al., 2011), to as high as 60% in larger studies (Hansen et al., 2002). Potential reasons for the discrepancy are discussed below.

As with change, non-response is difficult to define conceptually and often findings relating to non-response depend upon how it is operationalised (Schottenbauer, Glass, Arnkoff, Tendick, & Hafter Gray, 2008). From a quantitative perspective, as with the change literature, non-response is largely defined as a lack of reliably and clinically significant change in either direction; as opposed to the reliable and clinically significant change in a positive direction for improvement or in a negative direction for deterioration.

One attempt to conceptualise non-response has been made by Linden (2013). Here, ‘treatment non-response’ (TNR) is defined as a “*lack of improvement in spite of treatment*” (Linden, 2013, p. 288). In this case, TNR is understood as an unwanted effect of therapy, which may or may not be considered as an adverse treatment or malpractice reaction dependent on the circumstances. However, as the primary focus of this paper is to provide a model for definition, classification and assessment of side effects in psychotherapy, TNR is not further explored and the difficulty in operationalising and measuring non-response remains, i.e. it is defined by whichever method has been used to define change.

### *Non-Responders*

As indicated, estimates of non-response to therapy vary throughout the literature, most probably due to the variety of means by which to define and operationalise change. Official statistics report recovery rates following therapy at between 40-50% (The Centre for Economic Performance’s Mental Health Policy Group, 2012). Taking into account the further 10% of clients which the literature estimates deteriorate (Lambert & Ogles, 2004), it can be estimated that around 40-50% also fail to respond to psychological therapy.

In one study, 313 outpatients diagnosed with major depressive disorder were randomly assigned to either pharmacotherapy, short-term psychodynamic supportive

psychotherapy or combined therapy, for six months. Non-response was defined as a change less than 25% on the Hamilton Rating Scale for Depression (HAM-D-17). In this case, 39% of participants were found to experience no change in therapy (Van et al., 2008). A large scale American study reported a much higher rate of non-response (Hansen et al., 2002). A total of 6,072 patients were considered, across six treatment sites. These included an employee assistance programme offering short-term treatment for adjustment difficulties, a university counselling centre, a number of health maintenance organisations and a state run community mental health service. 'No change' was defined as those with no reliable change on a standardised measure, the Outcome Questionnaire (OQ-45). On average, 56.8% of those who had therapy experienced no change. This was in comparison to 8.2% who deteriorated (made a reliable change in a negative direction), 20.9% who improved (made a reliable change in a positive direction) and 14.1% who recovered (made a reliable change in a positive direction and moved from within the range of the dysfunctional distribution to within the functional distribution) (Hansen et al., 2002). Despite these statistics, the literature researching the experience of those who do not change remains surprisingly sparse (Hodgetts & Wright, 2007).

Lorentzen et al. (2011) also highlight the paucity of research available on non-responders. They studied non-responders in a psychotherapy group setting using observational methods. Lorentzen et al. identified non-responders as those who had made no clinically significant change on an outcome measure of psychosocial functioning. They found non-responders demonstrated less initial distress, completed shorter durations in therapy, and showed more dissatisfaction with their group and therapists. They posit that it is likely treatment preference also played a role as 50% of non-responders would have preferred individual as opposed to group psychotherapy.

### *Predictors of Non-Response*

As there is limited research into non-responders at present, it follows that research into predictors of non-response would be even more scant. Current research points to some client characteristics as predictors of non-response, such as being over the age of 40 years, experiencing chronic depression and being non-adherent to treatment (e.g. Van et al., 2008). The majority of the research in this area looks at predictors of non-response to specific treatments, or within specific populations. For example, a recent review of meta-analyses of treatment for anxiety disorders attempted to explore predictors of non-response to cognitive behavioural therapies (Taylor, Abramowitz, & McKay, 2012). After highlighting the issue

of lack of a universal definition or measure for non-response, the authors go on to state that there is only limited, and often contradictory evidence, for predictors of non-response in cognitive behavioural therapy for anxiety disorders. For example, Taylor, Abramowitz, and McKay (2012) note that high expressed emotion has been indicated as a predictor of poor treatment outcome for major depression and schizophrenia (Butzlaff & Hooley, 1998), however was not a predictor of poor treatment outcome for social anxiety (Fogler, Thomson, Steketee, & Hofmann, 2007).

In addition to these predictors of non-response, we may also be able to extrapolate some findings from successful and unsuccessful therapy to contemplate what may contribute to non-response. We know factors such as quality of client therapist alliance, therapist empathy, congruence and positive regard can contribute to a positive outcome (Norcross, 2002), while lack of empathy, distance and premature interpretations are causes of deterioration in therapy (Castonguay et al., 2010). In addition, Whipple et al. (2003) used factors associated with poor outcome to predict deterioration in clients. These included early dissatisfaction with the therapeutic relationship, clients at a less-than-favourable stage of change and lack of adequate support networks outside of therapy, as predictors of poor outcome. It may therefore be reasonable to suggest these lay on a continuum, with predictors of non-response somewhere in the middle. However, as argued above, interpreting the outcome literature is not straightforward and it may be that non-response has its own unique set of predictors.

Although again not directly linked to non-response, Nilsson, Svensson, Sandell, and Clinton, (2007) explored satisfactory and unsatisfactory experiences of cognitive behavioural therapy (CBT) and psychodynamic therapy (PDT) with potentially relevant findings. As with this current study, they posited, that quantitative evidence supporting the equivalency of therapies (Wampold, 2001) may mask differences in clients' experiences of different therapies. Indeed they found that while numbers of satisfied and dissatisfied clients was approximately equivalent in CBT and PDT (57% vs. 65% satisfied; 43% vs. 35% dissatisfied, respectively), the qualitative experiences of the comparative groups were "*starkly different*" (Nilsson et al., 2007, p.563). Although it is non-response of interest here, it may be useful to note clients who reported dissatisfaction also reported feeling insufficient change had been achieved. In addition they reported termination had been too abrupt, a more thorough and deeper therapy would have brought about more change, that there had been a difference of opinion in how to do therapy between the client and therapist and a sense that a different kind of therapy would have been better. Beyond this, Nilsson et al. also found

differences in the type of dissatisfaction dependent on the type of therapy received, a consideration to take forward when considering any outcomes from this study.

### *Summary*

Previously, research and service evaluation have relied heavily on practitioner accounts of therapy. As noted, this is not always the most accurate depiction of outcome in therapy, particularly when outcomes are poor (Hatfield et al., 2010). In addition, as it is now generally accepted that psychological therapies are effective (e.g. Smith & Glass, 1977), research has continued to focus on proving efficacy (often with a focus on specific therapies for specific disorders). Whilst some attention has been paid to deterioration in therapy (e.g. Castonguay et al., 2010; Lilienfeld, 2007), those clients who do not respond, have been largely overlooked.

Commonly, non-response is reported as an additional statistic with which to compare those who improved (e.g. Hansen et al., 2002). Primarily, studies of non-response report the difficulties in defining non-response, and although there are a small number of studies examining non-response, these tend to evaluate predictors and characteristics of non-responders and often use quantitative methods with predefined categories thereby limiting the scope of the research (e.g. Coffman et al., 2007; Mohr et al., 1990; Van et al., 2008).

Clients who fail to respond to therapy are an important group to study. Non-response can be seen as having opportunity costs for the client in terms of time and input, as well as possible feelings of failure or hopelessness for not being able to use, or be helped by therapy. For example, Dalenberg (2004) reports that clients perceived the therapist's response to their ongoing symptoms and lack of change as an angry response from their therapist. Non-response is therefore likely to have an emotional cost for both the client and the therapist, as well as an economic cost to healthcare services.

Additionally, there are clinical and research implications in studying non-responders in the context of their experience. Firstly, by investigating experience, we can gain a greater understanding of the intermediary process which result in therapeutic change, or lack thereof (Elliott & James, 1989). Secondly, we can gain greater insight, and thereby adapt practice to elicit more effective interventions and enhance engagement of this understudied group (Elliott, 2008).

## **Aims**

The aim of this research is to explore clients' subjective experience of non-response to therapy. By exploring subjective experience, we can begin to understand what may need to be asked to initiate discussions when therapy has failed to produce the desired and expected changes. From this, it is plausible we could devise more relevant strategies to promote client change within therapy, ultimately improving outcomes. It is hoped that the following questions may at least in part be answered through this research:

- How do participants who feel they have not responded to psychological therapy experience, and make sense of their therapy and their relationship with the therapist?
- Do participants have views regarding why they did not benefit from therapy?
  - How has this experience affected their view of therapy and whether they would engage in therapy again
  - What do they think has contributed to this non-response?
  - What do they think would have helped them to get more from therapy?



## CHAPTER TWO: METHOD

### Methodological Approach

This section provides background and rationale for the methods chosen, as well as explanations as to why other approaches were rejected. It will also outline the experimental design and procedures, including details such as sample, inclusion criteria and data collection.

A qualitative methodology allows a discovery-orientated approach to a naturalistic study (Chenail, 2011). Due to the paucity of research in this area, a qualitative approach was taken in order to be free from confines of predefined categories and ideas, and to avoid the use of measures which assume certain aspects of experience. As it is client experience which is of interest here, i.e. what happened in therapy and how sense is made of it, Interpretative Phenomenological Analysis (IPA) was selected as the most appropriate methodology. As highlighted by Smith & Osborn (2008), IPA is particularly useful when dealing with “*complexity, process or novelty*” (p.55). This is applicable here as this is examining the process of therapy, which has previously shown to be a complex area to study, from a different viewpoint to most previous research (Elliott & James, 1989; Lorentzen et al., 2011).

### *Alternative Methods*

Before settling on IPA as the chosen analysis, alternative approaches were considered. As the current research base is limited, it is important to begin at a micro level, examining nuances within detailed accounts of experience within therapy. Grounded theory (GT) is a well-established qualitative approach, often seen as the main alternative to IPA, as much overlap can be observed (Smith et al., 2009). Although GT would be a suitable method for this study, it was considered to be less appropriate as this would have led to a greater focus on moving towards a conceptual explanatory level and theoretical claims, which could then be supported by individual accounts. Instead, IPA has a more micro level analysis of individual experience with “*texture and nuance arising from the detailed exploration and presentation of actual slices of human life*” (Smith et al., 2009, p.202) which is arguably warranted for this relatively novel area. Although IPA is not opposed to macro level theoretical claims, it asserts that micro level analyses may in the future lead to larger scale IPA or GT accounts in order to further develop these initial ideas (Smith et al., 2009).

Alternatively, a discourse or conversational analysis of naturally occurring data from individual sessions may have been utilised (Barker, Pistrang, & Elliott, 2002), but would not have allowed for subjective accounts and for eliciting experience which is of interest here.

### *Interpretative Phenomenological Research*

IPA entails detailed analysis of perceptual experiences of a small number of individuals, requiring depth rather than breadth of participants. As a result, it is not useful to interview a random sample, rather a homogenous group to whom the experience being researched is significant (Smith & Osborn, 2008). Smith and Osborn recommend 5-6 participants as a reasonable sample size in IPA. If the sample is too small it fails to identify differences and convergence, whereas, if it is too big, it may be overwhelming, meaning that in depth analysis is not able to be appropriately conducted (Smith & Osborn, 2008).

Semi-structured interviews (SSI) are primarily used for data collection, although alternative methods such as focus groups and written accounts can be used within IPA. For this study it was thought that individual interviews would allow participants a more confidential space to speak openly of their experiences. Furthermore, as both the researcher and interviewer, I could use the lived experience of being with the person to add to the richness of the data collected. These strengths made interviews the best data collection strategy.

In SSIs the researcher has an interview schedule as a guide, rather than questions to be asked verbatim. This flexibility allows the researcher to enter the psychological and social world of the participant, allowing scope for the client to provide richer data. These interviews can often last over an hour and are recorded and transcribed for analysis (Smith & Osborn, 2008).

Data is then analysed according to IPA protocol. This involves interpretation of the individual's psychological world, including that which is not directly available from the transcript, as described in Table 1. Although this is a proposed method, it is by no means a prescriptive, linear process and can be used flexibly according to the question asked (Smith & Osborn, 2008; Smith et al., 2009).

*Table 1: Stages of IPA data analysis. (Adapted from Smith et al., 2009)*

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<b>IPA Strategy</b>
Close, line by line analysis of experiential data of each participant
Identify themes emerging from experiential data. Identify convergence and divergence, and commonality and nuance, first with single cases, then across cases
Dialogue between researchers regarding coded data, using psychological frameworks to begin to develop interpretative accounts of data
Development of a structure which illustrates relationships between emerging themes
Data organised to allow analysed data to be traced through from initial transcription notes through to final themes
Develop coherences and plausibility of interpretation through supervision and collaboration
Full narrative developed, supported by transcripts. Explanation of interpretation theme by theme, supported by diagram or table
Reflection as researcher on own perceptions and processes.

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#### *Foundations of Interpretative Phenomenological Analysis*

IPA draws on the philosophical approach of phenomenology and is described as “*an idiographic commitment, situating participants in their particular contexts, exploring their personal perspectives...starting with a detailed examination of each case before moving on to more general claims*” (Smith, Flowers, & Larkin, 2009, p. 32).

The roots of phenomenological philosophy originate with Husserl, who believed reality involved peoples’ perceptions of objects and events (Giorgi & Giorgi, 2008). Variables affecting a phenomenon are not controlled in qualitative research, which aims to situate the experience within the context in which it sits within everyday life. Phenomenological philosophy is specifically related to the lived experience of the individual. Further to this the psychological meaning which underpins these experiences is sought to be understood in order to gain insight into the experience of the individual (Giorgi & Giorgi, 2008).

Whilst phenomenology is one theoretical axis of IPA, it is the theory of interpretation, or hermeneutics which is the second axis. This theory asserts that humans aim to make sense of situations and in doing so, any account gathered will reflect the individual’s attempt to make sense of that particular situation. The researcher must therefore be aware that the information gleaned from the individual is only what they have chosen, or are able to tell at that point in time, and as a result the researcher has to engage in a second

level of interpretation; in making sense of the participant making sense of their situation. In this way IPA is often described as engaging in a double hermeneutic process due to the dual levels of sense making (Smith et al., 2009).

### *Reflexivity*

As IPA encompasses this dynamic, double hermeneutic stance, as interpretations are made, the researcher must be aware of their own processes. Reflexivity therefore refers to the “*explicit consideration of specific ways in which it is likely that the study was influenced by the researcher*” (Smith, 2008, p.250). This may be aided by keeping a reflective diary to track understandings and viewpoints of certain concepts at differing stages in this process. Smith et al. (2009) describe a cyclical approach in which there is a ‘whole’; the researcher’s ongoing story and the ‘parts’ which equate to new experiences with each new participant. In this respect, the whole evolves as the parts begin to form; reflexive attention should be paid to previous stages in order to facilitate future interpretations.

This process also includes quality checks (Elliott, Fischer, & Rennie, 1999), by reflecting upon, and taking ownership of the researcher’s perspective. As such I have attempted to explicitly situate myself within the context of the research, expressing my interests in the area, so that the reader is aware of this when understanding how the data has been interpreted.

### *Critique of IPA*

Although IPA is appropriate for this study, as with any methodology it has limitations. Due to the small, homogeneous sample, findings from IPA studies are not able to be generalised. Furthermore, the sample size is often criticised; it is argued it is difficult to draw out the salient issues from such a small sample, while the homogeneity of the group may lead to overly specific conclusions, with little relevance to the wider context (Pringle, Drummond, McLafferty, & Hendry, 2011). Although this is often seen as a criticism of IPA, its proponents argue that IPA instead provides useful insights, with broader implications (Reid, Flowers, & Larkin, 2005). In addition, Smith et al. (2009) recommend that IPA be considered in terms of ‘theoretical transferability’ rather than ‘empirical generalisability’.

As IPA researchers are particularly interested in the sense making of participants, critics argue IPA is *too* interpretative, forcing the researcher to move away from original meanings (Pringle et al., 2011). However, although interpretation is championed in IPA, any

interpretation is to be firmly rooted in direct quotes so as to substantiate any interpretations, with the aim of making the process as transparent as possible (Smith et al., 2009).

Finally, critics of this approach argue that it is too difficult for researchers to disregard prior knowledge and interpret from an open minded perspective (Finlay, 2008). However, by rigorously following the quality assurance protocols laid out by Elliott et al. (1999) below, this again can be addressed through owning of one's own perspective and the transparency of data analysis, which in turn allows the reader to draw their own conclusions on the validity of the data.

## **Method**

### *Procedure*

Therapy non-response was client defined. Therefore, all clients who had received therapy and been discharged within the past six months having completed at least six sessions of therapy, were written to by the Psychological Therapy Service (PTS) informing them of the project and advising them of the opt-in and research process (Appendix 1). The letter provided a telephone contact number, email address and response slip with a freepost envelope through which clients could opt-in. The letter explained that by opting-in the client consented to be contacted for an initial screening. A telephone screening questionnaire was then administered to identify those to exclude (outlined in Table 2).

Following the screening, clients deemed suitable were posted further information and consent forms (Appendices 2 & 3) to read, complete and return within an allotted time period – a minimum of 24 hours to allow time to consider the implications of participation in the study. This included gaining permission to access any CORE data (outcome measures) stored at the PTS to be used as part of the interview.

Following the receipt of the consent form, CORE data was accessed and interview appointments arranged. Initially the CORE data had been intended to be used alongside the qualitative findings to report change on an objective outcome measure and allow comparison with the qualitative findings. However, when this data was received it was clear this had not been collected in a systematic enough way to calculate reliable and clinically significant change; some participants had only one recorded CORE outcome measure, while others were only completed for previous group therapy, rather than the individual therapy. As such it was not possible to provide any corroborating objective outcome data. Instead, the CORE data was viewed prior to the interviews and was used as an additional resource to prompt further discussions regarding the progress participants felt they had made in the

therapy or lack thereof. The interviews took place at the University to provide a neutral setting.

In total 25 clients responded and were screened. Six participants were screened out at the initial telephone contact and five declined to take part or did not respond following receipt of the detailed participant information details (Appendix 2). This left six clients who responded after the maximum number of participants had been recruited. These participants were thanked for their response and informed that the maximum number of participants had already been reached.

### *Participants*

Participants were recruited from a PTS within a single Mental Health NHS Trust. In doing so the following inclusion and exclusion criteria were used (Table 2).

**Table 2: Study Inclusion and Exclusion Criteria**

<b>Inclusion Criteria</b>	<b>Exclusion Criteria</b>
<ul style="list-style-type: none"> <li>• Age 18 or over</li> <li>• Completed a course of therapy for common mental health difficulties within the PTS</li> <li>• Discharged within the previous six months</li> <li>• No upper age limit (if cognitive decline was indicated, capacity to consent would have been considered)</li> <li>• Subjective experience of non-response (client defined). Participants had to identify with the statement ‘I have not benefitted from therapy’</li> <li>• Completed a minimum of six sessions of therapy and at termination had come to an agreed end with their therapist. (A minimum of six sessions was necessary to ensure some level of psychological intervention had taken place)</li> </ul>	<ul style="list-style-type: none"> <li>• Clients who had dropped out of therapy, or felt they had not completed the course of therapy</li> <li>• Clients who felt their experience of not benefitting from therapy was related to events outside the therapy</li> <li>• In inpatient mental health services</li> <li>• Experience of psychosis. It was thought that their experience of therapy would be sufficiently different to compromise the homogeneity of the sample</li> <li>• Clients diagnosed with dementia or deemed not to have capacity</li> <li>• Insufficient level of spoken English that an interpreter would be required. Due to the qualitative, interpretative nature of the study the use of interpreters may have raised cultural issues relating to different cultural understandings of mental health issues, an understanding beyond the scope of this study. Due to the small scale nature of this study there was not a resource to fund interpreters</li> <li>• To prevent a skew of results that could have potentially arisen if a majority of the participants were selected from the same therapist, it was decided that at the point two participants from one therapist had been selected for interview, no further clients from that therapist could be included</li> </ul>

Although the final sample remain homogeneous in that they all responded to the statement ‘*I have completed a course of therapy with the service, but do not feel anything is particularly different as a result of it*’ (Invitation Letter: Appendix 1), within this there is an element of heterogeneity as there were a variety of experiences of non-response. From a

qualitative perspective, non-response occurs along a continuum; just as there are degrees of improvement and deterioration, there are degrees of non-response. In order to remain transparent regarding this heterogeneity within the group, these differences of experience are captured with the pen portraits for readers.

### *Interviews*

The interview schedule (Appendix 4) was initially developed by the researcher with feedback from supervisors. This was then piloted with two individuals known to the researcher; one interviewee had direct experience of non-response to therapy and the second was a colleague who role played a potential participant. Feedback from both parties was taken into account and minor changes to the wording were made. The schedule was further developed in consultation with service user panels (discussed below) and again minor changes to the wording were made.

As participants came with stories of multiple experiences of therapy, it was agreed that the focal point of the interview would be the therapy that had prompted their response to the study, i.e. the therapy that they felt they had not benefitted from. However other therapies and experiences of mental health services were also discussed as part of the narrative and to provide a context for the focal therapy.

The interviews lasted between 66 and 237 minutes and were audio-recorded. Immediately after each interview my initial reflections were recorded to refer back to during the analysis stage. Each interview was transcribed verbatim in order to be analysed. I transcribed interview one and interviews two to eight were transcribed by a professional transcriber. In transcribing, the convention '[name]' has been used to indicate when a name or place has been removed to ensure anonymity of participants and '...' has been used to indicate a pause or short break in speech.

### *Individual Analysis*

Analysis began on an individual level. To begin analysis transcripts were read and checked by listening to the original audio-recording. Each transcript was read and re-read to allow familiarity with the data and ensure that the participant "*becomes the central focus of the analysis*" (Smith et al., 2009, p. 82). After these primary readings initial notations were made on the transcript. As suggested by Smith et al., this step maintains an open-minded approach, is almost a free analysis of the text and examines semantic content on an

exploratory level. Again, this process allows a growing familiarity and engagement with the data.

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

*Pink* – Practical issues such as signing of consent forms etc. Usually found towards the beginning and end of interviews.

*Blue* – Background information; including personal history and mental health history.

*Green* – Service information not directly related to therapy experience, including referral processes and engagement with mental health services.

*Yellow* – Therapy experience; data relating directly to the client's experience of the therapy.

An example of this process, with initial annotation can be found in Appendix 8.

Throughout these readings information was drawn out to allow the development of a pen portrait for each participant; to capture information about the participant's history, current circumstances and their journey through therapy, with the aim of conveying how it was to be with the person and interview them as part of the process. The primary aim was to provide the reader with a context through which each individual's story could be understood.

The next phase of analysis was the development of emergent themes. Here the goal is "*to produce a concise and pithy statement of what was important in the various comments attached to a piece of transcript*" (Smith et al., 2009, p.92). There is a sense of not only capturing the meaning of discrete pieces of text, but also to begin to reflect and interpret the piece of transcript as a whole. Emergent themes should aim to depict the 'psychological essence' of the data. Although the entire transcript was used in the process, the focus was on the sections of data which were directly related to the client's experience of therapy as this was the focus of the study. These themes were drawn onto a series of 'maps' on A3 paper so as all the concepts that emerged could be encapsulated in one place. This allowed me to see overlaps and relationships within and between themes. This was an iterative process which continued over a series of A3 'maps' until I had developed a set of themes and sub-themes which encapsulated the essence of the participant's experience (e.g. Appendix 8). Within the current document, it is not possible to present all the individual level analyses. Instead these have been included within the pen portraits.



### *Group Analysis*

I conducted the group analysis at two levels. The initial stage represents a descriptive analysis with themes of the experiences of the participants. This stays closer to the data set, reporting more directly what has been said. A second analysis was then conducted, with a much more interpretative phenomenological stance. This involved returning to the raw data, drawing on the initial analysis and synthesising the ideas into a model of the therapy experience.

