Clients' perceptions of unhelpful factors in CBT in IAPT serving a deprived area of the UK

Omylinska-Thurston, J, McMeekin, A, Walton, P and Proctor, G

http://dx.doi.org/10.1002/capr.12249

Clients perceptions of unhelpful factors in CBT in IAPT serving inner city/ deprived area of the UK.

Dr Joanna Omylinska-Thurston, Counselling Psychologist

j.omylinska-thurston@nhs.net (address for correspondence)

Dr Aaron McMeekin, Consultant Perinatal Psychiatrist

aaronmcmeekin@nhs.net

Greater Manchester Mental Health NHS Foundation Trust, Trust Headquarters, New Bury Road, Prestwich M25 3BL

Peter Walton, PhD Researcher

peter@peterwalton.co.uk

Queen's University Belfast, Centre for Public Health, Institute of Clinical Sciences, B, Royal Victoria Hospital, Grosvenor Road, Belfast, BT12 6BJ

Dr Gillian Proctor, Clinical Psychologist & Person-Centred Therapist

g.m.proctor@leeds.ac.uk

The University of Leeds, Baines Wing, Woodhouse Lane, Leeds, LS2 9GT

BIOs

Joanna is an experienced Counselling Psychologist who has been practicing within NHS for the last 20 years providing psychological therapy and supervision. She integrates humanistic, cognitive-behavioural and psychodynamic approaches in her work. She has worked in learning disabilities, psycho-oncology and mental health. Joanna has undertaken several research projects using qualitative methods examining the psychological aspects of immigration, the therapist's use of self and helpful factors in psychological therapy with cancer patients. She is also co-leading a project exploring the use of creative methods in the treatment of depression.

Aaron is a Consultant Perinatal Psychiatrist who trained in Sheffield and Manchester with postgraduate qualifications in Medical Education and Cognitive Behavioural
Therapy. He has specific interests in psychological medicine and perinatal psychiatry and has developed CBT orientated groups for women with lived experiences of postnatal depression and anxiety.

Peter is a former PhD student in Medicine. He previously studied Undergraduate and Masters level degree courses in Psychology at the University of Manchester during which he developed an interest in CBT.

Gillian is an independent clinical psychologist with 22 years of experience of adult NHS mental health care including primary, secondary care and forensic services offering psychotherapy, supervision, evaluation, research, service development and training. She is a Lecturer in Counselling at the University of Leeds. Gillian is a research supervisor with a particular interest in qualitative research, ethics, power and reflexivity.

Abstract

Aim/Purpose:

IAPT (Improving Access to Psychological Therapies) is a main provider of psychological therapy for adults within the NHS. NHS Digital (2015) reported the drop-out rate in IAPT is as high as 43%. Proctor (2014) found that unhelpful factors in therapy could contribute to the dropout rate. As CBT is the main modality in IAPT, it is important to explore unhelpful factors in CBT as they might be contributing to the dropout rate in IAPT.

Design/Methodology:

Nine clients (five men and four women) for whom CBT was not helpful were interviewed using a semi-structured protocol. The interviews were analysed using thematic analysis.

Results/Findings

Main themes included clients' difficulties with CBT such as not addressing core and underlying issues, and difficulty identifying negative thoughts and feelings. The purpose of homework was questioned including how it was followed up. During CBT, internal patterns (such as being critical of self) were activated and sometimes left clients feeling worse. Previous negative CBT experiences were recognised as a barrier to therapy. Clients perceived assessments and outcome measures as not identifying their needs. Other psycho-social factors such as underlying mental illness and housing were also obstacles to engagement in CBT.

Conclusions/Implications (including practice implications):

The findings indicate that all practitioners should consider unhelpful factors in therapy as they have potentially detrimental effects on clients' outcomes. Additionally, this research found that therapeutic interventions need to be tailored to clients' goals, internal patterns and preferences. Importantly it was found that unhelpful factors extend to health and psychosocial issues which should be addressed prior to therapy.