In both cases, having coded the entire transcripts in the individual level analysis, I then focused specifically on the therapy sections in order to answer the questions posed by this study and to provide a group analysis. With the individual level analysis in mind I returned to the transcripts and began to draw out themes that appeared over a number of transcripts. After doing this, as with the individual level analysis, I again used A3 'maps' to draw out concepts and the relationships between them (Appendix 8). In an iterative process of reading the transcript, drawing out themes and checking these back with the transcripts, I was able to conceptualise a model of the participants' experience of non-response to psychological therapies, following the IPA principles outlined in Table 1.

### *Quality of IPA Research*

Qualitative research can be subject to criticism for lacking the scientific vigour of quantitative research as noted above. This led Elliott, Fischer and Rennie (1999) to propose an evolving set of guidelines by which to evaluate the quality of qualitative research. This was developed by initially addressing over forty sources, including previous formulations of quality standards for qualitative research, in order to examine what constituted quality research. From this eleven principles were drawn out. These were then taken to various discussion groups, condensed and presented at the American Psychological Association. Elliott et al. (1999) do not set out these guidelines as a rigid checklist against which all qualitative research should be measured; instead they offer them as a collection of ways various qualitative research may be evaluated. The resulting seven guidelines are referred to in the discussion in relation to how they have been used within this current study (Table 6).

### *Ethical Issues*

Ethical approval was granted (Appendix 5) and the study was registered with the appropriate Research and Development Department (Appendix 6). The ethical issues considered and addressed in these applications included:

*Distress:* In recounting aspects of a therapy an individual had not found helpful or events that brought an individual to therapy, participants may have become distressed at points during or after the interview. The participant was informed that they may stop for a break and/or withdraw from the interview at any point without question or it affecting any current or future treatment. Further to this, the participant was provided with an information sheet with advice and contact details of what to do should they feel distressed at any point following the interview (Appendix 7).

*Risk:* The participant was informed that their responses remained confidential unless it was felt they posed a significant risk to themselves or others. This was outlined in both the participant information sheet and consent form (Appendices 2 & 3) and was explicitly discussed prior to the interview. The participant was informed that if any information regarding significant risk to themselves or others (including children) was disclosed then information would have to be communicated to the relevant parties in order to safeguard themselves and others. The participant had an opportunity to ask any questions regarding this, as well as any other aspects of the study they had concerns about. If risk issues had arisen during the interviews appropriate clinical support would be provided with referral to the most suitable service dependent on the level of risk. It was also made explicit to the participant I had the same responsibilities as any member of the public to inform the authorities of any criminal act disclosed.

*Confidentiality:* Participants were informed that all responses would remain confidential. Interviews were audio-taped with the participant's permission and transcribed verbatim. Transcribers were required to treat the contents of the recording confidentially (and signed a confidentiality agreement). Transcribed data was anonymised to prevent identification. Data was stored on encrypted devices, locked away whenever not in use and destroyed following transcription. In line with university requirements, recordings and transcripts are being kept on a password-protected server in the university for three years. Participants were informed that the results were to be written up as part of the Doctorate in Clinical Psychology Training Programme and that it was also possible that the study may be written up for publication in a peer-reviewed journal in the future. Participants' details are not stored with the research materials, and participants are, and will not be, identifiable in the reports that result from the research.

*Privacy and Informed Consent:* Participants were contacted by the PTS where they received their therapy. Only when participants opted in to the research were their personal details given to the researcher. Participants were also informed they were only registering an

interest at this point and were in no way committed to taking part in the project. Participants were informed that their therapist would not be aware of their involvement in the study. After agreeing to take part in the study, participants were given a minimum of 24 hours to read the information sheet, after which informed consent was obtained.

*Researcher Safety:* Interviews were carried out in a private, comfortable room at the University. I ensured my research supervisors were aware of the interviews and at least one supervisor was available during the interview should additional support have been required.

#### *Service User Involvement*

As this research focused on client experience it was particularly relevant to be mindful of service-user involvement. In this respect, I consulted with service-user panels at both Leeds University and the relevant Mental Health NHS Trust. I sought advice from these groups regarding recruitment methods as well as the development of the interview schedule and process. This offered a service-user perspective on how it may feel to go through the recruitment procedure and interviews. Minor adjustments were made to the wording of the participant information and interview schedule as a result of this process.

#### *Situating Self in Research*

Before moving on to present the results of the analysis described above, it is important to restate the significance of the role of the researcher in the interpretation of the data. The researcher can never maintain a neutral, objective or detached stance. Instead there should be a scrutiny of their role in the process of gathering new knowledge in relation to the position they are gathering it from (Mason, 1996). As such, and in line with transparency in qualitative methods (Elliott et al., 1999), I will provide a short summary about myself in order for the reader to be able to consider how my intentions, influences, current situation and background may or may not have influenced my understanding of the data and formation of concepts I will present shortly.

My initial interest in this study came about through an essay entitled 'Harm in Therapy' which I had written as part of the requirements for the Doctorate of Clinical Psychology. With such a dominant focus in the literature on how we can enhance therapeutic outcomes, it was refreshing to have an opportunity to consider the discussion from another angle. From this, further research of the literature and ensuing discussions with thesis supervisors, I settled upon the topic of non-response in psychological therapies. From my initial reading it was apparent this was an under-researched area. As I develop as a

psychologist, I have a growing realisation that I find it rewarding to be able to convey the views of minorities and possibly misunderstood groups in therapy. This may also be reflected in my choice to work with individuals with personality disorder presentations as my final year placement. I frequently see clients who have been involved in services for a number of years, often with no lasting benefit, and in some cases with apparent iatrogenic effects.

As a 28 year old, White-British, female born and raised in West Yorkshire, I have had a relatively unremarkable upbringing. I have some experience of mental health problems in family and close friends and am aware of individuals in my social circles who have had therapy, with both positive and negative outcomes (although I have not been privy to discussion about how or why this may have been). I have not undergone any therapy of my own, although I intend to do so in the future.

My work in mental health began after completing my undergraduate degree in psychology. Having decided this would be an interesting career path I began to gain experience with voluntary mental health organisations, which led to a role as a mental health worker in a Primary Care setting. Both of these roles gave me insight into therapy not working for some people; in the voluntary sector role I saw people with severe and enduring mental health problems often lose faith in the systems around them, while in Primary Care I saw the frustration of individuals who felt the ‘time-limited’ therapies they had received had not met their needs. On reflection, both of these experiences may have influenced what initially seemed to be a more arbitrary decision to study this research area.

In addition to providing details of my background and values, I also completed a reflexive interview with my supervisor to determine some of my assumptions prior to carrying out the interviews. During this interview I reflected on what I expected from the interviews. For the most part, I described expecting to interview a group of people who although had experienced non-response to therapy, were generally angry and unhappy about their experiences. Although I expected there may be another group of non-responders who may not have had such a negative response to therapy, I predicted that these people would have less incentive and motivation to want to tell their stories and so would not come forward for this study. I was looking forward to being able to carry out these interviews and hear what it was for these people that had not worked in therapy (as therapist). I was aware that this would only be one side of the story (i.e. I would not have the therapist’s account) but imagined many of these clients would be in some way blaming of the therapist as a causal factor in their non-response. I also completed a reflexive journal throughout the

process and kept notes on my immediate reflections of each interview to use when analysing the data.

It is with these factors in mind I present the findings of this study. I will return to my own position and the potential role this has played in the analysis and interpretation of these results in Chapters Three and Four.

## CHAPTER THREE: RESULTS

This chapter is broken down into several sections to provide ease of reading and offer a logical, transparent, step by step approach to the data analysis. It begins by providing descriptive demographic details of the participants, followed by pen portraits which encapsulate the distinct experience of each individual in the context of their situation and incorporates the themes arising from their accounts in context. Following this, it presents the group analyses; initially as themes and secondly as a model. Throughout this section, direct quotes from the participants are used to demonstrate the concepts described.

### Participants

#### *Overview*

Throughout this document, pseudonyms have been allocated to protect the client's identity.

**Table 3: Demographic Details of Participants**

<b>Participant</b>	<b>Gender</b>	<b>Age</b>	<b>Ethnicity</b>	<b>Marital Status</b>	<b>Educational Level</b>
Cameron	Male	22-29	White-British	Single	Degree Level (Unfinished)
Melissa	Female	40-49	White-British	Married	Degree Level
Melanie	Female	40-49	White-British	Married	Degree Level
Chad	Male	30-39	White-British	Single	Degree Level
Christine	Female	60-69	White-British	Divorced	Left school at 15 Diploma in later life
Donna	Female	30-39	White-British	Single	College Level
Peter	Male	60-69	White-British	Married	Left school at 15
George	Male	60-69	White-British	Married	Left school young College in later life

#### *Pen Portraits*

##### *Cameron*

Cameron grew up in a large family and described a difficult relationship with his parents. In recent years he had studied at university, however dropped out on two occasions due to a deterioration in his mental health. Cameron described himself as a thinker; *“I mean it’s something I’ve always done...kind of ended up as being one of the only things I can really do”* and tended to hold the view *“expectation leads to disappointment”*.

Cameron's initial contact with therapy was through university counselling services followed by voluntary sector counselling services, where he spent a year. Cameron described the end as a "*realisation moment*", that "*these things really are kind of bad*". Up to this point, Cameron felt he had not had a chance to talk about what he had gone through or make sense of his experiences. He described learning to explain things away; "*tell myself it's something else and wear a mask and put on a face*".

Cameron was then referred into Primary Care Mental Health Services and received 25 sessions of CBT. Cameron's experience of CBT was positive. He described a good relationship with his therapist. He described her as being "*better at her job than everybody else I've seen*" and felt that "*as a first experience of...the therapeutic process...I think, maybe I was a bit spoilt*". At the time Cameron's CBT finished he was feeling in a more stable place generally, but still felt there was work to do and as a result he was referred to Secondary Care.

Cameron's Secondary Care therapy got off to a "*rocky start*". His first therapist reminded him of one of his parents and so requested a change. He then saw another therapist who was at the service temporarily and as a result he was transferred to a third therapist who he saw for approximately 26 sessions. This is the therapy Cameron reported no change from and the focus of the interview.

Since discharge from therapy, Cameron had been in the care of the Community Mental Health Team (CMHT). This had been difficult for Cameron as he would have liked more therapy and described being denied this by the CMHT. He quoted their reason for denying him therapy as he was "*too broken...for therapy, too damaged*" and that he had to get himself better before he could have therapy. This had been confusing for him as he felt he needed therapy in order to do this. Cameron's dissatisfaction with the services he received proved to be a strong motivator for him to take part in the study; "*I kind of feel like I've been jilted by the services that were dealing with me this year and I'm sick to my back teeth of it really so I just thought if there's any way I can do anything*".

Cameron's interview was the first and longest of the interviews. The length of the interview may have been a combination of the fact that this was the first interview and I was keen to leave no stone unturned, coupled with Cameron's self-declared love of conversation; "*Well you've got to stop me somewhere, else I will talk for days*". Despite this, it felt Cameron had lots of useful detail to discuss and it felt like a rich data set. On reflecting on the interview Cameron said "*I mean over the course of the interview...it's a strange thing*".

*because...I think I really appreciate more...the space and the time you've offered me to talk about it...this has been a very...beneficial experience for me".*

With regards to the individual themes from Cameron's interview, there was generally a sense of not being listened to and dismissed by his therapist and being made to feel like an average patient; *"they should at least respect the fact that you're a person, individual and different enough from their scripted model of the person...their non-existent average patient"*. In addition to this, there were feelings of not being contained by the process and left without answers, not given any guidance or direction, not having enough time and as a result feeling abandoned by the therapist at the end. Finally, Cameron was angry, confused and tired out by the process and overall felt worse off as a result of the therapy; *"...that's kind of how I feel about the therapy when I look back on it. I just feel a bit burnt out...I don't really know how much has changed"*.

#### *Melissa*

Melissa worked seasonally as a self-employed consultant and described enjoying this. Outside work Melissa liked to keep busy, giving structure to her day, as she recognised this was helpful to her mental health. She described her motivation to take part in the study as a way *"...to help other people going through the same thing"*, as well as a general interest in anything scientific.

Melissa spoke of feeling she had probably suffered some level of depression since she was 13/14 years old and thinks this was due to a difficult family situation, as well as ongoing anxiety and sleep difficulties. Melissa described sleep playing a big role in her mental health and described periods of not being able to sleep at all, which dramatically affected how she was able to cope with life.

In terms of seeking help for her difficulties, Melissa had tried a number of treatments, (Table 4) including counselling. Melanie described feeling that *"just talking about stuff"* perhaps was not helpful to her, especially as the dominant narrative in her family was that problems were not something to be shared. For her, the idea of talking about your problems felt *"self-indulgent"*.

More recently, Melissa was referred to Primary Care Mental Health Services for short-term work on assertiveness, but this simply highlighted *"the whole thing was a much bigger thing"* and following discussions with a friend requested a course of CBT. Melissa received 21 sessions of CBT and this was the therapy that was the primary focus of our interview.



Shortly after the completion of the CBT Melissa's mood deteriorated due to various life stressors. She engaged with Secondary Care Services and was referred to group therapy, which she found unhelpful. Her lack of sleep contributed to a continued deterioration in her mental health culminating in an inpatient stay, to which she attributes her recovery – *"I don't think I would have got better if I hadn't gone to the...hospital"*.

When reflecting on the interview, Melissa told me it had felt fine talking through this as she had already thought about what had been successful in her recovery and again reiterated that she was glad that her experience was going to be of help to others.

I found my interview with Melissa very comfortable. She told a coherent story and was easy to listen to. From her calm, friendly presentation and way she talked about her experience I was at times taken aback by her description of the extent of her difficulties. Melissa also seemed able to look back and see the funny side of some of the more difficult situations, perhaps as a way of coping with the enormity of what had happened to her – *"...and I kind of quite liked the fact I'd been thrown out of group therapy....yeah, I think it generally appeals to my sense of humour [chuckles]"*.

On an individual level, the themes that arose from Melissa's experience of non-response to therapy included feeling a failure at therapy, therapy as difficult and pressurised, and although therapy had been helpful to an extent, it had felt like a limited resource and rushed; *"I felt it was kind of a bit rushed...and that yeah, you couldn't really have any more than 20 sessions...which, I guess, you know it all costs money doesn't it? So...you can't just keep, go on forever"*.

#### *Melanie*

Melanie differed from the other participants as she had not completed therapy. The decision was made to interview Melanie as although she had not completed the full course of therapy offered, she described a planned ending with her therapist and in this way would not compromise the homogeneity of the group.

Melanie was off work due to her mental health. She suffered with depression and described herself as a *"bit of a sponge"*, soaking up criticisms. Although Melanie left school when she was young, in later life she attended university. She rates this as one of her proudest achievements and was able to begin a graduate career. Due to health problems Melanie was forced to leave this role and has since had a number of different jobs, which she has not enjoyed.

Melanie has had a number of significant stressors in her life both in the past and currently which had contributed to her difficulties. Prior to the current episode of depression, Melanie previously suffered with depression some years ago. At this time she was sectioned, had an inpatient stay and received medication and ECT. Melanie reflected on this saying, *“you know there are no, you know like there used to be [hospital], where you could go to and have your treatment, you were taken out of your environment so you could step back and have that...time to reflect and look at things, whereas at the moment I’m still at home so I’ve still got [daughter] and things like that”*.

More recently, Melanie was referred for Secondary Care therapy. As stated, Melanie did not complete her therapy in full. Primarily this was due to pressure from work to return without provision to continue therapy, however Melanie reports she was almost three quarters of the way through and did not feel it was helping; *“it came to a decision where I had to let the therapy go...I felt that at that time we weren’t particularly making any progress that I would say ‘I desperately need to keep going ‘cause it’s doing me some good”*. In the last year, Melanie had been signed off work sick, had been referred to the Crisis Team and engaged with day services, followed by CMHT input. Melanie had recently begun longer term therapy with voluntary sector services. She felt that by having the option of sessions for up to two years she would have longer to talk through her difficulties.

Melanie felt that the therapy provided in Secondary Care gave her no benefit and this was therefore the focus of the interview. Melanie was keen to take part in the study so as to provide *“a different perspective”* of services. Melanie had well formed views about what had been unhelpful about her therapy experience and was able to take me through a coherent narrative of her experience with little prompting.

The main individual themes from Melanie’s interview included feeling as though therapy did not meet her expectations, that there was a right way to ‘do’ therapy and that she had failed at this; *“you think you’re not doing it right...you think I must be not, not doing something right for me not to be able to get a better benefit out of this”*. Melanie also spoke about feeling uncontained, as well as not feeling understood and feeling invalidated. As such Melanie struggled to be honest and because this had felt like her last chance, she felt as though she was running out of time in therapy, which was frustrating to her.

#### *Chad*

Chad took part in this study as a way of reflecting on past therapies; *“I was aware that past therapies didn’t do anything for me, or very little. So then I thought to myself, well*

*it might be good for me personally just to talk about how it went*". At the time of the interview he was undertaking further therapy with a voluntary sector organisation and had approximately 20 sessions with them when we met. Whilst he did not feel his problems were resolved, he felt that his current therapy was more beneficial as it focused explicitly on the issues he wanted to work on.

Chad felt he tended to try to please people and put on an act so others would not see what was really going on for him. Being the entertainer had become a coping mechanism; how he dealt with bullying when younger. Chad described having his difficulties "*forever*", which included anxiety and depression. He was spending a lot of time on his own, beating himself up, and it got to the point where he felt he needed to sort this out. Initially, Chad described finding it difficult to get help as he struggled to discuss his problems. After a number of years, Chad was able to talk to his GP and was referred for therapy in Primary Care. However, Chad was made redundant and as a result moved. He was then referred for therapy in Secondary Care. He believes he was supposed to receive 12 sessions, but eventually had around 20. Following this, he was referred to group therapy, where he remained for a year and a half until he was '*free!*' Chad did not find either of these therapies helpful, however this study focuses on the individual therapy in Secondary Care.

I found Chad a very likeable individual, his sense of humour made him easy to interview, however reflecting on the transcript I was aware that I had done a lot of the talking in the session and sometimes Chad needed prompting to expand further on his answers, which may have reflected his therapy experience. The major individual themes from my interview with Chad were that therapy was anxiety provoking and that he felt under pressure to fix himself. Chad also felt there was a lack of direction and he was stuck in a pattern in his therapy in which he struggled to be honest and as a result left feeling angry and disappointed; "*and then walking out but then getting angry with myself because I've not explored what, what I was there for kind of thing. And that carried on and on...and I got more and more anxious and angry at that bit because the sessions were running out*".

#### *Christine*

Christine had retired after having a variety of jobs and described finding it increasingly difficult to fill her time. She lived alone, but had some contact with family, however due to a number of issues over the years Christine had become estranged from some of her children, an issue which continued to cause her distress.

Christine described a difficult upbringing with traumatic events which have left her with flashbacks and nightmares. As a result of this, Christine left home when she was 17 to join the Armed Forces. Since then she travelled and moved around, finally resettling in West Yorkshire. There was a sense Christine had invested a lot in attempting to gain distance from her childhood experiences, but since retiring this had become increasingly difficult, *“I feel as though I’ve been running all my life”*.

Christine first sought therapy following a relationship breakdown and initially attended group therapy. She said however that *“always in the back of my mind perhaps I wanted a one to one”*. When the group failed to meet her needs she was referred to Secondary Care for psychological therapy. Here she received therapy for around 10 months. Christine describes reaching a point at which she felt she had taken all she could from therapy, *“there came a time where I really wanted to not go anymore, but I had been quite a few times. But it was just, I couldn’t see where it was taking me”*. At this point she began to *“wind it down”* with the therapist and they came to an agreed ending.

Christine spoke positively of her therapy and therapist and described feeling a *“fraud”* for attending the interview as she felt she had gained much from therapy. However, Christine felt she had been left with a lot of *“unresolvedness”* and wanted to give input about the services she had received.

The interview with Christine was different to some of the other participants as it seemed she had come with a different purpose. She was keen to tell her story, and was also keen to inform me of how she felt services could be different, particularly what would be helpful for individuals who had been through similar experiences to herself. Although she noted it had been hard for her to attend the interview as she was aware it would raise issues that she had actively tried to avoid, and had almost not attended, she felt glad she had been able to come; *“well mainly, if it’s help to anybody else. That’s the main reason. And I must admit I was close to not taking part. It was down to the wire this morning...But I’m still glad I’m here, because if anything helps anybody else, I think it’s a good cause”*.

For Christine the main individual themes were the concepts of going to therapy with questions she wanted answering, gaining the freedom to speak, but with consequences beyond the therapy and a sense that some things had been made worse as a result of the therapy. There was also a strong theme of guilt and shame for Christine, alongside a sense of acceptance for the limitations of therapy, *“I’ve just got to accept now, there’s some things you can achieve and some things you can’t...it’s only when you’ve been through it and you come out the other side, it gives you chance to assess everything”*.

### *Donna*

Donna lived with her two pre-teenage sons. Ten years ago, Donna was “rescued” from a violent relationship of five years. She believed without the support of her family and friends she would have struggled to be where she is now. At the time of the interview, Donna classed herself as on long term sick due to her mental health difficulties, but had worked in the past.

Since the relationship, Donna had experienced depression and symptoms of PTSD. Donna had sought help from services on numerous occasions, but felt let down by a frustrating system; *“And it’s taken so long to get help, when if it was a broken bone or something physical it would be very quick to fix. But with mental health and the monitoring of it, a lot of doctors are quite happy just to, and I want to change that you know, they’re quite happy to give you pills and send you on your way and that’s it...So if I can help in a tiny way to change it then, then that’s good I suppose”*.

Donna’s first contact with mental health services was through voluntary sector services but felt this did not meet her needs; *“basically me having to talk to somebody and them just going ‘yeah, um-hum’ and not really...there was no kind of interaction. There was no questioning...if I just wanted to talk to somebody, I’d’ve done it to a friend”*. Although Donna acknowledged this may be helpful for some people, it was not the approach she needed. Donna independently sought help from a private therapist who she felt had the best approach to her difficulties. However, this was too expensive and Donna was only able to have six sessions.

Donna also had a number of sessions with a mental health nurse at the GP surgery and again, as with the voluntary sector work this was *“just talking”*. Donna was seen on a fortnightly basis, but described becoming *“lost in the system”*. Donna struggled to get more appointments and found the whole process frustrating; *“I kept phoning up asking if I was going to get any therapy, any help and they told me that they couldn’t find my files, that I wasn’t in the system for whatever reason, and I just kind of sunk again”*.

It was not until Donna’s mental health deteriorated again and she was forced to leave her job that she sought further help. Donna eventually received 20 sessions of therapy, and this is the therapy that will be primarily discussed in the findings. Following this, she was referred to a mindfulness group. Donna stated that the individual therapy she had was useful to start as they began to discuss the difficult issues from her previous relationship, but mid-way through the focus shifted to the use of mindfulness techniques. Although Donna found the mindfulness helpful for dealing with everyday stresses, she described it as

worsening her PTSD. She spoke of an increased intensity of symptoms and a reduced ability to cope.

Donna appeared very serious at the start of the interview, however warmed as the interview progressed. She became emotional at points, particularly when discussing her previous violent relationship. It was clear this was still raw for her. Donna attributed the changes she had been able to make to the support of her family rather than therapy. However, Donna did state she would consider therapy again and was at the point of requesting a re-referral from her GP due to worsening anxiety at the present time.

For Donna, the primary individual themes were a sense of her symptoms increasing as a result of therapy, past issues were not sufficiently addressed and she felt let down and undervalued by the service as a whole, being left with a sense of ‘what now?’ following her therapy. Despite this, Donna described a positive relationship with her therapist in which she felt heard and understood; *“She was lovely and it was really easy to talk to her...And I knew she’d been listening to me as well, that she was actually listening to everything I’d said”*.