Five Keywords: *CBT, IAPT, unhelpful factors, clients in deprived area*

Word Count: 7078

Introduction

Improving Access to Psychological Therapies (IAPT) is a main provider of psychological therapy for adults within the National Health Service (NHS). IAPT was introduced following Layard's Report (2004) arguing that making psychological therapies available on NHS would pay for itself by a reduction of benefits claimed and people going back to work. Layard & Clark (2014) also argued that addressing mental health issues would lead to the reduction of cost in physical health. IAPT was developed in 2008 as a way of organising a systematic delivery of evidence-based interventions for anxiety and depression within the NHS (The National Collaborating Centre for Mental Health, 2018).

The main therapeutic modality within IAPT is Cognitive Behavioural Therapy (CBT) which is an evidence-based intervention for mild to moderate anxiety and depression (NICE, 2009). Within IAPT, the clients' therapeutic change is measured by standardised outcome measures. Depression by the Patient Health Questionnaire (PHQ9) and Anxiety by the General Anxiety Disorder questionnaire (GAD7). Although clients' subjective views on their therapy are collected via Patients' Experience Questionnaire (PEQ), this information is not integrated in reporting clients' recovery as they are collected anonymously.

The empirical research suggests that it is the client who is at the heart of change in therapy (Bohart & Tallman, 1999). Cooper (2008) suggested that about 75 per cent of

therapeutic outcomes are due to the client factors. Therefore, it is important to research client's subjective perspective on change processes in therapy as these factors will have a significant impact on the therapeutic outcome. According to Elliott (1985) factors reported by clients as helpful and unhelpful in therapy will have the most impact on the outcome of therapy. Parry et al., (2014) identified that factors that clients perceived as unhelpful have adverse effects on therapy outcomes and 5.5 per cent of clients reported that they led to lasting negative effects from treatment. Unhelpful factors could be also responsible for drop-out rates (Proctor, 2005) which is particularly important in IAPT as 43 per cent of IAPT clients drop out of therapy (NHS Digital, 2016). As CBT is a main treatment in IAPT (with a local CBT drop-out rate of 40.2 per cent) it is important to focus on the unhelpful aspects of CBT. If the unhelpful factors in CBT are responsible for the high drop-out, not addressing these issues will have ethical and economic implications.

A literature search revealed limited studies specifically focused on unhelpful factors in CBT. This may be due to the "file-drawer" effect - where trials finding negative effects of therapy are not published (Jarret, 2008). It might be also related to the fact that clients who find therapy unhelpful often drop-out of therapy without discussing the difficulties in therapy (Henkelman & Paulson, 2006). However, Bystedt et al. (2014) found that the majority of clinicians agreed that negative side effects of psychological treatments are a problem. Foa et al. (2002) Mayou et al. (2000) and Scheeringa et al. (2011) found for example that patients with PTSD or anxiety disorders felt worse after imaginary exposure or exposure in vivo (Bystedt et al., 2014) but they were considered as short therm negative effects presumed to be beneficial in the long term. Schermuly-Haupt et al. (2018)

identified a range of unwanted events and 'side-effects' following CBT including negative well-being and distress, deterioration of existing symptoms and strains in family and work relationships. Taking the above findings further, the aim of this research was to explore clients' perceptions of unhelpful factors of CBT in an IAPT serving clients within an inner city / deprived area**.**

Procedure

Participants were recruited by IAPT Practitioners *(High Intensity/ CBT Therapists, Counsellors or Mental Health Practitioners)* either at the review/end of their CBT therapy, following triage/ reassessment to the service or during assessment for another therapy. All participants said that the CBT they received was not helpful for them. Clients on the IAPT waiting list (where it was identified that the client did not find CBT helpful in the past) were also invited to participate in the research. The research was advertised in the Trust's internal mail so other Practitioners in the Trust could get in touch with the researcher (first author) in regards to potential participants.

Clients who wished to discuss the research were contacted by phone. Where clients agreed to be interviewed, a convenient date, time and location was arranged for each client. The clients were given as much time as they needed (minimum 24 hours) to

consider participation in the interview. Clients were sent the Participant's Information Sheet (PIS) in the post/ email.