#### *Peter*

Peter was married with children and described taking his duties as a husband and father seriously. Peter described suffering from a long term physical illness, since the age of 17. Due to his experiences with the medical system he felt *“completely cynical”* about services and wanted to take part in the study to express his opinions regarding this. He felt he did not know as much about what should make the *“psychological people”* he had seen good or bad at their job, however felt the system was at fault, *“...the reason I’m here is because of the seven different therapists in just over two years...incident, and all that pushing from pillar to post. It, it just, I think, you know it’s rubbish that really”*. He felt annoyed that he had to see well paid professionals, who he viewed as inadequate. Peter was cynical about what difference taking part in the study would make.

Peter described himself as a tradesman who took a pride in his work. Peter had 36 jobs in 28 years, and described a pattern of initially enjoying a job, but then suddenly feeling low. This feeling then increased until eventually he felt suicidal and would change jobs, never really settling on anything that led to contentment.

Peter’s primary difficulty for which he had sought help had been work-related stress, but felt he had realised *“it’s a bit deeper than that”*. This had affected Peter in different ways over the years *“...you know it’s just...it’s ruined me life, if you know what I mean and it’s affected me wife’s life and it’s affected me kids’ life”*. For Peter his difficulties

stemmed from childhood, *“I think as a kid you see I was left more or less to me own resources, I wouldn’t say me parents didn’t love me but they just, I was a bit of a mistake”*.

Peter first tried to get help in the seventies when he was referred to a psychologist; *“I was wasting two hours a week going, going getting changed, going there...so this was not helping so I packed it in I found it was, it was having a detrimental effect because...it was putting me further behind with me work”*. Following this, Peter received some useful support from an *“industrial psychologist”* at the job centre; basic, practical skills, which kept him going for another four years or so.

Most recently, Peter attempted to get help following a flare up of his eczema, which for him was indicative of increasing stress levels, *“so it was two, two-fold; it was one to try and sort me stress out for me eczema...and the other was to try sort some of these problems I’d been living wi’...all me life”*. Peter attributed this stress to worries relating to the welfare reforms and his benefits.

Again, Peter accessed services via his GP and was assessed and referred on three times; each therapist stating he needed *“a different type of therapy”*. He was eventually offered Primary Care counselling, only to be told after three sessions; *“you’re gonna have to see somebody else! Somebody that can go a bit deeper”*. At this point he was referred to Secondary Care Psychology and offered 20 sessions of therapy. Unfortunately, his therapist went off sick and after a difficult period, Peter was given a new therapist who he saw over a two year period (20-26 sessions), with a break (requested by Peter) in the middle. This was the therapy that was the primary focus of our interview and the analysis, *“so I went back and finished the sessions...but I just – to sit in a room talking...it just...yeah, I’m always going over things and going through it in my head constantly...so basically it was doing that only out loud...it just wasn’t helping”*.

Peter came across as a man with strong principles about how things should be done. I also felt an undercurrent of regret and sadness, that if he had been able to get the right help sooner then things might have been different. When interviewing Peter I could sense the anger and frustration he had towards services. There was also a sense that nothing could or would be done about it despite the fact it was unjust. I felt drawn in to this as hearing his story it was apparent health services had not always provided him with the most appropriate and timely care, both in terms of physical and mental health.

The main themes arising from Peter’s interview were that of frustration at a stagnant, passive process in which *“nothing changed”*, therapy not fitting his needs and not feeling valued by the system. In addition, Peter felt a sense of responsibility for the therapy

not having the desired effect, as well as a sense that this was his last option – *“I’d nowhere else to go...that was all that was available”*.

### *George*

In his spare time George enjoyed gardening and DIY. Singing had been an important hobby for most of his life; he had been a member of a pop group who would perform on weekends, whilst he worked full time during the week. Unfortunately, George was unable to continue when he began to go deaf. At the time of the interview George described himself as profoundly deaf, he wore a hearing aid and lip read. He lived with his wife and had three children and five grandchildren. George explained he suffered from anxiety, with associated depression and felt his difficulties stemmed from what happened to him as a child, although explained this link only become apparent through therapy.

George described his journey with mental health services began almost 20 years ago when he suffered his first nervous breakdown. He was admitted to hospital and described this as a helpful experience, *“the thing is, while I was in there I just felt all my problems and stresses go, I was...I felt as though I was in a safe place”*.

On discharge, he was referred to day services which he attended for three months and following this, weekly group therapy for 10 years; *“in my case I was unable to talk about my problems, so, I should have never have been there for that length of time, I felt it...wasn’t for me”*. He explained he struggled to assert himself and felt this is why he was with the group so long. George then attended a self-help group which he found useful as the group members experienced similar difficulties to him; unfortunately after three years this group disbanded and he was *“sort of left to rely on medication”*.

More recently, George had several contacts with mental health services; due to the often short term nature of these and large number of professionals George had seen, he found it difficult to put these in a specific order. However, over the past few years George attended an anxiety management course, CBT with various therapists, EMDR and group therapy.

George described gaining no benefit from his initial course of CBT as his first therapist had left and was replaced by a second therapist who he felt was too young, *“she just looked like she’d just got out of school. Now I found that a bit difficult...”*. However, at a later date George had a course of 25/26 sessions of CBT which he described as helpful. George struggled with the most recent group therapy due to his hearing difficulties and left



as he felt unable to interrupt other members of the group when he had not heard what was being said.

The course of therapy which will be considered for this research is the EMDR George undertook. George had approximately 20 sessions which he did not find useful. He describes being left “*disappointed*” by the experience, but again stuck with it as he felt unable to express that it was not helpful.

Following his final group therapy, George felt he would not pursue therapy further. Although he is now able to link his childhood experiences to his current difficulties, which he had not done before therapy, he feels therapy will not help him further.

Although I found George a pleasant gentleman to interview, at times I struggled to follow his story. However, on reflection I feel this is more an indication of the quantity of therapy and different services George had undergone on his journey, rather than his ability to tell the story coherently. One of the biggest difficulties George wanted to convey was how unsuitable services were, particularly group therapy, for deaf people. He described large rooms, in converted houses, with no loop systems and therapists advising him to simply “*interrupt people*” if he could not hear them. As an anxious individual who struggled to assert himself, he considered that this was unhelpful advice. It appeared this was perhaps George’s main motivation for becoming involved in the study.

In George’s case, the main individual themes were a sense of not being able to see the validity of the therapy, feeling that at times information was being withheld from him regarding how therapy may work; “*we kept having discussions about...what, what may happen...I mean, it’s like being drip-fed information*”. George also noted feeling as though he was given the wrong type of therapy and a sense he was responsible for his non-response to therapy. However, George was also able to speak of how he had a felt a pressure from professionals and at times had not felt understood.

Although details of the participants’ mental health histories are largely outlined above, Table 4 provides an overview of the difficulties and treatments described by the participants in their interview to provide ease of comparison and an overview. Some of these were historical difficulties, others were ongoing at the time of the interview. Participants may have had other experiences, which were not discussed in the interview, as such this list may not include all such contacts.

**Table 4: Overview of Self-Reported Mental Health Difficulties and Treatments Undergone by Participants**

		Participant							
		Cameron	Melissa	Melanie	Chad	Christine	Donna	Peter	George
<b>Mental Health Difficulty</b>	Depression	X	X	X	X	X	X	X	X
	Anxiety/Stress	X	X	X	X	X	X	X	X
	Sleep Difficulties	X	X	X			X		
	Agoraphobia		X						
	Suicidal Self-Harm	X	X	X		X		X	
	Post-Traumatic Stress Symptoms					X	X		
	Relationship Difficulties	X	X		X	X		X	
<b>Treatment</b>	Primary Care Individual Therapy	X	X		X		X	X	X
	Secondary Care Individual Therapy	X	X	X	X	X	X	X	X
	Private Sector Individual Therapy		X		X		X		
	Voluntary Sector Individual Therapy			X					X
	Group Therapy		X		X	X	X		X
	Hypnotherapy		X					X	X
	Inpatient Service		X	X					X
	Day Services		X	X					X
	Community Mental Health Team	X	X	X			X		
	Crisis Team	X		X					
	Medication		X	X	X	X	X		X
	Electroconvulsive Therapy			X					
	<b>Current</b>	Ongoing Individual Therapy			X	X			
Attempting to access Individual Therapy (NHS)		X					X		
No Current Therapy		X	X			X	X	X	X

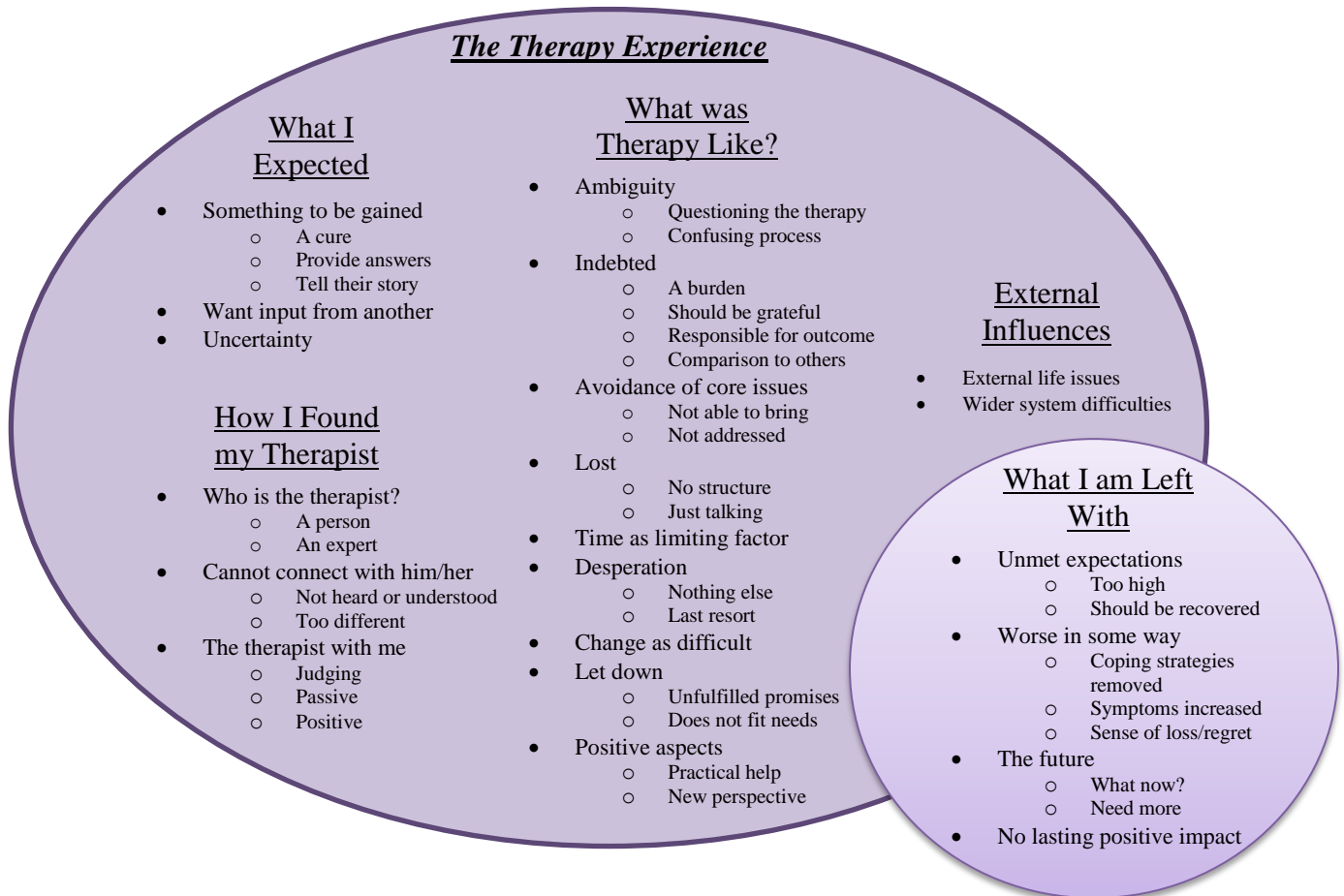
## Group Analysis

As described in the Method, the analysis is in two parts; the development of the initial themes, followed by an interpretative model which allows further meaning to be drawn from the accounts. The initial analysis is a descriptive analysis of the themes that arose from the data, while the second analysis uses IPA to develop an interpretative model of the experience of therapy for this group of participants.

### Analysis

This section outlines the direct, lived experience of the participants, and remains closer to the data set. Themes were grouped according to the area of therapy they relate to, in order to allow the reader to see which themes belong to which part of therapy. Within this

21 main themes were identified with various sub-themes within these (Figure 1). Consistency across themes is demonstrated in Appendix 9.



**Figure 1: Experience of Therapy**

**The Therapy Experience**

**What I Expected**

This group of themes encapsulates participants’ beliefs about therapy and what they had hoped to gain from undertaking this journey.

**Something to be gained**

Participants were often optimistic that there was something to be achieved from embarking on therapy;

*“...like I’ve said before, since I’ve got put onto it, I’ve felt strongly that there’s something to gain from being in therapy” Cameron*

Many of the participants spoke of high expectations of therapy providing them with a solution, cure or fix for their problems. There was a sense once completing therapy they would no longer face the difficulties they initially had;

*“And basically I think what I thought – that once I’d had counselling that would be it”*  
Christine

For others, along with a cure, some participants spoke of gaining answers;

*“I always seem to be looking for answers [sigh] about a lot of stuff”* George

*“And I suppose that’s what, I was looking for a miracle answer”* Christine

For some this was in the form of direction and guidance;

*“I needed help in showing me how to change...”* Peter

For others, they had specific questions they wanted answering;

*“...what I mainly wanted from this therapy – to find out what’s nature and what’s nurture”*  
Christine

Some participants spoke of wanting a space to be able to tell their story;

*“...but the main thing for me was to get my story out. So I could perhaps, in my mind I thought if I could get all of my story out it would be lesser on me, that’s what I thought”*  
Christine

Whatever the expectation, five of the eight participants had a sense there was something to be gained from therapy.

#### Want input from another

Across most of the participants’ experience was a sense that they were unable to deal with their issues themselves. There was a sense they needed input from another to be able to move forward;

*“I already had the book...is it Mind Over Mood?...I’d already bought that...and I found that difficult to...do myself”* George

*“...and I feel I really need to do that with some expert guidance behind it...and that’s where you sort of hope with the counselling that guidance will come from”* Melanie

There was an idea for the majority of the participants, change would come through help from another, rather than themselves.

#### Uncertainty

Three of the participants spoke about feeling unsure of what to expect from therapy;

*“It’s kind of difficult because...I obviously expected something...because I went...but I...on one hand I didn’t expect anything...”* Cameron

*“I didn’t know I think, because of previous experiences I didn’t know what to expect”  
Donna*

There is a sense here that therapy was an unknown.

### ***How I Found my Therapist***

This group encompasses the experiences participants had in relation to their therapist.

#### Who is the therapist?

Participants spoke about different ways they viewed the therapist. Most participants saw the therapist as a person, separate to their role as the therapist;

*“...[therapist] was lovely – I will not knock her...I don’t feel like I’m knocking her. I think...for what she...I’ll say it before anything else, it wasn’t her fault that I only had those sessions” Donna*

*“I mean she’s a nice lady and stuff” Chad*

*“And she seemed like a nice, good person...” Melissa*

One participant also spoke about viewing the therapist as an expert, having the answers and being able to sort things out. Melanie describes her perception of the therapist as *“this big, old wise owl”* and goes on to say;

*“Surely if you are a psychologist/psychiatrist, whatever, you should be in that position. You’ve studied this thing. You’ve seen these scenarios, you know statistically in thousands of people, surely that you should be able to say. ‘Oh, yes, you fall into this category and this is what we need to do for ya”*

It seemed it was important for participants to separate the therapist as a person, from their role as therapist in order to talk about the difficulties they had with them, which are outlined below.

#### Cannot connect with him/her

In some cases participants described being unable to feel connected to their therapist. Participants did not feel either heard or understood by the therapist;

*“You do your bit and then you’re out...so, you don’t get that feeling of someone personally connecting with you that I needed...I don’t know whether other patients feel like that but it’s this almost as though you need this connection with them, this empathy from them that they understand what’s going on for you” Melanie*

*“I mean with hindsight I can say...there’s quite a...mountain of evidence that says she wasn’t listening to me and she hadn’t read what the previous people had said, and that she’d kind of got in her head this idea about how it should be and what she was going to work on, without any kind of erm...a consultation with the patient” Cameron*

In some cases participants felt as though they were unable to connect to the therapist as they were too different from themselves and as such could not relate to them;

*“I did have some therapy with someone...and it wa’ a female and she just looked like she’d just got out of school. Now I found that a bit difficult...”* George

*“so you think now it’s almost, you’d be better if you say, ‘right, these three people are available for your timeslot, who do you think you would best work with?’ and give you that option rather than just say, ‘I’m your counsellor’ cause you can just think, ‘Oh god no’, you know it might be that they’re older than you or a lot younger than you, and you feel like some of the things you want to talk about, they might not understand”* Melanie

It appeared that the qualities that separated the therapist from the participant meant that the participant felt they could not be understood adequately as a result.

#### The therapist with me

This theme encapsulates how the participants experienced the therapist in relation to them. A number of participants felt that the therapist was judging them in some way;

*“there’s sort of the idea when you’re in your counselling session, you are being judged...that what you’re saying is analysed”* Melanie

For some participants, it was felt that the therapist took too much of a passive stance in therapy which was unhelpful;

*“...it...just didn’t help...it were just like this [interview]...it were just talking...me talking and [therapist] occasionally pulling sympathetic faces! Yeah! You know...and not doing nothing”* Peter

*“but the she would just sit there and nod her head at me, and would never interject and you think, “say something”* Melanie

Despite some of the more negative experiences of the therapist, a number of the participants reported positive relationship. For some it was a positive rapport;

*“I think as well ‘cause you’ve got this like rapport with each other, you’ve got this...at ease thing...I felt as though I could, I could and did ask, what was going off...”* George

While for others it was the sense of being cared for;

*“that is something I’d never experienced with any therapist was the, the care. It was almost like a personal, on a personal level you know”* Donna

Participants either felt the therapist was passive and/or judging, or they had a positive experience; in this sample these feelings were mutually exclusive.

### ***What was Therapy Like?***

This group of themes covers the experience of the therapeutic process and contains the majority of the themes.

#### **Ambiguity**

This theme summarises the questions that the process of therapy brought for participants. Once in therapy, some participants were unable to see how therapy would work, sometimes accompanied by a sense of doubt;

*“and after that first session I looked it up and read about it, and...I found it hard to take on...to be honest I didn't think it would work”* George  
*“But it was just; I couldn't see where it was taking me. And I'd had the freedom of speaking and I couldn't think of what could happen more to make what I was going through then...”*  
Christine

*“so you think, ‘where am I going with this?’...is my talking to this person just an hour of rambling that makes me feel better or worse, dependent on what we discuss...and what is the focus of it all; or what is the purpose?”* Melanie

Aspects of the therapy caused the participants to feel confused by the process;

*“it had always been a bit of a problem because I always, I'd never sure whether I'd got the thought diaries right”* Melissa

*“...like it's a really confusing place to be when they're saying ‘we've got to work on our relationship’...and I'm saying ‘well what does that mean?’”* Cameron

There were questions as to how the therapy would work, doubt about whether it could work and a general feeling of uncertainty and confusion.

#### **Indebted**

This theme encompasses factors relating to participants feelings of being in debt or responsible for the use of therapy. Most participants spoke of feeling that they were a burden to the therapist;

*“And just...the feeling that you're not a nuisance, because sometimes, I suppose it's because of the structure of it, in that, you know this poor lady must have loads of people that she sees on every hourly timeslot...and you do get that feeling that sometimes you were an inconvenience”* Melanie

*“probably she got sick of trying to prompt me!”* Peter

*“I felt like it's almost like I didn't want to burden somebody with it”* Donna

Some participants felt they should be grateful for the help they had received, no matter whether it had been of help or not;

*“it's almost like you should be grateful for the fact you've had these sessions”* Donna

*“...and I stuck it out for four sessions, telling myself well this is what you’ve been given, be grateful that you got something...” Cameron*

More than half the participants felt somehow responsible for their inability to get the most from, and use therapy;

*“and I’ve, you know I’ve missed the hint or whatever!” Peter*

Most individuals compared themselves to others receiving help in an unfavourable light;

*“I, still don’t know what the success rate is. It works for some people and it doesn’t for others and perhaps that’s...the way it was for me” George*

*“you know...probably does some people good...I can’t judge everybody on...my sort of...way I am but. Yeah...it just didn’t work” Peter*

*“I know there are other people and it sounds – it’s probably the way loads of people think – but there’s people worse off than me” Donna*

*“And she did say I could go back, but then I thought, ‘there’s somebody far worse than me needing that’ Christine*

Throughout this theme is a sense that the participants are beholden to therapy in some respect and should take responsibility for the end result.

#### Avoidance of core issues

This theme related to how participants felt that their real (or as they were often referred to, ‘deeper’) issues were dealt with in therapy. Most participants felt unable to disclose their deeper concerns in therapy or reveal how they were really feeling;

*“we’d only just started talking about him and I’d never ever been able to you know speak much about him, and I still haven’t you know” Donna*

*“I think because I haven’t got the most deepest things out...so the only thing is I’ve never got everything out” Christine*

*“even when you’re really aware of lying about something like the answer to that question [“are you okay?”]...even if you’ve got in your mind like I want to say no, I’ve had a really shit day erm...I just, can’t do it” Cameron*

*“I could say everything is fantastic and it’s not, the person can only go on what information I give them. And dependent on how ill you feel your...propensity to be truthful is a bit shaded. You can be very guarded” Melanie*

Participants also felt that the issues they wanted to bring were not addressed and they remained unchallenged in therapy;

*“but we only just skimmed the surface I think” Donna*



There is a sense that both participants and therapists somehow avoided the real issues that were difficult to bring to the therapy. All participants spoke about this theme.

### Lost

Some participants felt like the therapy did not provide them with any tangible or concrete help and left them feeling lost. For a number of participants, the lack of structure or direction to the session felt like a key factor in the outcome of therapy;

*“like I’ve said about structure, like I said about checking in for reviews...it’s something that would have been useful every session” Cameron*

*“and then it’s knowing where to start because there’s no structure to the session. I found we would go in; sit down opposite each other and then she would say. ‘and so’ and that was the only line and, ‘so what? Where do you want me to start?’” Melanie*

There was evidence that structure, for those that had it, was something that had been useful;

*“it was really nice to have that kind of structure” Melissa*

Some participants felt that the process of ‘just talking’ was not helpful for them;

*“but I just – to sit in a room talking...it just...I’m always going over things and going through it in my head constantly...so basically it was doing that only out loud...it just wasn’t helping” Peter*

*“I mean, and if I just wanted to talk to somebody, I’d’ve done it to a friend. You know I needed something more than that, so that didn’t work” Donna*

*“I didn’t think it was actually doing anything...because I didn’t really see the point in just how does just talking about stuff was gonna...change anything” Melissa*

Within this theme was a sense that the participants had not received the structure and containment that they felt would have been of use to them.

### Time as a limiting factor

The majority of participants spoke of some awareness of time which negatively impacted on their experience of therapy. The awareness of time for some, limited what the participants were able to do in therapy;

*“I think if it had been longer and, we could have dug a lot deeper then it wouldn’t just be a case of having a painkiller” Donna*

*“...yes, I was shortening things – conscious of time I was shortening things...I was always conscious of that and thinking... ‘I won’t go into that now’, yeah” Christine*

A number of participants felt that because of the time limit on therapy they were aware of time running out;

*“...it’s like a deadline, in’t it?” George*

*“...it’s the ability to have...the time, I can’t emphasise enough, that luxury of having – it’s almost like instead of having a sword hanging over your head at this point if you’ve not talked about it, it’s too late”* Melanie

Or that they had been rushed in therapy because of the number of sessions they had;

*“I felt it was kind of a bit rushed...yeah, you couldn’t really have any more than 20 sessions”* Melissa

The amount of time a participant had for therapy felt like an important theme and came up throughout the interviews for all but one participant who did not mention time as a factor.