In terms of inclusion criteria, those asked to take part were 18 years old or more and were clients of IAPT. They were fluent in English and had a course of CBT they identified as not helpful to them. In terms of exclusion criteria, IAPT practitioners did not approach clients who were too distressed to take part in the interview and were at risk of harming their self and/or others. Other exclusion criteria included current heavy use of alcohol or other recreational drugs, current psychotic experiences, any condition which would make the research interview particularly problematic, for example significant dissociation, severe social anxiety, paranoia, comprehension issues, difficulties in emotional regulation, severe personality disorder and severe depression. Clients who were too physically unwell to attend the interview were also not approached.

Participants were not pressured to take part in the research and were free to withdraw at any time prior to the analysis. They were reassured that the withdrawal would not affect their further contact and care they received from the Trust. Written consent was obtained from each participant prior to the interview, indicating that they understood and agreed to the study procedure.

The interviews were anticipated to be a beneficial experience for the participants (Kvale et al., 2009) as they had an opportunity to voice their thoughts and feelings which could

be empowering for them. Participants were also provided with the time to express their views about CBT which may benefit future clients.

However, clients were informed in the PIS that if pre-existing distress was uncovered or unmet clinical needs identified a follow up session was available to discuss these. The lead researcher could access supervision or colleagues' support to discuss any concerns she might have.

Participants' participation and personal data were confidential. However, clients were informed that if a risk to self and/or others was identified this would have to be disclosed to the relevant professional, in accordance with the Trust's procedures. Participants were assured that only general findings would be made available to practitioners and specific answers would not be linked to specific clients' details.

The interviews were semi-structured and based on Elliott's (1999) Client Change Interview. They explored participants' subjective experience of CBT they received. . The interviews explored the ways CBT was not helpful; the goals the participants had for therapy and in what ways CBT was not helpful in achieving these goals. Helpful processes were also briefly explored.. The questions were paraphrased and adapted to the dialogue with each participant. The style of the interview was kept open, dialogical and aiming to explore the issues at depth (Kvale, 2009). The interviews were digitally recorded and clients were allocated pseudonyms to ensure confidentiality.

The research received NHS Ethical Approval. The REC Reference is: 16/EM/0517.

Analysis

In terms of epistemology the analysis was conducted from contructivist-interpretivist perspective (Schwandt, 1994). The method used to analyse the participants' responses was thematic analysis which used deductive process of identifying codes and themes (Braun & Clarke, 2006). The overarching themes were developed through the coding. Some codes were based on Elliott's (1985) taxonomy of helpful factors. Thematic analysis included five-phased process. Phase 1 aimed to familiarise the authors with the data. This process involved the transcription of the digital recordings either by the authors or by a professional transcription service. The transcripts where then re-read by the authors ensuring each author had a full knowledge of every transcript. Phase 2 aimed to code the data. This was a lengthy process with each transcript coded twice by two authors in order to mitigate against individual bias. Additionally authors aimed to bracket individual assumptions by reflection and discussion in the research group. Two researchers in our team were pro CBT (Aaron and Peter) and two researchers were humanistic practitioners (Joanna and Gillian) which made a balanced discussion. During this phase three authors (Joanna, Peter and Aaron) were allocated three transcripts each with the aim of grouping the coded data into the following sections emerging from the coding (1) Goals identified by the client (2) Hindering factors divided into: NHS issues, therapists' issues, CBT issues, client issues, external factors, why CBT was not helpful and outcome (3) Helpful

factors divided into: NHS issues, therapist issues, CBT issues, client issues, external factors, why CBT was helpful and outcome. A small number of helpful factors were identified in the interviews but these were not analysed further as that was beyond the scope of this research. All of the codes sections were summarised in a table format. Phase 3 involved identifying themes in the coded data focusing specifically on hindering factors. Previous research on helpful and unhelpful factors in therapy (Elliott, 1985, 1999) was consulted in this process. The next step included producing summary tables for each participant making sure the themes were relevant for each of them. Phase 4 involved a further review of identified themes by all the authors through discussion. This allowed a thorough rechecking, ensuring the themes identified were relevant and consistent against all the data collected. The discussion also ensured bracketing of individual bias which might have interfered with this process. Phase 5 involved a final review of the themes ensuring they were well defined and named.