### Desperation

Therapy was often seen as a last resort. Participants could feel like there was nothing else available to them;

*“well I’d nowhere else to go, had I? You know that was it. That was all that was available”*  
Peter

*“... ’cause the problem with the NHS ones is you get a set block of ones and then that’s your lot basically”* Chad

It felt that this was the last, or only chance participants had to be able to address their issues;

*“I’m thinking, ‘oh, what am I gonna do?’ and...cause I was thinking, this is like my last chance to sort myself out’...”* Chad

*“...because you do get in this dark place. And I know people say it and that sounds ludicrous; me dark place. But it is a dark place ‘cause you don’t see any way of getting out of it, so your life line is your counselling, like I say, you’ve only that one chance”* Melanie

Due to this sense of this being a last resort and nothing else being available to the participants afterwards, there was an overall sense of desperation that this therapy needed to work.

### Change as difficult

Participants reflected that change felt difficult;

*“nothing’s gonna change ‘cause [therapist] has put in a letter to my GP, you know like a summing up letter, and she says I find it hard to change...I find it difficult to change the way I am”* Peter

*“I mean...yeah after four years you do start to question whether or not...change is possible”* Cameron

*“I did really want it but maybe...because of...the mundanity of it you can kinda like just...plod along, y’know like and just like you’re used to it kind of thing. Change is the hardest thing”* Chad

This recognition came as a result of therapy, rather than something that was known to participants before therapy.

#### Let down

All but one participant felt let down and disappointed by the therapy they had received;

*“...I’d come out and I’d think ‘I’m so disappointed with that’, because I wanted her to be able to say to me something, you know like me husband had”* Melanie

For some there was a sense that participants did not get what they had been promised;

*“...the promise was always for every bit we break down, for every bit we tell you this isn’t working, we’re going to give you something else to, like...so that you, you can cope with the stuff, and that was the point!...but that has never happened”* Cameron

*“I mean how long is it gonna take, I mean, it’s like being drip-fed information”* George

*“...I’m not going to pour my heart and soul out for an hour for you to turn round and say...and she said, ‘oh no’...and she reeled off quite a few qualifications, ‘...I’ll be able to help ya’...so after the third session she said ‘you’re gonna have to see somebody else!*

*Somebody that can go a bit deeper”* Peter

*“And it’s the anti-climax, because it hasn’t happened I’ve still got that kind of tension...”*

Donna

There was also a sense that the therapy was not the right match for what the participant had needed;

*“It’s...the type of therapy which I think didn’t fit...and I just don’t think that I’ll get the right therapy given the circumstances”* Peter

*“It’s being in this moment and being aware of everything in this moment, whereas there needs to be some other therapy to deal with that, you know the past and not just burying it”*

Donna

It seemed that for most participants the therapy had not done what either they had been told it would, or what participants had expected it to do at the outset.

#### Positive aspects

Despite many of the negative experiences described in some of the other categories and an overall sense of not gaining what had been desired, all but two of the participants reported they had been able to take something positive from the process at some point. Some participants were able to talk about specific practical strategies they took away from their therapy experience;

*“I did get a couple of points...yeah, she did, one in particular is: I can’t think on my feet...and [therapist] says if that ever happens, just say, ‘Oh, that’s a good idea. Can I just think about that? I’ll get back to...and, you know I thought that’s a good idea”* Peter

*“I’d improved a lot with the mindfulness and everything else she saw it as – you know, it was a positive thing” Donna*

Although some participants did not feel they had any practical help, they felt they had been able to gain a new perspective on some aspect of their life;

*“I now, in here look at them differently to when I was in therapy. Well what I mean is I put them in a different compartment” Christine*

*“So I guess the only thing that I did take out of then was the fact that I found it easier to actually open up with...a relative stranger and...maybe...learn more...how to end something as well” Chad*

It appears that although participants felt they had not benefitted overall from therapy, there were some aspects they felt they were able to take away in a more positive light.

### ***External Influences***

Here, participants spoke of factors external to the therapy, which had impacted on how they were able to experience the therapy.

#### External life issues

Participants were often able to identify factors outside of therapy that, whilst not the main reason for lack of change, were identified as affecting the outcome to an extent;

*“...we’ve got news reports on the telly. We’ve got...I’m doing homework on the computer and I’m seeing all this stuff going on. There’s all that going on in the background, which is not having a good effect on both me and my wife ‘cause my wife’s ill an’ all” Peter*

*“the thought diaries always seemed to be a bit of a... ‘cause you can’t, you can’t...I think my expectations were not realistic...I think that was partly because I wasn’t sleeping very well”  
Melissa*

When speaking about these issues participants were often clear that they had played some role in the outcome, but were not the only reason that therapy had not worked for them.

#### Wider system difficulties

This theme encapsulated the practical difficulties that all participants experienced regarding therapy such as waiting lists, budget restraints, problematic therapeutic environments and communication between services;

*“I remember seeing an advert in the paper, recruitment for therapists, psychologists and therapists. And I’m thinking well are they just recruiting people and just giving ‘em like a small part of training so they can just do that talk...and like therapy on the cheap. That’s the impression I got...I might be miles wrong with that but that’s what it felt like” Peter*

*“...and they’ve got to make cuts somewhere but it feels from, from my perspective that there’s been a lot of cuts in mental health, you know from when I were last ill, what is available to ya therapist wise and treatment wise was far wider than it is now” Melanie*

*“So then the way the system works it’s almost like you’d have to kind of, you wait forever, you know, you wait for about six months to get into the system to get onto whatever therapy you’re having, say 20 sessions, and then it’s a case of well, you know, you’re alright, your grade scores or whatever have gone right the way down from 100 odd whatever down to 24 so obviously you’ve improved...so after these sessions I don’t think you need anymore, and then six months, a year down the line all of the buried stuff comes back up again, so then you go back into the system, wait another six months, go and have some more therapy which is pretty much the same as the one before, and still don’t deal with everything that’s going on back here and you know, you’re okay, see you later, a year down...you see it’s that cycle, it’s that constant cycle” Donna*

There was a sense that these factors, such as lack of funding, resulted in participants feeling their problems were not valued or seen as important by the system that was put in place to support them.

### ***What I am Left With***

Following therapy participants were able to reflect on how they had felt once they had finished.

#### Unmet expectations

On reflection, over half of the participants thought that their initial expectations of therapy had been too great;

*“Because you know, you think you’ve done therapy and you know – that’s it. But it’s not, is it?” Christine*

*“I feel that my expectations probably were too, too great” Chad*

Some participants thought that they should have recovered because they had undergone therapy;

*“You know, you’ve had your therapy you should be...you know and well you should be better” Donna*

This theme links to the initial expectations that participants spoke of in their interviews.

#### Worse in some way

For over half of the participants, they felt that they were in some way worse off from having therapy. For some, the coping strategies that they had developed had been taken away from them by the process of therapy and as such they were worse off;

*“And it’s almost like relearning how to cope with it again, because it’s almost like my brain’s gone ‘well you knew how to do that sort of thing, and you knew why I was giving you these flashbacks. I’m going to change all that now’, so” Donna*

*“So I’ve got to go away on my own and sort out the problems that I’ve been trying to...deal with for my whole life and in the last four years have been brought to a position of...complete...separation of all the different problems and my ways of coping with them*

*and being told categorically that I am wrong about those things and that my ways of dealing with it are...damaging to me and non-beneficial to anyone around me” Cameron*

For a couple of participants, therapy worsened the symptoms they had been experiencing prior to therapy;

*“it’s made it worse, because like I said it’s kind of buried it more. So it is a lot harder to access, so then when it does happen, it happens with a vengeance, it’s awful” Donna*

*“But like I still get flashbacks now a bit you know so I’ll get like...things have come back more since the counselling than what I remembered before” Christine*

Some participants felt that time had been wasted in session or that they had lost their chance to get the most from therapy;

*“...and she [a friend] said she’d spoke to people in the peer groups, to like older people, who were like mid-30s saying...they really wished they’d sorted it [mental health] out when they were younger...because they’d wasted their time, and that was, I think...yeah, now...in that mid-period I realised...how much has been wasted regardless” Cameron*

*“but it’s, it’s come a bit late...well it ‘asn’t come, but if it ever did come it would be too late for me” Peter*

*“If you don’t get that feeling back from them that they are understanding what you’re saying and that they can help, that’s when you start to feel that you’re wasting your time, or wasting their time” Melanie*

For others there was a sense of regret about the wider impact of therapy, for example for Christine this involved therapy allowing her to share information with her family;

*“Because maybe that’d made me different that I could talk about it, and on reflection I regretted that...I told him a bit about what had happened to me and I wish I never had. I have to live with that now” Christine*

In all these cases there was a sense that it was not just that the participants had not benefitted from therapy, but that something has been made worse as a result of undergoing therapy.

### The future

Participants also had thoughts about their future beyond therapy. Some participants were left questioning what was next for them and trying to understand how they would cope without therapy to support them;

*“Because obviously you’re going to get that 20% where it’s not going to work and they’re the ones that are going to kind of leave going ‘Yeah, that’s great, but what do I do now?’ And that’s, that’s how I feel now” Donna*

*“...and when you’ve not got that anymore and you’ve got used to it, it’s like ‘what now? Where do I go for that support? What do I do now when I don’t have that facility available to me, and...I don’t feel like the problems have been solved?” Melanie*

Half the participants felt that despite the input they had received they still needed more therapy;

*“...I’m...so...strung out and so desperate for somebody to just guide me a little bit, it’s not like I’m not willing to work” Cameron*

*“I’ve been thinking about it for a while anyway, of going to my GP and just saying look I really want some cognitive therapy” Donna*

Indeed two participants were already undergoing further therapy outside the NHS;

*“I’m actually back in...therapy at the moment with someone” Chad*

For these participants there was a sense that the therapy had not been enough and that what they needed was more in order for them to address their difficulties.

#### No lasting positive impact

A key theme in relation to the sample was that the majority of participants felt that there had been no lasting impact on the problems they had gone to therapy with;

*“And it [sigh] it sort of helped to go and talk, I suppose, but it didn’t help me problem...you know it were like a sounding board and I could get things off me chest but it didn’t solve anything” George*

*“...[therapist] kept asking me if I was getting anything out of it...you know say: how do I feel? Do I feel any better? Just feel the same...nothing’s changed. The thoughts are still there you know me thought patterns...you know the way...I treat other people you know. It’s...just the same” Peter*

*“But I still can’t sleep. And I still get the bad dreams, and I still have the flashbacks, and I don’t think I’ve moved any further on those sides of things...” Donna*

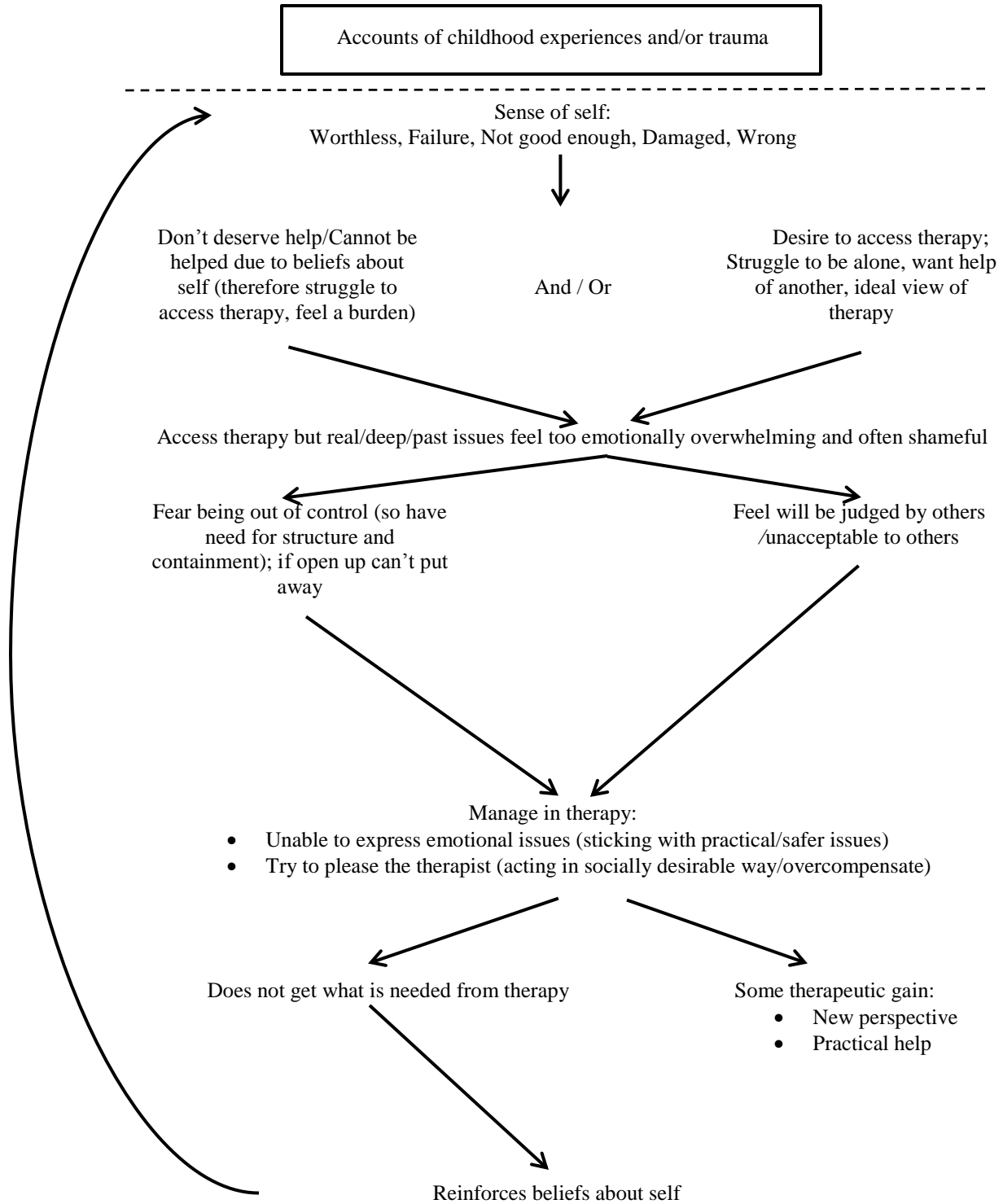
*“But you’re still left with the unresolvedness, I’m still living with it basically” Christine*

*“I was aware past therapies didn’t do anything for me, or very little” Chad*

All participants felt that there had been no lasting impact from the therapy that they had described in the interview for the problems they had gone for help with.

#### *Experience of Therapy Non-Response: A Model*

This section will present the results in the form of a model which aims to make sense of the above interpretations as a process experienced by the participants (Figure 2). This model holds in mind the specific therapy events, but is also informed by the participants’ descriptions of their life experiences, and the other treatments they had received. Although there was some variation in the data (discussed in ‘Divergence’ below) the model appeared to cover more common ground (Table 5) than the initial analysis.



**Figure 2: Experience of Therapy Non-Response: A Model**



**Table 5: Breakdown of Participant's Responses in Relation to the Therapy Experience Model**

Theme	Sub-theme	Participant							
		Cameron	Melissa	Melanie	Chad	Christine	Donna	Peter	George
Childhood experiences and/or trauma		X	X	X	X	X	X	X	X
Sense of self	Worthless	X							
	Failure/at fault	X	X	X		X		X	
	Not good enough (undeserving)	X	X		X	X		X	X
	Damaged						X		
	Wrong	X							
Don't deserve/cannot be helped		X	X	X	X	X		X	X
Desire to access therapy	Cannot be alone	X				X			
	Want help of another	X		X	X	X		X	X
	View of ideal therapy			X		X			
Emotionally overwhelming/shameful	Fear of being out of control	X	X	X	X	X	X		
	Feel judged/unacceptable			X	X				X
Manage in therapy	Unable to express emotional needs	X		X	X	X	X	X	
	Try to please therapist	X	X		X				
Does not get what needs from therapy	Do not get what need from therapy	X	X	X	X	X	X	X	X
	Reinforces self-belief	X	X	X	X			X	X
Therapeutic gains	New perspective	X	X		X	X			
	Practical help		X				X	X	

**Overview**

This model begins by highlighting that all participants mention in some form or another difficult childhood experiences and/or trauma. These experiences cannot be causally linked to the model, but are an important factor to keep in mind when considering the rest of the model.

The model therefore begins with client's negative sense of self. From this participants hold conflicting views of not being deserving of help and being unable to be helped opposed by a view of wanting to access therapy. For these participants, they were able to access therapy however once in it the deep/past issues felt too emotionally overwhelming or shameful; participants feared becoming out of control or being judged by others if they revealed these emotional truths. In order to manage this participants found that they were unable to express these emotional issues or tried to please the therapist. Although most participants were able to speak of something they took from therapy (new perspective,

practical help), they did not get what they needed from therapy. This in turn then reinforced the negative beliefs about themselves, taking participants back to the beginning of the cycle.

I will now present each stage of the model, supported by direct quotes from the participants.

#### Childhood experiences and/or trauma

In describing their experiences of therapy, all the participants spoke about some of the childhood and/or traumatic events that they believed had affected them. In discussing difficult events that happened to him in childhood Cameron reflected that;

*“...you just get used to it, or like me, you think that it’s right for that to happen. Um, because of the way things were when you were very small”*

*“...like my mum used to say, ‘Oh don’t go on about you problems and stuff to people’ ...so I think that’s...just been drummed into me...So I still, I still feel like that about it now...”*

Melissa

*“...it all stems from the life I had as a young three year old till I was 17 and a half. And you...just get on with your life the best way you can”* Christine

For others the connection between childhood experiences and current difficulties was a realisation gained from therapy;

*“So like before, yes, I knew that my parents were quite controlling but I’d not realised that, the extent that their interference, if you like had influenced what I’d done in my life”*

Melanie

*“I honestly didn’t understand why like my behaviour was like it was, what was behind it all. And it’s all childhood stuff...and...the therapies I’ve had since I’d had the chance to ask people what’s behind it”* George

For some participants, they felt that these experiences had affected their experience of therapy;

*“...and the fact that...I hadn’t had a great childhood, and, you know as a teenager as well. So that probably made a difference in what I expected...”* Melissa

In the most part, participants attributed their current state to past experiences and it is therefore an important context to bear in mind over the remainder of the analysis.

#### Sense of self

During the interviews there were indications of how the participants viewed themselves. These were often evident when participants were describing both their experience of therapy, but also their wider situation. These included being worthless, at fault, or a failure of some kind;

*"because the latest lady that I went to she said, 'You would never have felt important enough and you lived with the guilt of thinking everything's your fault.'" Christine*

*"...and I think all this is 'cause of me. All that that I see going on, is down to me and my failings" Peter*

*"...like most things that happen...I don't have any right to question it, like people do what they got to do and...you know if it negatively affects me so be it" Cameron*

One participant spoke of being damaged;

*"But then that 20% they will be the people that there's more, very deep scars running through the, like me, where mindfulness will work for the day to day stuff, but it won't kind of help everything else" Donna*

While others had a sense of being wrong about how they understood the world and themselves;

*"...so by reverting to type and believing that...I was wrong it kind of, I was already set up...in a weird...negative way to go into that [therapy] believing that something could change, because if I was wrong, like I hated myself and thought that I was [parent's name] waiting to happen and that I was necessarily a bad person and that...all I ever did was damage people" Cameron*

During the interviews all participants spoke of holding strongly negative views of themselves in one form or another.

#### Do not deserve care/cannot be helped

Due to the negative beliefs about the self, illustrated above, most participants described feeling like they did not deserve help or could not be helped. This was often alongside a desire to access therapy which is outlined below (*'Desire to access therapy'*).

There was a sense that some participants felt they should help themselves. For example, Melissa stated;

*"... I didn't really believe that anyone else could help, I think...in some ways. So I had to make myself better I had to work really hard at it"*

Cameron described experiences of feeling undeserving of what he received;

*"It's like I'm more inclined to take responsibility and blame myself for things and in light of that feel that I'm not necessarily deserving of the happiness or the care that people might show"*

While Melanie talks of others being more deserving of the time;

*"and then you get a guilt because I'm taking up a slot that could be somebody else's that probably needs it more than I do"*

Participants often felt underserving of the therapy they received.

### Desire to access therapy

As noted, these feeling of being undeserving of therapy or being unable to be helped often co-exist with a desire to access therapy. In contrast to feeling she could not be helped (*‘Do not deserve care/cannot be helped’*) Melissa states:

*“I just didn’t know where else to go or...didn’t feel as though I could be on my own”*

*“it was really nice to have that kind of structure and in a way, and have someone...there to...help you if...you didn’t think things were going well, I guess”*

Similarly, Cameron’s sense of being underserving (above), goes in opposition to a sense of being unable to be on his own;

*“But by the time I’d gone, spent another...year...with [therapist] and I really kinda feel like she should’ve been a lot more focused on getting me to a place where it would’ve, I would’ve been all right on my own”*

Cameron also spoke about feeling as if he needed somebody else to help him make the changes and as such accessed therapy;

*“...and I’m like well if I knew the answer to that I wouldn’t need the help in the first place”*

Alongside this, Cameron held an idealised view of what the therapy might have offered him in terms of solution to his difficulties;

*“...I’ve...stuck with either chasing therapy or being in it or the principle in general as somewhere I might be able to get um, help”*

Melanie similarly summed up the idealisation of therapy;

*“you sort of hope that the counselling will sort things out that it’s gonna be the be-all and end-all; that when you come out of it it’s like, ‘Oh. It’s amazing. I feel better. I’ve sorted this out. I know where I’m going. Know who I am and now I can face the world and get on”*

While Christine captured the sense of seeking care more generally;

*“And not to feel so...desperate for company, for someone to love you. But often that’s what gets you into trouble”*

In summary, participants spoke of often conflicting views between wanting to access therapy and receive help and support whilst also reporting a sense that they do not deserve this help or are beyond being helped. These beliefs are returned to later in the cycle when participants reflect on the impact of therapy on their sense of self (see *‘Reinforces belief about self’*).

Emotionally overwhelming and/or shameful

Despite the conflict between seeking therapy and beliefs about not deserving or being able to be helped by therapy, all the participants had accessed therapy – often through the recommendation of another;

*“...so with the help of...the girlfriend at the time, she kind of said...you can get help and you need help and that was that...I...can say almost that you know I wouldn't have sought out...something like therapy if I was on my own...”* Cameron

However, in accessing therapy the real issues that caused the distress then felt emotionally overwhelming and participants describe attempting to avoid the emotion;

*“you start talking, a lot of emotion comes up when you're fighting to keep it down”*  
Christine

For some they described this as being related to feelings of shame;

*“and sometimes when you do say it, you feel ashamed of saying what you're saying but it's how you feel”* Melanie

*“I mean, so I've lived with all of that as a terrible guilt thing. I think I'm being weighed down with guilt and shame”* Christine

Due to the overwhelming nature of the issues, to discuss them would have caused the participant to feel out of control; were they to 'open up' these issues they would be too hard to put away;

*“...because my brain has never been able to do that, it's either been completely shut off because of the trauma...and when it's been switched on it's kind of like open the flood gate and there it goes. It's never been, been able to let it slowly come out. So I can deal with a little bit at a time. And that's what was happening with the therapy – I was just dealing with the tiny...but it's the rest of it still behind the dam”* Donna

*“But then there's always that danger at back of your mind that you'll slip backwards and sometimes with your therapy you do feel like that's happening because it does open up a can of worms and sometimes it's a good thing and sometimes it's not such a good thing, you know especially with like some of the subjects...and that it can touch a nerve, and you think I'm not comfortable with this”* Melanie

For Melanie, along with others, this was often attributed to the time limits put on therapy;

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

In response to this participants described a desire for structure and practical help, which may be understood as gaining a sense of containment in order to not feel out of control;

*“Personally, structure is, really important I...that was part of...the reason why the people...who I’ve worked well with have been good is...there’s such a limited amount of time when you go into a session with someone it’s so good for them to say, right...this is, what we’re looking at today” Cameron*

*“probably it being structured a bit...better and kind of...being more kind of...giving me more opportunity to talk about the stuff that...I feel at ease about” Chad*

Structure and practical help also featured in what participants were able to take out of therapy despite it being unhelpful (see ‘*Therapeutic gains*’).

Additionally, if the participant were to disclose what they perceived as shameful issues, there was a feeling of inevitable judgement from the therapist (and more widely, those around them) and that what they have experienced or needed to say about their experiences was somehow unacceptable to others;

*‘I think you don’t want to be totally honest because you don’t want someone else knowing what’s going on in your head because you feel like it’s strange’ Melanie*

*“I thought he’d be going to the pub with his mates going, ‘God, I’ve got a right one in the...shrink’s room here!’ So, I just thought I couldn’t really work with him even though he seemed a really nice chap” Chad*

Chad then reflected that in his current therapy, which he was feeling more positive about, he had been able to let some of this feeling go;

*“you don’t bother anymore about hiding stuff. And you think, ‘actually, I’m just gonna talk now.’ You don’t get as anxious about what the other person’s thinking, which I’ve got a big thing about that as well about how people seem, if I’m. . . my emotions and how...sensitivity and stuff”*

Again, all but one participant spoke explicitly of the emotionally overwhelming and shameful nature of the therapy experience.

#### Managing Therapy

In response to these perceived threats above, participants found a number of ways of being in therapy that can be understood as being a way to manage these feelings of potentially being emotionally overwhelmed, shamed and judged.

In most cases participants felt unable to express their needs and emotional issues. For some participants they were aware of actively avoiding their issues or emotional content;

*“It was more just going in mask, masking myself over the real issues...and just talking about stuff that I wasn’t passionate about...I’d only ever skirt what I wanted to talk about but then go into more safe stuff” Chad*

*“I mean I remember the first session I just, I didn’t really want to talk a lot about what had happened. I wanted to kind of...try and think about what was happening in the present and try and change that. So I only spent about five or ten minutes talking about what had happened at home in the past and all that kind of thing, ‘cause I thought just don’t want to dwell on that”* Melissa

Peter reinforces this idea by commenting on how he might feel should he undertake a therapy that he felt forced him to address emotional issues;

*“one [therapy] that forces me to dig deep...I’d be worried about doing a runner then! [chuckles] you know if somebody really forced to...you know like into a corner, I don’t know how I’d react to that...”*

Other participants described feeling as if there are certain things that they were unable to say;

*“...but the main thing for me was to get my story out. So I could perhaps, in my mind I thought if I could get all of my story out it would be lesser on me, that’s what I thought. But I didn’t get it all out, because there’s some things you can’t say, ever”* Christine

For some there was more a feeling of the therapy not being the right space to be able to disclose these issues. There was a sense in both cases that practical help (away from emotional issues) was more useful, both within the current therapy and when reflecting on more helpful therapy experiences;

*“...looking at a day at a time...what things you can do during the day and having some fun bits and having some bits where you kind of try and achieve some goals, that kind of thing...so that was quite good”* Melissa

Donna was also able to speak about a time in a previous therapy in which she had found being able to share difficult emotional content, a beneficial experience;

*“there was one time I told him [therapist]...the first time I’d said it, I couldn’t breathe because I’d said it...it had always been in my head...it was a release for me to be able to actually get that word out and get all those horrible things out”*

In addition to this, but to a lesser extent, there was a sense of wanting to please the therapist, in order to not be judged;

*“I don’t think there was much direction, to be honest. But again I can’t really blame it on her ‘cause it was, it was probably more me but, again it was probably me turning up and just trying to please her and then, but then going away and being frustrated with myself ‘cause it was another session gone”* Chad

What is clear is that most participants found some way of managing these emotionally overwhelming experiences in the therapy situation. For the most part this appears to have involved avoiding these issues in one way or another.

Participant does not get what he/she needs from therapy

Due to the perceived inability of the therapy to provide a space in which the participant felt able to discuss their 'deepest' issues, most participants did not get what they felt they needed from the therapy;

*"I'm dealing with stress levels on a daily level a lot better than I used to. But I still can't sleep. And I still get the bad dreams, and I still have flashbacks, and I don't think I've moved any further on those side of things"* Donna

*"[therapist] kept asking me if I was getting anything out of it, you know say: how do I feel? Do I feel any better; just feel the same, nothing's changed. The thoughts are still there, you know me thought patterns . . . you know the way...I'd treat other people, you know. It's, just the same"* Peter

*"I began to think, well how's this gonna work seeing my life flash before my eyes. It works for some people, I suppose. It just didn't work for me"* George

*"Because I don't think I'd have been, I mean I talk better now about it, than I did before I had therapy. But you're still left with the unresolvedness, I'm still living with it basically"*  
Christine

Their needs remained unmet and for some they felt reinforced their sense of self;

*"...it's just the fact that...I've taken this kind of...risky set of steps in trying to fix something...and I really feel that it's only, I've only been convinced that it's very definitely broken"* Cameron

For some this led to a sense that they could not be helped by therapy (I'm too damaged);

*"I don't know whether I am, or whether I can be cured, you know let's say cured, I don't know whether I can be helped"* Peter  
*"...and I'm questioning all the time up until that point of being well...you know it's bad, and this is being stretched out over a long time and maybe...they can't do anything...does that mean I'm beyond help?"* Cameron

Some participants felt that they were responsible in some way for the failure of therapy;

*"...so I'd kinda got to this point where I thought that the CB...I'd kinda failed on kind of doing this CBT, which it had, it had always been a bit of a problem because I always, I'd never sure whether I'd got the thought diaries right. I got a bit obsessed with that, with...whether I was good enough or whether I was doing things right"* Melissa

*"There is a feeling of disappointment and failure 'cause it's not working um, but again it was more this overwhelming feeling that I'd got it wrong, something I'd done hadn't worked"* Melanie

*"...and I guess I just felt a bit...just like I've lost all steam and...I think...the other part of it is, yeah just me kind of thinking well it's my fault and that I should...try harder and learn something from it"* Cameron

For others this let them further into the cycle of seeking care;



*“...because I believe there’s something to be got from it, even though I kinda felt a bit worse after the last set, if anything, surely that’s a bit more reason to give me help this time because I’m still willing to work” Cameron*

*“So you were back in that situation again...and in need of this counselling and guidance”  
Melanie*

All participants reported not getting what felt they needed from therapy. For some this led them to seek more therapy, whilst others had stopped.

#### Therapeutic gains

Despite participants feeling they did not make the changes they expected, most were able to reflect on something gained from therapy. For some this was the practical aspects that they had been able to connect with over the emotional content;

*“I did get a couple of points, yeah, she did, one in particular is: I can’t think on me feet...and [therapist] says if ever that happens, just say, ‘Oh, that’s a good idea. Can I just think about that? I’ll get back to ya’, and, you know I thought that’s a good idea” Peter*

*“like I say, mindfulness is great for the day to day stuff – for the grounding me in the here and now, and just focusing on that and getting on with it so to speak” Donna*

For others it was a new acceptance or perspective on their difficulties and the role of how therapy may or may not be able to help with these;

*“I think if anything she kind of, one of the very few useful things that she did say...and I say it’s useful, it’s a flag that I don’t really understand because I’ve always thought of it in another way...so the only, like one of the things [therapist] really did was to say that, anger was possibly constructive” Cameron*

*“something that I can learn to do now for definite but yeah, back then...it was just that whole new experience and learning curve for me. So I guess the only thing that I did take out of then was the fact that I found it easier to actually open up with . . . a relative stranger and . . . learn more...how to end something as well” Chad*

*“I mean at home I’ve got two big A4 pads, not when I wasn’t in, just all my scribbles and poems, I’ve got two A4 pads of how I actually felt at them times. And I don’t feel like that now. I stopped picking the pad up and writing for England, dya know what I mean. So in that respect, that was good because I didn’t feel the need to do that as much. And even now, when I get down now, I’m able to think about it in a different way in my head.” Christine*

All but two participants were able to comment on some therapeutic gain that was made in therapy, in addition to feeling they had not gained what they had needed from the therapy.

## *Divergence*

Despite the above convergent experiences of the participants, it is important to highlight some of the differences between the experiences. For example, Cameron describes a difficult relationship with his therapist, which clearly affected his experience of therapy;

*“I mean with hindsight I can say...there’s quite a...mountain of evidence that says she wasn’t listening to me and she hadn’t...read what the previous people had said, and that she’d...got in her head this idea about how it [therapy] should be and what she was going to work on, without any kind of...consultation with the patient”*

This does not appear to be a theme for any of the other participants; other participants held the therapist in high regard and tended not to blame the therapist;

*“She [therapist] was so clam even when she was having bad days you could never really tell because she was so calm with you and, she was lovely. Even the way she spoke to you, even if she was a bit, not upset with you, but upset by something you’d said, because it upset her, it wasn’t kind of judging you” Donna*

The participants described different outcomes from the therapy. For some there had simply been no change;

*“I felt that at the time we weren’t particularly making any progress that I would say ‘I desperately need to keep going ‘cause it’s doing me some good” Melanie*

*“I needed help in showing me how to change and showing me...and sat in a room talking didn’t give me that” Peter*

*“I just felt as though it wasn’t...working for me” George*

For others there was a sense of reaching a point of acceptance that things were as they were;

*“I think there’s no such thing as an ideal world. And I’ve got to the now, the fact that yes I have talked about it but there’s no quick fix, and there’s, the benefits must be just being able to talk” Christine*

Some participants felt that they were, in the most part, worse off from therapy (despite in all cases being able to describe something positive that they had taken from the therapy);

*“Through no fault, it’s made it worse, because like I said it’s kind of buried it more. So it’s a lot harder to access, so then when it does happen, it happens with a vengeance, it’s awful. And it’s almost relearning how to cope again” Donna*

*“I think what hurts worse is the fact that...just the little bit of light in the dark is, is enough to give you hope and then, when time runs out...and you’re crashing and burning...”  
Cameron*

It is of note that Donna’s sense of self seems to be a feeling of being damaged, rather than being a failure or worthless as is the case with the other participants. She also does not appear to experience any of the conflict that the other participants experience (to a

greater or lesser extent) between not deserving help and seeking therapy. Although this does not affect the fact that she does not get what she needs from therapy, it would appear that her negative sense of self is not reinforced by this therapy experience.

Despite some of these minor differences in the accounts, for the most part, participants' stories appear to fit with the proposed model (Table 5).

### **Reflexivity**

I was looking forward to completing the interviews, in part due to the long process that had led up to this point, but also to hear what participants had to say regarding their non-response to therapy. As a psychologist it felt like a privileged position to be in to be hearing about 'the other side', the client's experience which, no matter how strong the therapeutic alliance, can remain elusive in therapy. At points during the interview I had to remind myself I was in a researcher role as opposed to the therapist role; participants often discussed details of what had taken them to therapy and I had to stop myself from being drawn in to giving what might be considered more therapeutic responses, whilst remaining empathic. I was surprised at how much participants appeared to give in the interview and how open they were able to be.

Throughout the interviews I had to attempt to hold judgement on how I might have experienced each particular participant in therapy, had I been their therapist. I was constantly fluctuating between this role and genuine empathy with the participant's experience. As some of the participants had negative experiences of therapy and their therapist, it was important for me to hold in mind that this was the participant's experience of the situation and the therapist's view may or may not complement this. At points I felt empathy for the participant, at other moments my empathy was with the therapist.

Although I was aware that these interviews had the potential to be distressing for participants, this was really brought home to me in participants' expression of ambivalence in attending the appointment, often telling me that they had nearly backed out, or called to cancel. However, having completed the interviews participants generally reported that they were pleased they had been able to attend and I felt grateful for the time and effort participants had taken.

## CHAPTER FOUR: DISCUSSION

Although the current evidence base suggests that a significant number of people improve from therapy (The Centre for Economic Performance's Mental Health Policy Group, 2012), alongside a minority who are significantly worse off (Lambert & Ogles, 2004), it is also apparent that a large number of people can be classified as 'not responding' to psychological therapy (Hansen et al., 2002). Conceptual and methodological difficulties in defining and measuring non-response have been discussed previously. Despite these difficulties it is clear that this is an under represented group in the literature. The aims of this research were therefore to examine:

- How do participants who feel they have not responded to psychological therapy experience, and make sense of their therapy and their relationship with the therapist?
- Do participants have views regarding why they did not benefit from therapy?
  - How has this experience affected their view of therapy and whether they would engage in therapy again
  - What do they think has contributed to this non-response?
  - What do they think would have helped them to get more from therapy?

This chapter will attempt to answer these questions, relating them to the results above, and discussing them in the context of the literature outlined in the introduction, in addition to further literature that allows us to make sense of the findings. I will then consider these in terms of their clinical implications and finally, I will outline the limitations of the study and future research directions.

### **Summary of Results**

In summary, the analysis (Figure 1) highlighted four important issues that the themes could be mapped on to; 'what I expected', 'how I found my therapist', 'what was therapy like?' and 'external influences'. Participants also spoke of an additional theme which was encapsulated by the title 'what I am left with' following therapy.

It became clear from the interviews that participants often had high expectations of what therapy could offer and that these expectations were often unmet. There were three patterns of experience of the therapist; either as a positive figure, or participants felt that

they were judged or not understood, or that the therapist had taken too much of a passive role. In order to be able to talk about the therapist, participants often separated the therapist as a person, from the therapist in their role.

With regards to their experience of therapy, although most participants were able to talk about something they had gained, most were not satisfied and none had got what they wanted from therapy; participants had spoken of wanting a cure, answers or the opportunity to tell their story (*'what I expected'*). Some had found the process confusing and felt lost due to a lack of structure. Others had felt indebted to the process and in particular that they should be grateful for what they had got. There was often a sense that the real issues that had taken them to therapy were avoided and that time had limited the amount that could be said. There was an overall view that change was hard and a sense of desperation that this was all that was available to them so they should make the most of it. In the end, participants often felt disappointed and let down. In addition to the factors within therapy, there was also recognition that external factors within the person's life, as well as problems with the wider system, had impacted on the participants' experience of therapy.

Finally, participants spoke of what they were left with following the process. As stated, many felt their expectations for therapy had been too high, a number felt they were in a worse place than when they had started and participants often had questions about their future beyond therapy. Additionally, there was the finding that none of the participants felt that there had been any lasting positive impact from their therapy with regards to the problems for which they had initially sought help.

The themes and concepts from the analysis were brought together into a process model (Figure 2). All participants spoke of difficult or traumatic childhood or later life experiences to which they often attributed their difficulties. Although these cannot be implicated directly in the model, as it was a key feature for all participants, it was important to retain as contextual information.

The model therefore began with the participants' negative sense of self. Although this differed between participants, all spoke at some point in the interview about negative self-beliefs which were often attributed to their childhood or trauma experiences previously mentioned. Participants also discussed a sense of either not deserving therapy or not feeling they were able to be helped by therapy. This was, for most participants, in conflict with the desire to access therapy, and often high expectations of what therapy could offer.

Once in therapy, participants spoke of finding the content of what they wanted to bring too emotionally overwhelming or shameful and were unable to do so as they felt they

would be judged or that to bring the issues would feel too out of control. As a result, participants managed therapy primarily through avoidance of these issues and to a lesser extent by attempting to please the therapist. Although overall most participants could speak of something they had taken from therapy, in the most part they did not get what they had wanted. For some this reinforced their negative sense of self. Participants either sought further therapy or concluded that they had got from therapy all it had to offer and were not able to be helped further by the process.

I will now attempt to use these results, along with the literature outlined in the introduction, to answer the research aims set out by this study.

### **How do Participants Experience Non-Response to Therapy and their Relationship with the Therapist?**

The findings relating to the first research question can be understood primarily through the four key areas of the ‘experience of therapy’ analysis (Figure 1); client expectations (what I expected), therapist factors (how I found my therapist), therapy specific experiences (what was therapy like?) and external factors (external influences). I will begin this section by addressing client expectations, therapy specific factors and external factors and conclude with therapist factors as this addresses the final part of this research question regarding the relationship with the therapist.

#### *Client Expectations*

The primary theme which seems important here is that participants described recognising that their hopes for therapy were too high. As a result, participants found that therapy was unable to meet these expectations and they felt let down and disappointed because of this.

Expectations have been dubbed the “ignored common factor” in psychotherapy (Weinberger & Eig, 1999, p.357). Lambert (1992) estimates that client expectations contribute to 15% of variance on outcome, and others hypothesise it may in fact be higher than this (Greenberg, Constantino, & Bruce, 2006). If we return to the concept of Client Theory of Change (CTC; Robinson, 2009) we are reminded that clients will have an informal theory of how change may come about. In addition, social psychology has taught us that what we perceive is often governed by what we think we ought to see (Greenberg et al., 2006). It is therefore unsurprising that if clients have high expectations of therapy, which cannot be met, this will affect outcomes.

Here, it is important not to lose the conceptual difference between expectation and preference. It is likely to be the case that if clients have an ideal view of what therapy entails this may encompass in some form or another their preferences for what therapy will involve. This would fit with the ‘matching hypothesis’ which supports the idea that certain clients do better in certain modes of treatment (Nilsson et al., 2007).

Indeed, evidence from Nilsson et al. (2007) would appear to support this perspective. As outlined previously, they examined both satisfied and dissatisfied client experiences of CBT and PDT. They proposed that the narratives of the disappointed clients in both groups supported the notion of the matching hypothesis i.e. dissatisfied clients felt dissatisfied with the specific therapeutic approach and felt it was this which had hindered their therapeutic progress (Nilsson et al., 2007). Furthermore, clients had differing views about how change would come about. Often clients were satisfied when their view was matched with the therapy they received. Nilsson et al. highlight that it is important to bear in mind that as these are retrospective accounts, an alternative explanation may be that the client had understood and learnt the principles and was reflecting on these retrospectively, rather than a pre-existing preference or expectation of therapy. It should also be noted that clients may have been given the therapy they would have preferred but it still failed to meet their expectations, so while the clients’ accounts suggest this, this is an account and the findings must be taken as such. This attribution may, or may not, be accurate in terms of causality. Additionally, Lorentzen et al. (2011) specifically studied non-response in group therapy and found that 50% of non-responders would have preferred individual, as opposed to group psychotherapy, and as such hypothesise that it is likely treatment preference also played a role in non-response, which further supports these findings.

### *Therapy Specific Experiences*

A number of factors which arose within this theme had previously been found to relate to dissatisfying therapy experiences in the Nilsson et al. (2007) study outlined in the introduction. Their participants reported that the ending was too abrupt, that a more thorough and deeper therapy would have been more beneficial and a sense that a different kind of therapy would have been more helpful. In addition, Nilsson et al., found that a common theme for satisfied patients (across CBT and PDT) was that they reported that enough structure had been created within sessions for constructive work to be done. This was something that participants in the current study consistently reported was lacking. Beyond this, Nilsson et al., also found differences in dissatisfaction between participants

dependent on the type of therapy received. For their participants, although both felt insufficient change had been achieved, CBT clients felt disappointed at the results, whilst PDT clients had more of an ambivalent response.

Although we know something of some of the therapies participants in this current study had, and could infer others from what had been said, participants were often unable to articulate what type of therapy they had undertaken, or were not told. As such it is difficult from the current study to say what, if any effects, specific therapies had on the experience of different participants. It is also important to highlight again that the Nilsson et al. research is focused on satisfactory and unsatisfactory therapy experiences as opposed to non-response as in this case.

However, parallels can be drawn between the themes found by Nilsson et al. and the themes in the current study. For example, time as a limiting factor, avoidance of core issues and therapy not fitting the needs of the client, could be seen as similar to the Nilsson et al. findings that participants report endings were too abrupt, deeper therapy would have been beneficial and different therapy would have been more helpful.

#### *External Factors*

We know factors external to the therapy can impact on therapeutic outcomes, (for example, Whipple et al. (2003) found that lack of adequate support networks outside of therapy was a predictor of poor outcome). Participants in this research spoke of feeling undervalued by the wider mental health system and being affected by other life issues such as lack of sleep, work constraints, welfare reforms or moving house. However, participants also noted that although these factors impacted, they were not perceived as the key reason for therapy producing no change.

#### *Therapist Factors*

In terms of the first analysis, three main themes arose in relation to the therapist; 'who is the therapist?', 'inability to connect with the therapist' and the experience of the therapist with the participant; 'the therapist with me'.

The first theme captures the participants' separation of the therapist as a person from them as a therapist. This may be understood in terms of the participants wishing to distance any negative comments from the actual person and attribute them to the role of a therapist more generally.



Participants also felt unable to connect with the therapist. For some this was about feeling like the therapist was too different, such as too young, while others did not feel heard or understood by the therapist. Some participants had a generally positive experience of the therapist, while others felt judged. Additionally, other participants found the therapist passive, again relating to the idea that this was ‘just talking’ and emotional issues remained unaddressed.

As discussed in the introduction, around 30% of variance in final outcomes in therapy is thought to be attributable to the therapeutic relationship (Hubble et al., 1999). Factors such as quality of client therapist alliance, therapist empathy, congruence and positive regard can contribute to a positive outcome (Norcross, 2002), while lack of empathy and distance are causes of deterioration in therapy (Castonguay et al., 2010). Whipple et al. (2003) found that early dissatisfaction with the therapeutic relationship was one of the factors associated with poor outcome that could be used to predict deterioration in clients in therapy. These ideas could be seen to capture some of the difficulties participants described in this theme. It is therefore feasible to propose that if most participants did not feel they had a positive relationship with their therapist, either through not being heard or understood, feeling judged or feeling unchallenged, this contributed to the outcome of therapy.

There may be a point to note here with regards to the research that finds that therapists have limited ability in predicting negative outcomes in therapy (Hannan et al., 2005). Although we cannot make any claims without the therapist’s perspective, it may be that therapists were unaware that their role was perceived negatively by their clients and as such took no corrective action; alternatively, this may be a retrospective dislike from the participants. Whilst this understanding remains hypothetical in nature at this point, it may be a useful avenue to pursue in future research.

### **Participants Views Regarding Non-Response to Therapy**

There are a number of aspects to this question in terms of the research aims, which will be addressed one at a time.

*How has this affected participants’ view of therapy?*

Participants’ views of future therapy are outlined in the pen portraits, which I will summarise here.

Of the eight participants, two had accessed further therapy with voluntary/private sector organisations at the time of interview; one participant was paying for therapy and there was no specified limit on the number of sessions available, the second participant was with a voluntary sector organisation who could offer up to two years of therapy. Two of the participants were attempting to access further individual therapy through the NHS.

The remaining four participants did not wish to access further therapy, one stating they did not feel they needed it currently, another questioned whether they could be helped by therapy, a third thought therapy had given them as much as it was able to and the final participant had found the process too stressful to want to undertake any further therapy. In summary, half the participants continued to seek care, while the remaining participants felt there was nothing more to be gained from therapy at the time of being interviewed.

*What do participants think has contributed to their non-response?*

From the analysis participants described a number of factors which they believed had contributed to the non-response. As stated, these can be related to the four themes of client expectations, therapy, therapist and external factors.

The primary themes key to this have been covered above; high (and often eventually unrealistic) expectations, therapy not matching these expectations, a poor therapeutic relationship and a lack of structure. In addition, for most participants, their sense of time had limited how they felt they could use therapy, in that there was not enough for them to be able to bring the issues they needed. It was also clear from the model that emotional issues felt too overwhelming or shameful to deal with within the confines of that particular therapy experience and so were for the most part, avoided. This finding may suggest that counter to an argument which may propose that these people were not able to use therapy, it appears that they knew what needed to be faced, but were unable to do so in this particular therapy at this time. This allows us to wonder whether they may have been able to use a different therapy, with other features, perhaps at a different point in their lives.

*What do participants think would help them gain from therapy?*

In line with the discussion above, participants spoke explicitly of more time and structure as the primary factors that would have improved their experience. Some participants had also wanted the therapist to take a more active role in challenging them. From the participant's perspective, a more challenging approach may have had a beneficial

outcome. While this may have implications for the matching hypothesis it is not possible to say from the current findings.

### **Psychological Implications and Literature**

Although many of the findings, particularly in relation to the four factors (client expectations, therapist, therapy and external factors) can be understood in the context of the literature outlined in the introduction, other findings seemed to link with different literature. With this in mind I will now consider further areas of the literature, which were not initially highlighted in the introduction, but that appear important to discuss in relation to the findings.

The theories outlined below appeared to be the most pertinent to the current study. It is at this point acknowledged that reflexivity and personal interest may well have shaped the direction of the review of the remaining literature. However, due to the wide range of narratives that could have been considered, decisions had to be made regarding what to include, based on what I, the researcher, thought were the most distinct findings in the participant accounts and eventual model.

#### *Attachment Theory*

All participants spoke of difficult childhood experiences and/or trauma and some of neglectful and abusive childhoods. As noted, participants often attributed their difficulties to these experiences, although these attributions do not necessarily reflect causal relationships. As childhood experiences were not a focal point of the interviews, there are insufficient details to make any definitive links. However, given the details that clients provided and the patterns of responding to therapy highlighted by the model, it could be argued that an insecure attachment style may be a factor to consider when reviewing the literature in relation to non-response to therapy.

Attachment theory posits that our experience of our early relationships with our primary caregiver forms our internal working models of relationships which we come to rely on when making judgements and expectations about relationships in the future (e.g. Bowlby, 1969; Jellema, 2002). Dependent on this experience we form secure or insecure attachments. Secure attachment occurs when a child has a mental representation of an attachment figure who is available and responsive to their needs. Infants are considered insecurely attached when they have been unable to form such a representation due to inconsistent or neglectful care giving (Cassidy & Shaver, 1999). Evidence suggests that those with insecure patterns,

will be uncertain of their own self-worth (Wearden, Peters, Berry, Barrowclough, & Liversidge, 2008). Additionally, there is some evidence that adult trauma may lead to an insecure pattern of attachment (Besser, Neria, & Haynes, 2009).

Daniel (2006) noted that attachment patterns are also likely to affect help seeking behavior, in this case accessing and using therapy. Those with anxious attachment styles, (preoccupied adult attachment) have had to respond to inconsistent care in childhood by becoming vigilant, fearful of abandonment and displaying 'clingy' behaviour when anxious or distressed. This continues to an extent, into adulthood. Equally, those with dismissing adult attachment patterns (equivalent to avoidant childhood attachment) have received over-intrusive or unresponsive care as a child and as a result have issues trusting that others can be available to them and so become overly self-dependent (Wearden et al., 2008). This is supported by further evidence which found that an avoidant attachment style often resulted in individuals denying their need for help. This can be understood as a means by which to protect themselves from a potentially unavailable caregiver. Those with a preoccupied style on the other hand, came across as needy and dependent, but were found to be no more treatment compliant than the avoidant attachment group (Dozier, 1990).

Research suggests that secure attachment results in greater treatment compliance, more self-disclosure and less rejection of the treatment provider (Dozier, 1990). Additionally, in a review of the attachment literature Daniel (2006) found most studies reported secure attachment to be more strongly associated with a good therapeutic alliance than insecure attachment.

It is also worth noting that studies suggest a connection between psychological difficulties and insecure attachment patterns (Daniel, 2006). It is therefore likely that the majority of individuals that come to therapy are those with insecure attachment patterns and according to the research, are therefore more likely to struggle with treatment and the therapeutic relationship. As we are aware, 30% of variance in therapeutic outcomes is attributable to the therapeutic alliance (Hubble et al., 1999). If the majority of clients have insecure attachments this makes forming a therapeutic alliance difficult (Daniel, 2006), which has implications for therapeutic outcomes.

### *Emotional Disclosure*

Another of the key findings not outlined in the introduction, was that once in therapy participants had avoided dealing with emotionally overwhelming and shameful content which they felt was hard to articulate. For some this manifested in a sense that it

would make them feel too out of control to open up these issues, and this often linked to a desire for structure, agendas, reviews and goals to contain these issues. To a lesser extent, participants felt that they might be judged and what they had to say would be unacceptable to the therapist. Both of these beliefs made it difficult for the participants to be able to use therapy.

Evidence suggests that expression of negative emotions can be helpful in that it allows some resolution i.e. in therapy expression is thought to allow clients to process their emotional experiences (Kennedy-Moore & Watson, 2001). It is also suggested that those who actively avoid emotional expression are less psychologically healthy. This was found to be particularly true in cases of trauma, where expression of trauma related feelings was related to increased psychological well-being (including improved self-reported health, as well as improved immune responses; Kennedy-Moore & Watson, 2001). Moreover, written expression of trauma-related emotions was found to create 23% improvement, similar to that of other psychological techniques (Smyth, 1998). In this model, Pennebaker (1997) proposes that the act of disclosure is a powerful therapeutic agent which is part of the healing process in therapy and advises that this can be done through the ‘written emotional disclosure paradigm’ which involves individuals writing about traumatic experiences. This paradigm has received further support for disclosure with meta-analyses finding positive and significant health and psychological consequences (e.g. Frattaroli, 2006).

In addition, clients who disclose traumatic events reported that “*the disclosure process initially generates shame and anticipatory anxiety but ultimately engenders feelings of safety, pride, and authenticity*” (Farber, Berano, & Capobianco, 2004, p.340). Furthermore, Farber et al. (2004) in their study of clients’ perceptions of the process of self-disclosure in psychotherapy found that work was inhibited when information was kept from the therapist. In contrast, disclosure was found to provide relief in terms of both physical and emotional tension and as such, therapists should actively encourage information that is difficult to disclose. Farber et al. also found that when information was disclosed in therapy, this facilitated further disclosures not only to the therapist, but also to family and friends. This was indeed the case for Christine in this study, although for her this was not a positive experience. Instead it left her with a sense of regret and a breakdown of the relationship with the family member to whom she disclosed. This is an important implication when considering the wider consequences of disclosure.

It may be that participants’ difficulty in expressing their problems was a contributing factor to their non-response. Additionally, although only a single case example,

Donna spoke of a positive experience of being able to recount trauma related experiences which, as noted in the model, provided further evidence for this conclusion. In a review of the client self-disclosure literature, Farber (2003) reported that clients have an acute fear that emotional disclosure will become overwhelming as painful memories will “*flood the system*” (Farber, 2003, p.590). Furthermore, Farber (2003) echoes the conflict we see earlier in this model; “*there is an exquisite ambiguity in patients regarding highly charged disclosures: They both want their therapist to know and desperately want to protect themselves from shame and scrutiny*” (p.590). It is this shame which therefore often inhibits the disclosure of negative emotions (Farber, 2003), which would fit with the proposed model generated from the study sample, that there is a link between non-disclosure and no improvement.

In addition, Stiles (1995) argues the ‘fever model’ of psychotherapy disclosure, in which disclosure in therapy is both a signal of illness and recovery. Stiles asserts that clients who are more distressed disclose more; however, these are also the clients who have worse outcomes on average. Therefore disclosure may not be a sign of absolute recovery but rather a move towards improved well being.

Despite the majority of the evidence pointing towards disclosure as a positive therapeutic process, there is some contradictory evidence regarding disclosure in psychotherapy. For example, Kearns, Edwards, Calhoun, & Gidycz (2010) asked female victims of sexual assault to write about either their sexual assault, or how they spent their time (control group), in line with the written emotional disclosure paradigm (Pennebaker, 1997). Although the group who had described their experience reported lower negative mood initially after the experiment, at follow up there was no significant difference between the two groups. It is worth noting that although the group wrote about their experiences, they did not disclose them to another person which may be one potential explanation for the lack of findings in this case.

Inevitably, participants in this study found ways to manage the therapy in relation to this fear of overwhelming affect and sometimes shameful feelings. In the most part these feelings were not expressed or brought to therapy and as such remained unaddressed. Participants stayed with safer subjects or more practical aspects of the therapy as a way to avoid difficult subjects, perhaps linking to the data that some participants took away some practical advice from therapy.

### *Length of Therapy*

Clients often also spoke of feeling that there was not enough time to open the ‘can of worms’. Farber (2003) reports that length of time in therapy (along with therapeutic alliance) was a predictor of disclosure, the impact of which is outlined above. It seems likely that the longer a client has to build a trusting and containing relationship with a therapist, the greater the opportunity to disclose. Farber (2003) also found that one of the facets least likely to be disclosed were those which involved personal failure. As has been hypothesised in the process, at least some of the participants had a belief of ‘self as failure’, it would follow that they therefore struggled to disclose feelings around this.

Seligman (1995) in his evaluation of the Consumer Report data in America, found that longer therapy produced more improvement than shorter term therapy, with overall ratings of improvement found to be a function of length of treatment. In addition, Seligman (1995) reported that clients who were limited in the duration of the therapy (for example, due to insurance coverage) reported worse outcomes than their counterparts who were not limited in number of sessions available, which would fit with the reports from this study that time was viewed as a limiting factor in therapy. In addition to limitations such as inadequate outcome measures and reliance on self-report, Seligman also highlights the difficulty of what he terms ‘therapy junkies’. Seligman uses this term to describe “*individuals so committed to therapy as a way of life that they bias the results in this direction*” (Seligman, 1995, p.973). He asserts that these people who have been in therapy such a long time may be “*true believers*” (p.973) in therapy, or unduly loyal to their therapist and likely to distort in a more positive direction. Seligman however dismisses this as unlikely as scores for those who ended treatment at two years and those still in therapy at two years were too similar for this hypothesis to stand. The finding that length of therapy and outcomes are positively correlated is not new (e.g. Cartwright, 1955). Orlinsky, Grawe, & Parks (1994) found a positive relationship between outcome and length of treatment in 64% (100) of studies, while only 6 studies found a negative relationship and a further 50 found no statistically significant relationship.

In the more recent ‘dose-response’ literature, which attempts to calculate the number of sessions (dose) required to produce a positive response, Hansen & Lambert (2003) found that in a naturalistic study, in order to achieve a 50% recovery rate according to clinical significance, between 15 and 19 sessions of therapy were required. It is however worth noting that previous studies have also found that different symptoms improved at different rates, ranging from five sessions for acute symptoms to 104 sessions to achieve a

50% response rate for ‘characterological’ symptoms (Kopta, Howard, Lowry, & Beutler, 1994). This once again highlights the complex nature of the therapeutic outcome literature. It may be expected that a proportion of the participants in this current study could have been classed as having ‘characterological’ difficulties; if 104 sessions allows a 50% response rate for a subset of clients, the average 20-30 sessions the clients I interviewed had, is only a fifth of what may potentially be required. The implications of this are further discussed below (*‘Clinical Implications’*).

### *Unmet Needs*

What is clear from the study is that participants did not get what they wanted from therapy and as such their needs remain unmet; whether this be the attachment relationship, ability to disclose, treatment length or getting needs met in terms of preference/expectations as the matching hypothesis would assert. This then had a further impact in that it reinforced participants’ beliefs about themselves as worthless, a failure and wrong, as they felt they had failed at therapy. This had consequences in terms of the events after therapy. In general, all but one participant who voiced thoughts of an undeserving sense of self, did not access further help. It therefore seems for these participants this may have reinforced the idea that they could not be helped and stopped seeking help in the form of therapy. For the others, they were then drawn further into the care seeking cycle and either undertook or attempted to gain access to more therapy. Although this was not a universal pattern it may be an area worth further research in the future.

### **Clinical Implications**

Although there is a growing evidence base on what causes deterioration in therapy (Mohr, 1995) and the beginnings of a literature on what the impact of potentially harmful treatments may be (Lilienfeld, 2007), alongside more anecdotal accounts (Bates, 2006), there remains little, if any research into the immediate and longer term impact for clients who have not responded to treatment. Non-response is a much more complex idea than simply walking away from therapy unscathed. For the participants in this study, there was no lasting positive impact and there was a worsening of symptoms and negative effects for at least half. There are emotional, time and opportunity costs for clients undergoing non-beneficial therapy. In addition, as played out in the participants’ stories, there is also an economic cost to healthcare services, in that some participants continue to seek further support following their non-responsive experience. Beyond the economic implications, there



are also other stakeholders in the wider system, for example costs to other clients who may have to wait longer, therapists being required to offer a treatment they discover does not help and ethical issues relating to offering people a treatment that is not suitable for their needs. In short, these findings have implications for all those delivering and receiving psychological services in the NHS.

Clinicians and those delivering therapy will not be unfamiliar with the ideas proposed here. However, what this study is able to bring together is the application of these well-known theories to an under studied group. Here I attempt to understand the clinical implications of these findings by first looking to explore ‘what is non-response?’, followed by thinking around how attachment issues, corrective experiences, treatment length, emotional disclosure and expectations may begin to influence our understanding of this group of clients and their treatment outcomes.

#### *What is Non-Response?*

For the purposes of this study, therapy was defined as “*a primarily interpersonal treatment that is based on psychological principles and involves a trained therapist and a client who has a mental disorder, problem, or complaint; it is intended by the therapist to be remedial for the client’s disorder, problem, or complaint; and it is adapted or individualized for the particular client and his or her disorder, problem, or complaint*” (Wampold, 2001, p.3) with the underlying emphasis on change (Beitman et al., 2003). The scant literature specifically focusing on non-response as a concept left definitions lacking. Linden (2013) defined non-responses as unwanted effects of therapy and a “*lack of improvement in spite of treatment*” (p.288).

The participants were self-selecting in that they subjectively defined themselves as having not responded to psychological therapy. The invitation letter (Appendix 1) clearly stated:

*“We already know something about the experiences of people who feel they have gained from therapy, and there is some research about those who come out of therapy feeling worse. We do not know much however, about the experience of people who undertake therapy, but who feel it made little difference to them... **We are looking for people who have completed a course of therapy with the service, but do not feel anything is particularly different as a result of it.**”*

However, what was apparent from the participants was that although some felt no different, clearly a number of these participants felt worse off as a result of therapy. It may be that there are sub-groups of clients within those classified as non-responders, some of

whom have more in common with the harmful effects literature and potentially others who can be closer aligned to the positive outcome literature. In either case, within this group of non-responders, is the fact that even a subjective judgement that therapy did not result in change is not an absence of experience. This therapy had effects, including for some, disappointment and discouragement, meaning that non-response may be something that is worse than nothing. This may result in some participants not returning for something that may help or blaming themselves for the lack of change, as suggested by the current findings.

### *Expectations of Therapy*

One of the other key findings is that participants' expectations may affect how therapy is experienced and ultimately the outcome. It therefore feels imperative that we are able to give clients a realistic understanding of what to expect.

In a study into the adverse effects of psychological therapies, Parry et al., (n.d.) explored both client and therapist perspectives of adverse effects of psychological therapies. The primary aim of this research was to develop and test practical support tools for clients and therapists, with the aim of reducing adverse effects of psychological therapy and prevent harm. Although the full results have yet to be published, as a result of their preliminary findings, a website has been designed (<http://www.supportingsafetherapy.org/>) as a tool for both clients and therapists to support safe and effective psychological therapy. As part of this there is a section dedicated to 'before you get there', including what to expect from therapy.

Additionally, in discussing negative treatment effects, Boisvert (2010) poses the question 'is it time for a black box warning?' with regard to psychological therapies. It would be interesting to find out how many of the participants were informed about the potential risks of psychological therapy – when you have surgery they have to run through all the potential complications and then ask for consent. The APA ethical guidelines ask therapists to gain informed consent, which includes informing clients of the anticipated course of therapy as well as potential risks (Boisvert, 2010). This may potentially temper some of the expectations clients may come with, or as Boisvert suggests, the warning could serve to cause harm in itself, causing some people to forgo therapy or misattribute increases in distress to therapy and drop out early.

### *Attachment and Corrective Experiences*

As has been discussed, many clients with psychological difficulties will have an underlying insecure attachment (Daniel, 2006), which is likely to affect their ability to form therapeutic relationships, as well as affecting treatment compliance, self-disclosure and potential rejection of treatment providers (Dozier, 1990). This has implications for the treatment we provide. Although the value of attachment theory is now largely recognised across therapeutic modalities (e.g. Jellema, 2002), it is questionable how much we are able to apply these theories to attenuate the potentially negative impact of insecure attachment.

In the case of this study, recruitment did not specify any particular model of therapy. Although some participants were aware of the model of therapy or techniques they underwent (CBT, EMDR, mindfulness techniques), and others could be inferred from descriptions in the interviews (CAT, psychodynamic), some participants may have also experienced a more integrative, eclectic approach. As such the model described in this study is not specific to any particular mode of therapy and is instead trans-theoretical. It may therefore be useful to return to a trans-theoretical model of change described at the outset; that of corrective experiences, and consider this in light of the attachment literature.

Corrective experiences (CEs) are those in which the client is able to come to a new understanding of an event or relationship through a novel affective experience (Goldfried, 2012). It may therefore be theorised that, as these clients did not gain from therapy, they were unable to have a CE, in this case the development of a secure attachment. Whether this had happened in the case of the current participants is unclear and as such, would require further research to test this hypothesis. For the purpose of this study, attachment and CEs may form a framework through which we can consider the remaining clinical implications outlined below.

### *Is More the Answer?*

There appears to be some evidence that longer therapy may be part of the answer to non-response (Seligman, 1995), through facilitating greater client disclosure (Farber, 2003). Attachment theory provides one (of many) theories through which to understand this finding. This could raise the question of whether services would be improved by providing a certain group of clients, i.e. those with what may be described as insecure attachments and therefore difficulty in interpersonal relationships, a longer course of therapy as opposed to the 'in and out' of mental health services that has invariably happened for the participants I interviewed (Table 4). This is a model currently adapted in specialist personality disorder

services (National Institute for Mental Health in England, 2003). The model proposes longer therapy allows time for appropriate attachment relationships, and potentially for CEs, to take place. This is in opposition to the continual experience of perceived abandonment that could be hypothesised as occurring in response to time-limited, short term therapies. For many of the participants in this study, they had brief therapeutic interventions that left them at best, not improved. However, it is important to note that attachment style was not assessed in the current sample and as such these remain speculation for further consideration.

One example of this tendency to ration type and duration of therapy is the Improving Access to Psychological Therapies (IAPT) initiative. The initial rationale was “*by spending more, we can save more*” (The Centre for Economic Performance’s Mental Health Policy Group, 2012, p.13); if you spend a little on improving people’s mental health you can get them back in to work and therefore save money on benefits. Although there are invariably downfalls to this system, it may be that this ‘spend to save’ mentality could be applied differently to a certain group of people that fit into the model proposed above. In describing the service he had felt he had received, Peter outlined how he felt the service worked:

*“I remember seeing an advert in the paper, recruitment for therapists, psychologists and therapists. And I’m thinking well are they just recruiting people and just giving ‘em like a small part of training so they can just do that . . . ‘cause they did something similar with joinery when I did me joinery course I was last one to do City and Guilds; and then they were splitting it into seven modules, and then from then on you could pick three out of the seven so then if you went – the only way you could work as a joiner if you went to work for a big building company where you could just do floors. And then another pair’d just do doors you know and I thought is that happening with this are we getting people that’s only part-trained so they can just do this particular type of training this therapy but they can’t do ought else and like therapy-on-the-cheap. That’s the impression I got I might be miles wrong with that but that’s what it felt like”*

Peter may be understood to be highlighting how the breaking down of therapy into its constituent parts and delivering them separately, does not necessarily mean they add up to the sum of its parts. Despite some evidence for longer therapy (Seligman, 1995), in an ever increasingly rationed health service where ‘more for less’ is the resounding message, this does not seem viable as a simple single solution. If this is the case, what are the alternatives?

### *Facilitating Emotional Expression in Therapy*

As has been noted, lack of affective disclosure may affect outcome, however the therapeutic relationship may affect how able a client feels to do this. Therapists may therefore benefit from knowing what clients typically do not disclose (Farber, 2003). Examples of this include sexual issues, money and personal failures. As therapists, if we are aware of what these issues may be, we may then be able to normalise these experiences, potentially opening the door for greater disclosure. Alternatively, the use of a tool such as the SRS may provide an opening through which to introduce these ideas. However, it may be argued that clients may continue to non-disclose even given this opportunity if the information feels too shaming or overwhelming. Therapists may also look to find other ways to facilitate appropriate disclosure. For example, the evidence that writing can play a role in the disclosure of traumatic events (Pennebaker, 1997).

However, the most pertinent research in this area is that of Saypol and Farber (2010) who draw together the attachment and emotional disclosure literature. They found, as the literature discussed above alludes to, a significant positive relationship between security of attachment to the therapist and level of self disclosure. They highlight that these findings signal a need for different therapeutic approaches dependent on attachment styles, an extension of the treatment matching hypothesis. Furthermore, taking attachment ideas into consideration, there is evidence that longer therapy improves disclosure (Farber, 2003), possibly as time has been allowed to form a secure attachment with the therapist and so the right environment in which disclosure can occur.

In terms of clinical implications, this can further be understood, again in terms of CEs; whereby the client is able to come to a new understanding of an event or relationship through a novel affective experience (Goldfried, 2012). It may be that for some clients the disclosure of these overwhelming or shameful experiences within the containment of a therapeutic relationship in which these feelings can be accepted and worked with, is the basis for the CE to occur. Corrective experience may therefore provide a trans-theoretical model by which to understand why disclosure appears so important in facilitating change within the therapeutic process.

### **Strengths and Limitations**

Here, I will attempt to critique the research, outlining both the strengths and limitations of the study.

### *Research Design*

The research here has examined therapy process; a complex area to explore. This study has taken a different viewpoint to most previous research (Elliott & James, 1989; Lorentzen et al., 2011) with an understudied group. As such, a qualitative methodology was used to allow a discovery-orientated approach in an area with a paucity of research, allowing data to emerge from the participants, rather than predefined concepts with attached assumptions.

Alternative methods were considered in Chapter Two, however for the reasons noted at that point, IPA was thought to be the most appropriate design for this novel area. Although as a researcher I was new to the IPA method, which may have been a limitation of the study, this method allowed a detailed analysis of the experience of a relatively homogenous group of participants. As such, I have been able to focus in depth on individual accounts bringing these together in a model of experience. Although producing a model is more typical of GT rather than IPA, it allowed an understanding of the process that participants appeared to describe during their interviews. It may be that future studies utilise alternative methods to answer different but related questions, such as a quantitative analysis of the model to determine applicability to different client groups or models of therapy for example.

### *Sampling and Recruitment*

Although the sample was a small homogenous group, the aim was not to come to a point of ‘empirical generalisability’, but rather ‘theoretical transferability’ as highlighted by Smith et al. (2009). In this way the findings, and in particular the model, allow a starting point from which further research can be considered to confirm or refute these initial findings as noted above.

One of the difficulties is that this study had no information from the therapist perspective; a valuable perspective missing from the current study. Although the therapist may be able to shed light on their view of clients, for example attachment styles or use of therapy, this was not what was in question in this study. In addition, it may also have been useful to know what type of therapy participants had, in order to be able to comment further on the previous findings in the literature. However, the fact participants were guaranteed anonymity that their therapist would not know they were involved, hopefully allowed them to speak more freely of their experiences.

We are also left to wonder about the qualities of those participants who responded to take part in the study in contrast to those who did not. As discussed above, none of the participants in this study were left completely unaffected by their therapy. Participants who responded felt they had enough to say to warrant attending an interview. There may be another group of clients who did not respond to therapy, but who felt much less affected by their experience and as such did not feel they had anything to say in an interview. This is of course speculation, however it is worth taking into account the characteristics of those who responded, and considering how these may have played a role in the findings here. Nevertheless, this research was not seeking to be representative of the population as a whole, but rather an attempt to find out something of what was important to some of those who had not responded to therapy.

The decision was also taken to primarily focus on subjective accounts and have objective outcomes of non-response (i.e. CORE data) as supporting information. This was a conscious decision as this study was interested in those participants who perceived they had not changed rather than those who had not changed on an objective measure. As highlighted in the method, due to non-systematic recording of CORE outcomes within the recruiting service, the objective CORE data was unavailable. It may be in the future there can be further research into how these experiences map on to more objective accounts of therapy outcomes in order to add to the findings.

Finally, in terms of recruitment, despite screening for attribution of therapy non-response to external factors, it was not possible to control for all other factors known to be associated with mental ill health and its' deterioration and improvement. Although this was a qualitative study and the aim was to situate the participants and the findings within the wider context rather than control for all variables, in future it may also be useful to obtain objective measures of these factors to further the research into contributors to non-response.

#### *Service User Involvement*

Service users were involved in the development of this research, in particular they were consulted in research design and the interview schedule which can be considered a strength. Although not standard practice in IPA research due to the interpretative nature of the analysis, there may be added value in taking the findings back to the participants for their views. This may be a thought for future research, perhaps using a different methodology, which is more suitable for client consultation following analysis.

## *Interviews*

Although interviews allow participants to explore their experiences in a one to one environment, which also allowed me to take into account body language, tone of voice, any emotions expressed, which would be missing from written or other accounts, interviews are very much reliant on clients' recollection. As it is retrospective, it is not always clear whether they are remembering how they experienced it at the time, or attributing current thoughts and feelings to that experience (although clues can be gleaned from the use of tense for example). However, it is this, the recollected narrative, on which participants would base decisions regarding future therapy and as such feels justified as an account worthy of analysis.

It may also be argued that if these participants are reporting that they have not disclosed in therapy, it could be questioned, why would they disclose in the interview? The results of this type of research must be understood in the context of the fact that in some instances, some participants will not reveal shameful truths about themselves, even when guaranteed anonymity (Farber, 2003). However, these participants were self-selecting and were at no point asked to reveal the content of what they did not reveal in therapy, but rather to discuss the experience of this which was the focus of the research.

What may have been useful would have been to allow greater space for the effects of any anxiety participants may have had. Some participants did speak of almost not attending, or feeling anxious about the interview. This was an unfamiliar environment and for the majority of participants, a single interview. It may have been that multiple interviews may have allowed familiarity with researcher and the process, in addition to allowing time between sessions to process what had been said and perhaps return with new insights. Due to time constraints this was not possible but may be a consideration for future research.

However, what should be noted was the reported benefit of the experience of the interview. A number of participants noted that they had found the experience a positive one;

*“Well, it’s been better than I thought. But I’m not, no disrespect, it’s just that because this morning I could just have stayed in bed because you know and I thought no – because from my point of view is if you don’t do it you never know. So I’m glad I’ve done it”* Christine

*“I mean it’s definitely interesting, it’s definitely something...even just for the experience of doing it like in itself this has been a very, beneficial experience for me”* Cameron

It may be that having space to further explore this experience was useful for some of the participants in processing their experience of therapy.



## Analysis

As noted in the ‘*Methodological Approach*’ section above, Elliott et al. (1999) outline a set of guidelines by which qualitative research can be measured against to ensure good qualitative research standards have been met. Table 6 outlines these guidelines and how I have attempted to address these in order for the reader to ascertain further strengths and limitations of this research.

**Table 6: Quality Measures of Current Research. (Adapted from Elliott et al., 1999)**

<b>Guideline</b>	<b>How I have attempted to address the guideline</b>
1. Owing one’s perspective	I have provided reflexive accounts throughout the research, stating my values and interest. In this I also outline my assumptions as discussed in a reflexive interview with my supervisor prior to carrying out the interviews. Additionally, I completed a reflexive journal throughout the process and kept notes of immediate reflections following interviews to use in the analysis of the data. I have also provided a further reflexive account of my reflections following data analysis for completeness of the process.
2. Situating the sample	I have provided detailed pen portraits of each of the participants in order for the reader to judge the range of people and situations to which the findings might be relevant.
3. Grounding in examples	Throughout the process, in the pen portraits and interpretative analyses I have supported all themes with direct quotes from participants. In addition, I have provided examples of the analytic procedure as appendices to allow transparency of the process (Appendix 8). Readers are therefore able to draw their own conclusions from the data.
4. Providing credibility checks	Supervisors and qualitative research peers were consulted with regard to the construction of the categories. Both full transcripts and data sections were shared in this process to allow credibility of final themes to be verified. In addition to individual quotes, tables have been provided for readers to ascertain which participants have contributed to each theme (Table 5 & Appendix 9).
5. Coherence	The findings are presented as initial themes, along with a model, supported by direct quotes from participants.
6. Accomplishing general vs. specific research tasks	Overarching themes have been developed with details of which participants have contributed to each theme (Table 5 & Appendix 9). Limitations of the study are discussed above and significant differences in participants’ experiences have been outlined above ( <i>‘Divergence’</i> ).
7. Resonating with readers	Using guidelines 1-6 it is hoped that this research has provided readers with an accurate description of the subject matter in which their understanding of this area has been expanded in some way.

As this is qualitative, interpretative research it is inevitable that my own assumptions will have played a role in the development of themes and the model. In my initial reflexive interview I noted that I imagined participants would be in some way blaming of the therapist as a causal factor in their non-response. This appears to be true to an extent as six of the participants spoke negatively of their therapist in some way. However, the fact that the majority of the participants mentioned this makes it less likely that this was a finding that resulted from my expectations and rather as emerging from the data. It is hoped that the process has remained transparent enough for readers to draw their own conclusions as to the validity of the results.

### **Future Research**

While this study illustrated a potential novel process through which non-response to therapy may be understood, it also brought to light a number of areas which may warrant further research. As highlighted, a field which appears somewhat absent from the literature is the consequence of non-response for individuals. What happens next for these individuals? For the participants in this study there was a split between seeking further care and managing alone, either because they felt they would not benefit from further therapy or did not need it at the present time as other interventions (such as hospital stays) had been more beneficial. Following on from this study, this is the area which appears to warrant greatest attention, due to the paucity of literature which exists in this field.

There is also potential to extend this research to those individuals who drop out of therapy. It may be that principles from the first stages of the model are applicable in some way to this group. Perhaps those who drop out of therapy, manage the situation by removing themselves from the therapy itself, in order to avoid the perceived overwhelming emotional content.

This research has provided an insight into an under represented group in therapy. It may be possible to take forward the ideas conceptualised in the model and apply what we know to be the experience of a small group, to a wider population, different client groups and therapeutic modalities. There is the potential for quantitative research to be undertaken to explore the proposed model. For example, we may be able to predict therapeutic outcomes and access to future therapy using what we know about an individual's sense of self. Additionally, despite the large attachment literature already available examining attachment styles and use of therapy and disclosure (e.g. Saypol & Farber, 2010) there may be further work to be done in relation to a direct exploration of the significance of

attachment issues for this group of clients. We may then be able to consider how this is relevant to factors such as treatment matching (e.g. Nilsson et al., 2007) or client expectations.

Again, it has been highlighted that it is difficult to draw any conclusions from the current research with regard to therapist and model of therapy, however future studies may focus on these areas. It is clear from the findings that clients had opinions on how their therapist was with them, future research into therapist accounts of these experiences, possibly matching therapist and client accounts of non-response would provide a unique insight into non-response to therapy. It may also be that objective measures may play a greater role in similar studies in the future to ascertain how subjective non-response can be understood in terms of objective measures as what is clear from this research is that non-response is a complex area to conceptualise and study. Furthermore, as outlined in the introduction, Kazdin, (2001) highlights the need for more research into the connections between constructs and the specific measures used to capture these which may highlight issues regarding the measurement of non-response on objective outcome measures.

Although these are ideas for future research, it is by no means an exhaustive list, what is clear from the results and consideration of the literature is that this is a novel area to which much previous literature is relevant. This model proposes a starting point from which future research in this area can develop and hopefully begin to populate an under researched area of the literature.

## **Conclusions**

As the literature suggests client perspectives are the strongest predictors of outcome, over that of therapists or outside observers (Lambert, 1992), client perspectives appeared to be an obvious starting point to begin research into an under studied area of the literature. In exploring client experience of non-response, this study hoped to be able to begin to shed some light on the mediational processes involved in therapeutic change (Elliott & James, 1989), or lack of, and contribute to the therapeutic outcome literature.

This study highlighted that participants often attributed their difficulties to difficult and traumatic experiences, usually in childhood. The individuals had a largely negative sense of self and were conflicted between seeking therapy to help with their problems, and feeling undeserving or unable to be helped. During therapy, their issues felt overwhelming and shameful and as a result, were often not disclosed. This resulted in participants' needs remaining unmet and, often, their negative beliefs about themselves being reinforced.

What is clear is that this group of ‘non-responders’ are not left unaffected by their experiences, but rather come away very much impacted on by their therapy. As such this feels an area which warrants a much closer examination and further research.

### **Final Reflections**

Finally, at this point I would like to return to the idea of the reflexivity of the researcher. It is clear to see the influence my psychological understandings and own therapeutic background have had on the formation of the proposed model. However, I wanted to acknowledge the extent to which I felt compelled to keep close to the participants’ stories. Many had experienced difficult times through mental health services and their accounts suggested that they had not received the care or responsiveness we would hope for in an ideal world. I wanted to be able to keep hold of this idea and keep in mind how powerful the work of a therapist can be. Although the primary focus of this study was non-response, and has focused solely on the experience of the client, I would nonetheless like to offer a statement from Cameron, a self-identified non-responder. Although objective measures may or may not have provided an alternative picture, Cameron identified as experiencing non-response to therapy. This statement not only illustrates the complexity and impact that so called ‘non-response’ can have for clients, but also captures the sadness I felt at times during this process. Absence of response clearly, for Cameron, did not equate to absence of impact. Here, Cameron describes a system which did not provide him with what he needed at a time he was perhaps at his most vulnerable;

*“...at the time...I...wasn’t aware of it, I wasn’t aware of the fact that...I mean, it’s kind of obvious really, but I wasn’t aware of the fact that it would end up...this bad, to the point where...I do honestly question sometimes like...with other or kind of...that...if I’d not started any of this, yeah I’d still be bad...I would have probably had quite a few episodes of being really depressed...err in the last five years, but I’d have a degree probably...and I’d probably still have friends and I wouldn’t have tried to kill myself twice and...load of other stuff...”*

I hope this can inspire researchers and clinicians alike to continue to keep in mind the individual client experience amidst the continuing focus on efficacy and effectiveness data. I would also like to once again thank those participants who took the time and often overcame great anxiety in order to contribute to researching this under studied area.

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## APPENDICES

### Appendix 1: Opt In Letter

Psychological Therapy Services  
17 Blenheim Terrace  
Leeds  
LS2 9HN

Dear *participant name*,

I am writing to inform you about a research study being carried out in the service and to ask you to consider taking part in it. We already know something about the experiences of people who feel they have gained from therapy, and there is some research about those who come out of therapy feeling worse. We do not know much, however, about the experience of people who undertake therapy, but who feel it made little difference to them. We hope that, by finding out more about this experience, we will be able to make recommendations to improve the therapy available to people, both in this service and more generally.

You have been contacted as you have recently completed a course of therapy with the Psychological Therapy Service at Leeds and York Partnership NHS Foundation Trust and have completed CORE questionnaires during your therapy.

**We are looking for people who have completed a course of therapy with the service, but do not feel anything is particularly different as a result of it.** Participation in the study would involve an interview about your experience. This may last between an hour and an hour and a half.

If you are interested in participating in this study please email [umksr@leeds.ac.uk](mailto:umksr@leeds.ac.uk), call 07970 213903 or return the slip at the bottom in the stamped addressed envelope. By responding to this letter you are not committing yourself to take part in the study simply registering further interest and consenting to a preliminary phone call for further information. If you decide to take part in the study what you say will be kept private, with some exceptional circumstances that I will discuss with you. Your therapist will not know whether or not you participate in this study.

Please feel free to contact Jacqueline Coule on 0113 3431962 if you have any questions or require further information. As previously stated an interest at this point does not commit you to participate in this study.

Yours Sincerely

Jacqueline Coule  
Consultant Clinical Psychologist  
Leeds and York Partnership NHS Foundation Trust

## Appendix 2: Participant Information Sheet

31/07/2013

v.2

*Study Title: An Interpretative Phenomenological Analysis of Clients' Experience of Non-Response to Therapy*

### Participant Information Sheet

Leeds Institute of Health Sciences  
Faculty of Medicine and Health



UNIVERSITY OF LEEDS

#### Participant Information Sheet

##### A study of clients' experiences of not benefitting from psychological therapy

We would like to invite you to take part in this research study. Before you decide we would like you to understand why the research is being done and what it would involve for you. Please feel free to talk to others about the study if you wish and ask me if there is anything that is not clear.

##### *What is the purpose of the study?*

I am interested in finding out about people who have completed a course of therapy but feel no significant change has resulted from it. It is hoped that by studying this we can improve peoples' experience of therapy.

##### *Why have I been invited?*

You have been approached to take part in this study as you have indicated that you have recently completed a piece of therapy and feel that it has not benefitted you at this time.

##### *Do I have to take part?*

No. It is up to you to decide to join the study. If you want to participate, I will describe the study and go through this information sheet. If you agree to take part, I will then ask you to sign a consent form. You are free to withdraw at any time, without giving a reason. This would not affect any future care you may receive.

##### *What will happen to me if I take part?*

You will be asked to attend an interview which will last approximately 60 to 90 minutes. Any travel expenses will be reimbursed. With your permission the interview will be audio-recorded and later transcribed verbatim so it can be analysed.

There is a possibility that by taking part and discussing aspects of therapy this may bring up past issues for you. If this is the case please inform the interviewer of this so that appropriate support can be offered. In addition you will be provided with a list of contact details should you feel distressed as a result of the interview at a later stage.

##### *Will my taking part in this study be kept confidential?*

Yes. Transcribers will be required to treat the contents of the recording confidentially and transcribed data will be anonymised to prevent identification. Data will be stored on encrypted devices, locked away whenever not in use and destroyed following transcription. In line with university requirements, recordings and transcripts will be kept on a password-protected server in the university for three years. The results are to be written up in a report as part of the Doctorate in Clinical Psychology Training Programme. A copy of the abstract will go to the British Library and a complete copy of the thesis will be held by the University of Leeds Library and will be available through Leeds University website. It is also possible that the study will be written up for publication in a peer-reviewed journal and may be presented

1

*Study Title: An Interpretative Phenomenological Analysis of Clients' Experience of Non-Response to Therapy*

at a conference of peers in the future. Again, your name will not be linked with the research materials, and you will not be identified or identifiable in the report or reports that result from the research. The only reason the researcher may have to break the stated confidentiality is if the researcher feels there is a significant risk to yourself or others. These circumstances will be explained in more detail prior to any interview taking place.

Your therapist will not be informed as to your inclusion in the trial.

*What are the benefits of me taking part in this study?*

You may find this a positive experience to have the opportunity to reflect upon your therapy. However, there is a possibility that you may not experience any direct benefits of taking part in this study. It is hoped that the results of this study can begin to inform future practice in psychological therapies which will be of benefit to others.

*What will happen if I don't want to carry on with the study?*

If you decide you no longer wish to take part in the study before it has been written up (Summer 2014), following discussion with the researcher, any interview data or transcriptions of the interview will be destroyed and will not be included in the final study. After this point it will no longer be possible to withdraw your data (i.e. Summer 2014).

*Who has reviewed the study?*

All research in the NHS is looked at by independent group of people called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by Leeds West Research Ethics Committee. The study has also been reviewed by the Leeds Researchers a Service User Group within LYPFT.

*Further Information and Contact Details*

Kay Radcliffe  
Psychologist in Clinical Training  
The University of Leeds  
Leeds Institute of Health Sciences  
Doctorate in Clinical Psychology  
Charles Thackrah Building, Room G.04  
101 Clarendon Road, Leeds, LS2 9LJ  
0113 3432732  
umksr@leeds.ac.uk

*Supervised By*

Carol Martin & Ciara Masterson,  
The University of Leeds  
Leeds Institute of Health Sciences  
Doctorate in Clinical Psychology  
Charles Thackrah Building, Room G.04  
101 Clarendon Road, Leeds  
LS2 9LJ  
0113 3432732

Dr Jacquie Coule,  
Psychological Therapy Services  
Leeds & York Partnership Foundation  
Trust  
17 Blenheim Terrace  
Leeds  
LS2 9HN  
0113 3431962



*Study Title: An Interpretative Phenomenological Analysis of Clients' Experience of Non-Response to Therapy*

*What if there is a problem?*

If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions (contact details at the above). If you remain unhappy and wish to complain formally, you can do this. Details can be obtained from:

Clare Skinner  
Faculty Head of Research Support,  
Faculty of Medicine and Health Research Office,  
Room 10.110, Level 10,  
Worsley Building, University of Leeds,  
Clarendon Road, Leeds,  
LS2 9NL

Alternatively you may wish to speak to a member of the Patient Advice and Liaison Service (PALS) who are available to help you find ways to resolve any concerns you may have about services being provided by Leeds and York Partnership NHS Foundation Trust:

Freephone: 0800 0525 790

Email: [pals.lypft@nhs.net](mailto:pals.lypft@nhs.net)

Write: The PALS Office

Therapy Suite

The Becklin

Alma Street

Leeds

LS9 7BE

### Appendix 3: Participant Consent Form

Leeds Institute of Health Sciences  
Faculty of Medicine and Health



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#### CONSENT FORM

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**Title of Project:** A study of clients' experiences of not benefitting from psychological therapy  
**Name of Researcher:** Kay Radcliffe

**Please mark all boxes**

1. I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these questions answered satisfactorily.
2. I understand that my participation is voluntary and that I am free to withdraw at any time during the interview without giving any reason, and without my care being affected. If I am unhappy about something being used, I know I can discuss this with the researcher, who will agree a course of action with me.
3. I understand that relevant sections of the data collected during the study, may be looked at by individuals from University of Leeds or from regulatory authorities, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my data.
4. I understand that my responses will be kept strictly confidential, unless the researcher feels there is a significant risk to myself or others, and these circumstances have been explained to me.
5. I consent to the audio taping of my interview. I understand that the audio recordings will be transcribed by a transcriber accustomed to transcribing sensitive recordings, and who has read and signed a transcriber confidentiality statement. After transcription, in line with university requirements, recordings and transcripts will be kept on a password-protected server in the university for three years. If I am unhappy about this I know I can discuss this with the researcher, who will agree a course of action with me.
6. I give consent for direct quotes to be used in the final report. I understand that my name will not be linked with these quotes, and I will not be identified or identifiable in the report or reports that result from the research.
7. I give permission for the CORE outcome measures collected by the CORE Net Project to be accessed for this research and to be used as part of the interview process.
8. I would like to receive a copy of a summary of the findings from the study, and agree to be contacted regarding this up to 12-18 months after my initial interview.
9. I agree to take part in the above study.

_____	_____	_____
Name of participant	Date	Signature
_____	_____	_____
Name of person taking consent	Date	Signature

## Appendix 4: Interview Schedule

*Thank you for agreeing to take part in the study. When we sent the information about the interview there was a participant information sheet and a consent form. Do you have any questions about these [Go through information sheet and consent form highlight risk issues with next paragraph].*

*I'd like to highlight the confidentiality issue raised in the information sheet and consent form. As stated everything in this interview will remain confidential. The only exception to this will be if you tell me something that makes me believe that you are a significant risk or yourself or others. In this case I may have to pass this information on in order to make sure you or others that may be at risk remain safe. In addition, if you tell me about any criminal activity I have the same duty as any member of the public to report this to the appropriate authorities. Have you any questions about this?*

[Go through consent form and sign]. *Have you any further questions about this?*

*Now I'm going to ask you some questions about your experience of the therapy you had and your thoughts about it, it should take about an hour to an hour and a half.*

I wanted to begin by asking you, what did you find interesting about the study? (*Why did you think it would be good to participate?*)

Tell me a little bit about yourself

*What do you do during the day?*

*Who do you live with?*

*What is important in your life?*

### Referral / Beginning Therapy

Tell me about what brought you to therapy.

*How were you referred?*

What were your initial thoughts and feelings about going to therapy?

*What were your expectations of therapy?*

How did you find beginning therapy?

### During Therapy

How did you find the therapy process as a whole?

*Tell me about any points at which your experience of therapy changed?*

For you, what do you think contributed to the lack of change you talk about?

How aware do you feel your therapist was of how you were feeling about therapy?

*Was this explored using the CORE scores?*

*How useful did you find this process?*

Tell me about anything you feel could have been done differently for therapy to have had a better outcome for you?

How did you feel when you finished therapy?

*What made you stay in therapy?*

### Reflections on Therapy

Looking back on your experience now, how do you feel about the therapy you had now?

*Have your views changed at all during the interview?*

### Future Therapy

How has this experience affected your view of therapy?

*What would your thoughts be about trying therapy again?*

*Under what circumstances might this happen?*

Anything else you would like to tell me that we haven't covered?

I'm wondering what this interview has been like for you?

### Additional Prompts

- Do you mean that...?
- Can you tell me more about that?
- What do you mean by ...?
- What was that like for you?
- What, When, Who, How, Where?

*Thank you for answering those questions, just before we finish I'd like to confirm a few details from the initial telephone call we had [check screening questionnaire]. Can I also ask:*

- *Do you know what type of therapy you had?*
- *How many sessions of therapy did you have in total?*
- *Address for summary of research (if agreed to)*

[Complete pen portrait table]

[Pay travel expenses]

*Thank you for taking part. Sometimes people find looking back on things like this difficult, and that's completely normal. But if in the future you feel you have been affected by the interview, or by talking about your previous therapy, here are some of the details about what you can do [Provide contact information sheet].*

*Do you have any other questions before we finish?*

*Thank you.*

## Appendix 5: Ethical Approval



**Health Research Authority**

### NRES Committee Yorkshire & The Humber - Leeds West

North East REC Centre  
Room 002, TEDCO Business Centre  
Rolling Mill Road  
Jarrow  
NE32 3DT

Telephone: 0191 428 3578

18 July 2013

Miss Kay Radcliffe  
Psychologist in Clinical Training  
The Leeds Teaching Hospitals NHS Trust  
Leeds Institute of Health Sciences,  
Charles Thakrah Building,  
101 Clarendon Road,  
Leeds.  
LS2 9LJ

Dear Miss Radcliffe

**Study title:** An Interpretative Phenomenological Analysis of Clients' Experience of Non-Response to Psychological Therapy.  
**REC reference:** 13/YH/0211  
**IRAS project ID:** 120110

The Research Ethics Committee reviewed the above application at the meeting held on 12 July 2013. Thank you for attending to discuss the application.

We plan to publish your research summary wording for the above study on the NRES website, together with your contact details, unless you expressly withhold permission to do so. Publication will be no earlier than three months from the date of this favourable opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to withhold permission to publish, please contact the Co-ordinator, Neil McCaffery, [nrescommittee.yorkandhumber-leedswest@nhs.net](mailto:nrescommittee.yorkandhumber-leedswest@nhs.net).

#### **Ethical opinion**

#### **Ethical issues raised by the Committee in private discussion, together with responses given by the researcher when invited into the meeting.**

The Chair, Dr Rhona Bratt, welcomed you, Dr Carol Martin and Dr Ciara Masterson to the meeting and thanked everyone for attending.

The committee informed the researchers that they thought that this was an excellent study that was well-prepared.

The committee queried why 16-18 year olds were not included in the study target age range.

*You informed the committee that this age group was not included as they do not access the service and this would impact upon the service delivery and that it was not possible to include this age group in the study.*

The members of the Committee present gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below.

#### Ethical review of research sites

##### NHS Sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

#### Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

*Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.*

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>.

*Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.*

*For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.*

*Sponsors are not required to notify the Committee of approvals from host organisations*

**It is responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).**

#### Approved documents

The documents reviewed and approved at the meeting were:

Document	Version	Date
Evidence of insurance or indemnity		21 September 2012
Interview Schedules/Topic Guides	V.1 Interview Schedule	29 April 2013
Interview Schedules/Topic Guides	V.1 Screening Questionnaire	29 April 2013
Investigator CV	v.1	03 June 2013
Letter of invitation to participant	V.1	29 April 2013
Other: Supervisor CV		16 April 2013
Other: CV - Dr Ciara Masterson		
Other: Security Protocol for Professional Doctorate of Clinical Psychology	V.1	10 December 2010
Other: Information Letter About The Trainee Clinical Psychology Research		04 June 2012
Other: Research Panel Constitution		29 April 2013
Participant Consent Form	V.1	29 April 2013

Participant Information Sheet	V.1	29 March 2013
Participant Information Sheet: Contact Information Sheet	V.1	29 March 2013
Protocol	V.1	29 April 2013
REC application	1	06 June 2013
Referees or other scientific critique report		19 March 2013

### Membership of the Committee

The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

There were no declarations of interest.

### Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

### After ethical review

#### Reporting requirements

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

#### Feedback

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

Further information is available at National Research Ethics Service website > After Review

**13/YH/0211**

**Please quote this number on all correspondence**

We are pleased to welcome researchers and R & D staff at our NRES committee members' training days – see details at <http://www.hra.nhs.uk/hra-training/>

With the Committee's best wishes for the success of this project.

Yours sincerely  
pp



**Dr Rhona Bratt**  
**Chair**

Email: [nrescommittee.yorkandhumber-leedswest@nhs.net](mailto:nrescommittee.yorkandhumber-leedswest@nhs.net)

Enclosures: *"After ethical review – guidance for researchers"*

Copy to: *Faculty Research Ethics and Governance Administrator  
Sinead Audsely, Leeds and York Partnership NHS Foundation Trust*



## Appendix 6: Research and Development Approval



Leeds and York Partnership   
NHS Foundation Trust

Our Ref: 2013/440/L

Research & Development  
North Wing, St Mary's House  
St Mary's Road  
Leeds LS7 3JX  
E-mail: [sinead.audsley@nhs.net](mailto:sinead.audsley@nhs.net)  
Direct Line: 0113 295 2387  
FAX: 0113 2954466

Miss Kay Radcliffe  
Leeds Institute of Health Sciences,  
Charles Thakrah Building,  
101 Clarendon Road, Leeds.  
LS2 9LJ

01/08/2013

Dear Miss Radcliffe

**Project Title: An Interpretative Phenomenological Analysis of Clients' Experience of Non-Response to Psychological Therapy.**  
**REC Reference: 13/YH/0211**

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

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

Document	Version	Date
Protocol	2	31 July 2013
Participant Consent Form	V.1	29 April 2013
Participant Information Sheet	V.1	29 April 2013
Participant Information Sheet: Contact Information Sheet	V.1	29 April 2013
Interview Schedules/Topic Guides	V.1 Interview Schedule	29 April 2013
Interview Schedules/Topic Guides	V.1 Screening Questionnaire	29 April 2013
Letter of invitation to participant	V.1	29 April 2013
REC Approval Letter		18 July 2013

This approval is granted subject to the following conditions:



- You must comply with the terms of your ethical approval (where applicable) Failure to do this will lead to permission to carry out this project being withdrawn. If you make any substantive changes to your protocol you must inform the relevant ethics committee and us immediately.
- You must comply with the Trust's procedures on project monitoring and audit.
- You must comply with the guidelines laid out in the Research Governance Framework for Health and Social Care<sup>1</sup>(RGF). Failure to do this could lead to permission to carry out this research being withdrawn.
- You must comply with any other relevant guidelines including the Data Protection Act, The Health and Safety Act and local Trust Policies and Guidelines.
- If you encounter any problems during your research you must inform your Sponsor and us immediately to seek appropriate advice or assistance.

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

Adverse incidents relating to the research procedures and/or SUSARs (suspected unexpected serious adverse reactions) should be reported, in line with the protocol requirements, using **Trust incident reporting procedures in the first instance and to the chief investigator<sup>2</sup>**.

They should **also** be reported to:

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

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

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

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

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

<sup>1</sup> Details from:

[http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT\\_ID=4108962&chk=Wde1Ty](http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4108962&chk=Wde1Ty)

<sup>2</sup> SUSARS – this must be within 24 hours of the discovery of the SUSAR incident

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

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

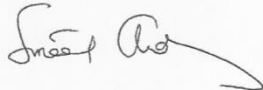
Note that NHS indemnities only apply within the limitations of the protocol, and the duties undertaken therewith, by research staff with substantive or honorary research contracts with this Trust.

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

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

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

Yours sincerely



Sinead Audsley  
Research Governance Manager

Cc Dr Donald Brechin

## Appendix 7: Contact Information

29/04/2013

v.1

*Study Title: An Interpretative Phenomenological Analysis of Clients' Experience of Non-Response to Therapy*

### Contact Information

Leeds Institute of Health Sciences  
Faculty of Medicine and Health



**UNIVERSITY OF LEEDS**

### Contact Information

#### A study of clients' experiences of not benefitting from psychological therapy

Thank you for taking part in this study. Although this can be a useful experience, some participants may find that they feel distressed / concerned / or wish to find out further information following the study. Details of what to do in these situations can be discussed with the researcher and have been outlined below.

#### Participant Distress

You may wish to contact your GP and make an appointment to discuss how you are feeling and what options are available to you. This may include taking up a further course of therapy if this is appropriate.

#### Participant Concern/Complaints

If you have a concern about any aspect of this study, you should contact to the researcher who will do their best to answer any questions:

Kay Radcliffe  
Psychologist in Clinical Training  
The University of Leeds  
Leeds Institute of Health Sciences  
Doctorate in Clinical Psychology  
Charles Thackrah Building, Room G.04  
101 Clarendon Road, Leeds  
LS2 9LJ  
0113 3432732

If you remain unhappy and wish to complain formally, you can do this. Details can be obtained from:

Clare Skinner  
Faculty Head Research Support,  
Faculty of Medicine and Health Research Office,  
Room 10.110, Level 10,  
Worsley Building, University of Leeds,  
Clarendon Road, Leeds  
LS2 9NL

Alternatively, you may wish to speak to a member of the Patient Advice and Liaison Service (PALS) who are available to help you find ways to resolve any concerns you may have about services being provided by Leeds and York Partnership NHS Foundation Trust:

1

*Study Title: An Interpretative Phenomenological Analysis of Clients' Experience of Non-Response to Therapy*

Freephone: 0800 0525 790  
Email: pals.lypft@nhs.net  
Write: The PALS Office  
Therapy Suite  
The Becklin  
Alma Street  
Leeds  
LS9 7BE

#### Research Opportunities

It may be that taking part in this study has made you curious about being involved in further research. If you have an interest in taking part in further research or becoming involved in a service user panel who contribute to the research which goes on both within the University and Leeds and York Partnership NHS Foundation Trust please contact:

Susan Moore  
Research Governance Administrator  
Leeds and York Partnership NHS Foundation Trust  
St Mary's House  
St Mary's Road  
Leeds  
LS7 3JX  
0113 2952387  
researchinnovation.lypft@nhs.net

Tracey Smith  
Clinical Tutor  
Clinical Psychology Training Programme  
Leeds Institute of Health Science  
Charles Thackrah Building  
101 Clarendon Road  
Leeds  
LS2 9LJ  
0113 3432732  
t.e.smith@leeds.ac.uk

One again, many thanks for agreeing to take part in this study. It is hoped that the information gained from this research will enable us to explore the experiences of those who do not feel they have benefitted from therapy and begin to improve their experiences.

Appendix 8: Analytic Process

Annotated Transcript

P1 I2 17/01/14

220 why it worked is because it is just a, this is a temporary working  
221 relationship; if I don't see you again, it's not going to bother. I can  
222 talk to you about stuff because you don't know any of the other  
223 people ... *Don't have to fully commit if temporary*

224 I: yeah *sense of distance from therapist which makes it ok.*

225 P: ... and, you know you're not involved in, I mean I guess,  
226 yeah, saying this now, I guess that's probably wrong because they  
227 do have a ... something of a vested interest in my well-being but  
228 that's always been my problem, is that I can't appreciate that in *something about*  
229 other people like ... I can't to other people, just not to me. And I *low own views of relationships affect therapy.*  
230 mean that's part of er, my own set of hypocritical thought-patterns  
231 that I fully appreciate that I have and wish I didn't but that's why  
232 I've been begging (?) for therapy. I think though [pauses] I mean I *- begging for desperation*  
233 don't really know what I'd suggest. I think, you know maybe if I  
234 was in a better place now, I'd have something to say about it!  
235 [Pauses] I think erm may, you know again, maybe this is a  
236 particular of me or people here have quite a ... a um, annoyingly  
237 tenuous er, analysis of almost everything. Erm, it would be to kind *Structure*  
238 of explain. I mean it's like I said last time about structure

239 I: mm

240 P: and that ... you're always aware of where it's going and *clarity about what therapy is*  
241 where it's gonna be and ... I think especially with [T4] it was  
242 difficult because of the change that I underwent in the time that I  
243 was seeing her

244 I: mm

245 P: and the fact that we weren't on, on a level with each other *Not on same page as therapist*

246 I: right

247 P: and she wasn't working with the guidance of the people I'd *not listened to*  
248 seen before *Individual plan not followed.*

249 I: mm

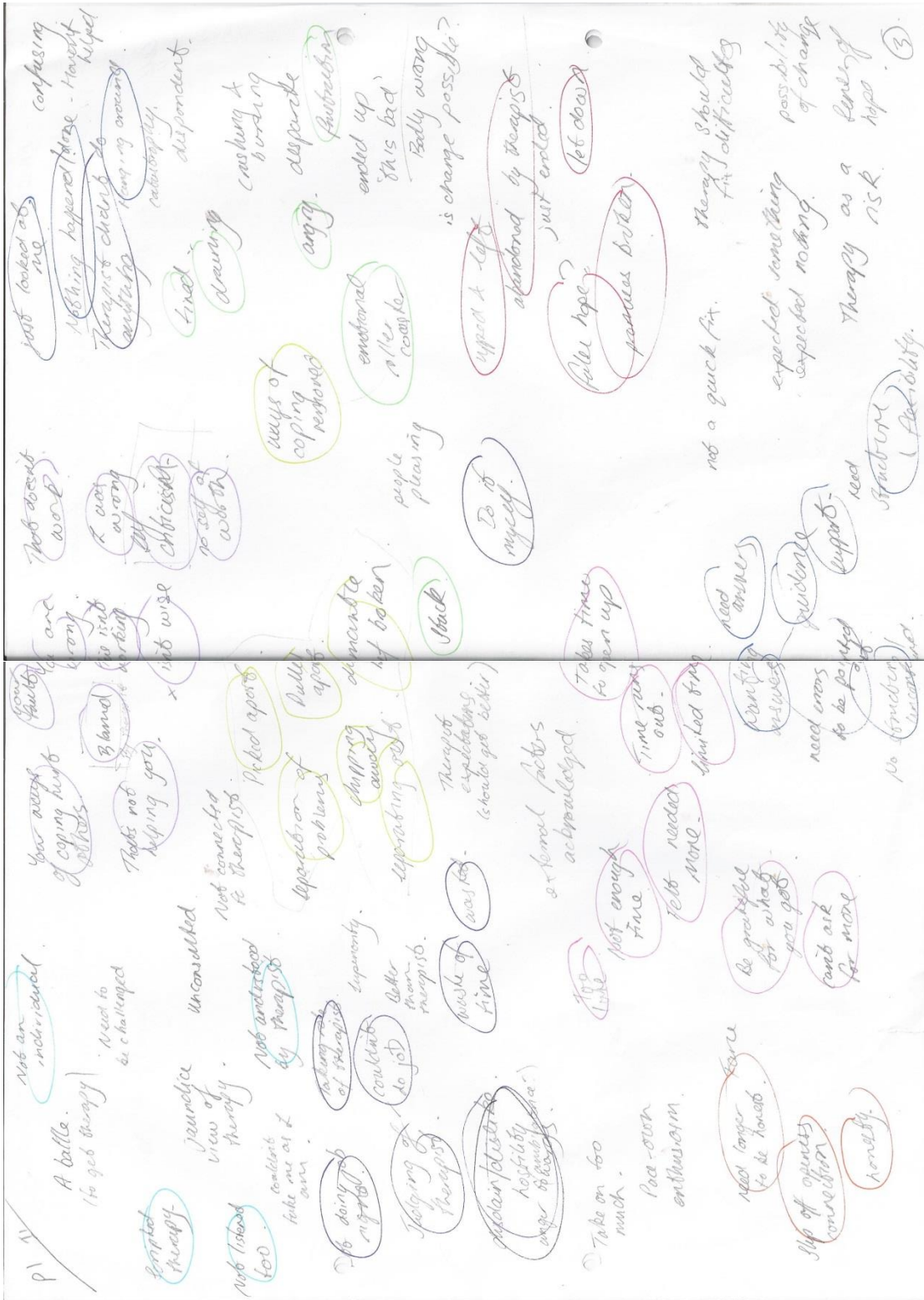
250 P: um, and that, I mean that's kinda what I meant about the  
251 continuity between people

252 I: yeah

253 P: it's like I don't, I mean ... it baffles me now or when I've  
254 read the letters from about five months ago that she could've gone  
255 so far away from the stuff [T1] had said need to be focused on and  
256 [T3] basically said same stuff

Page 7

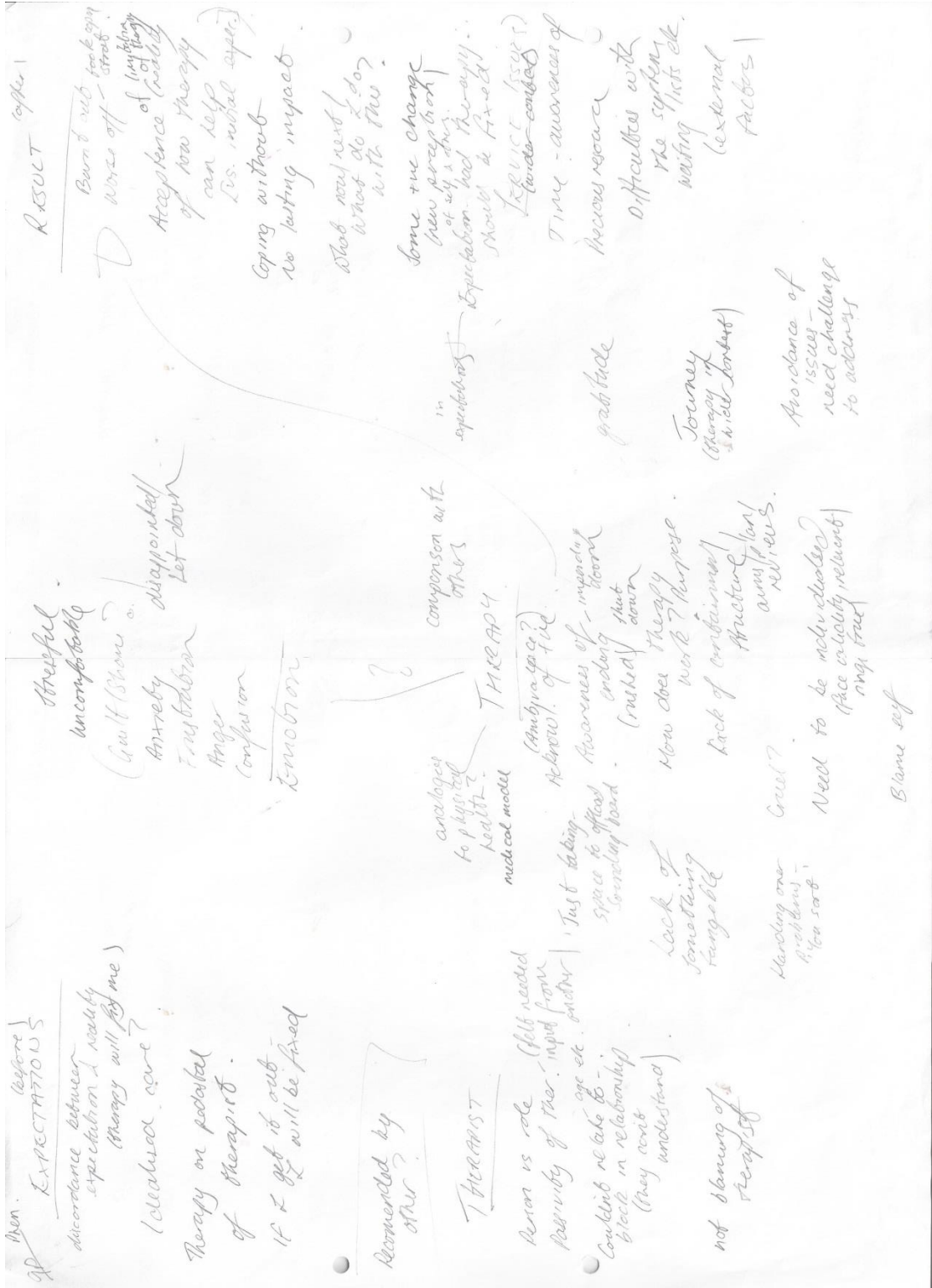
Individual Analysis

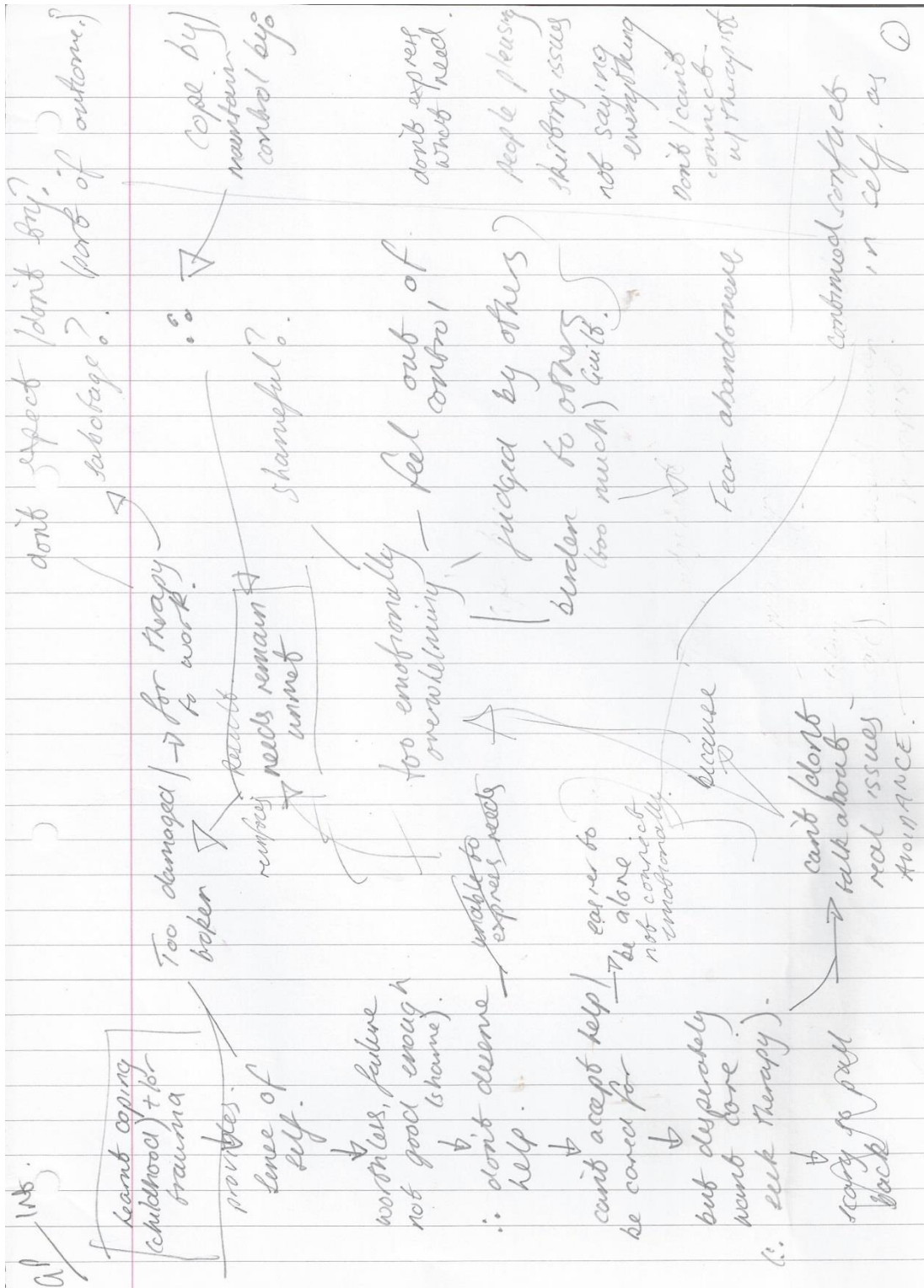






Group Analysis





## Appendix 9: Experience of Therapy Analysis

The table below outlines which participants mention each of the initial themes.

			Participant							
			Cameron	Melissa	Melanie	Chad	Christine	Donna	Peter	George
What I Expected	Something to be gained	A cure			X	X				
		Provide answers	X				X			X
		Tell their story					X			
	Want input from another			X	X	X		X	X	
	Uncertainty		X	X			X			
How I found my Therapist	Who is the therapist?	A person	X	X	X	X		X	X	
		An expert			X					
	Cannot connect with him/her	Not heard or understood	X	X	X					
		Too different			X	X			X	
	The therapist with me	Judging		X	X	X				
		Passive	X		X				X	
Positive						X	X	X		
What was Therapy Like?	Ambiguity	Questioning the therapy	X		X		X		X	
		Confusing process	X	X	X				X	
	Indebted	A burden	X	X	X	X		X	X	
		Should be grateful	X			X		X		
		Responsible for outcome	X	X	X	X			X	
		Comparison to others			X	X	X	X	X	
	Avoidance of core issues	Not able to bring	X	X	X	X	X	X	X	
		Not addressed	X		X	X		X	X	
	Lost	No structure	X		X	X				
		Just talking	X	X	X	X		X	X	
	Time as limiting factor		X	X	X	X	X		X	
	Desperation	Nothing else		X	X	X			X	
		Last resort			X	X				
	Change as difficult		X			X			X	
	Let down	Unfulfilled promises	X				X		X	
		Does not fit needs			X	X		X	X	
	Positive aspects	Practical help		X				X	X	
		New perspective	X			X	X			
External Influences	External life issues		X	X		X	X	X		
	Wider system difficulties		X	X	X	X	X	X		
What I am left with	Unmet expectations	Too high			X	X	X	X		
		Should be recovered	X		X			X		
	Worse in some way	Coping strategies removed	X					X		
		Symptoms increase	X				X	X		
		Sense of loss/regret	X		X		X		X	
	The future	What now?	X		X			X		
		Need more	X		X	X		X		
	No lasting positive impact		X	X	X	X	X	X		