Participants

Nine participants were recruited via snowball sampling. They were recruited from within NHS, IAPT services, in a deprived area in the North of England. The participants represented typical IAPT clients including male and female with a range of ages. Participants' demographic information is included in Table 1.

All participants had CBT which they did not find helpful. They worked with range of diagnoses such as Obsessive Compulsive Disorder, Depression, Panic Disorder and

Anxiety but not all disorders were known. The participants were recruited from Step 3 and Step 3 + parts of IAPT indicating moderate to severe and complex problems.

Table 1:

Participants' demographic information

	Gender	**Age**	**CBT how many years ago**	**No of episodes**	**No of sessions**	**Therapist**
TOTAL – 9	5 M 4 F	31-61	0-14	2-3	1-27	4 CBT Therapists 1 Mental Health Practitioner 1 Counsellor 3 Not known
MEAN		45.2	5.7	2.5	12	

Results

The results were categorized into six areas which will be discussed below. Themes that were mentioned by less than three participants will be not reported here due to space limitations but they will be listed in the table below. We have provided participants own words in italics, as appropriate, to allow the reader a greater understanding of their comments. The results are summarised in Table 2.

1) Difficulties with CBT itself

2) Negative perception of therapists

3) Unhelpful internal patterns

4) Physical health, mental health and psychosocial barriers

5) Unhelpful IAPT processes

6) Consequences of unhelpful treatment

1) Difficulties with CBT itself

Participants reported that they had difficulty identifying negative thoughts and feelings. They found challenging thoughts and finding alternative evidence difficult. Participants said that examples and explanations during therapy were too general and they also had difficulties with homework.

Difficulties identifying negative thoughts and feelings

Four participants reported difficulties identifying thoughts and feelings. Marie was able to identify the situation but, she was unable to identify the relevant thoughts. Michael did not manage to articulate the difference between thoughts and feelings, and for Jason "*the idea of capturing negative thoughts was very hard […] because they weren't out of the ordinary…They were just my normal day-to-day thoughts that I've had for the last…30 years".*

Difficulty challenging thoughts and finding alternative evidence

Five participants had difficulty challenging negative thoughts and finding alternative evidence. Michael found the process of finding alternative evidence to be unconvincing and Jason said that the bigger picture/context was ignored when looking for evidence. For Barbara "*it's an involuntary thing* [negative thoughts]*, although..., I'm trying to... rationalise things, it's not happening".*

Examples/explanations too general

Five participants found the CBT examples and explanations too general. Adam said they are: *just standard questions"...they're not... designed...to the person.* Carl commented that *CBT uses a lot of analogies* without reflecting *what happens when a person might start to feel".*

Difficulties with homework

Five participants discussed difficulties with homework. Michael disliked being given it as well as feeling obligated to complete it. He said *if something was feeling bad "…I wouldn't think…I'll get the…sheet out and write it down".* Both Jason and Michael reported that they undertook homework the night before rather than throughout the week. As a result of difficulties with homework, Carl found this made him feel negative towards himself: "*I knew it would benefit me but when I didn't do it……Christ I'm not even engaging with*

this".

2) Negative perception of therapists

Participants questioned if the therapists were committed to helping them with their problems and also expressed concerns in regard to therapists' limited empathy.

Questioned if therapists were committed to helping clients

Four participants questioned if their therapist was committed to helping them with their problems. Adam commented that he felt his therapist was not focused on his issues but was "*reading out of a medical book* and that he had to go *digging for answers himself".* Jenny would have liked if the therapist "*used their knowledge to pick things out of what I was talking about*" Jason stated that the therapist making a suggestion he buys a book and reads about the issues they were discussing indicated to him that the therapist was not fully trained.

Limited empathy

Four clients commented about the therapists' limited empathy. Jenny felt her therapists' comments indicated they did not understand her "… *He would send me things through the post that I didn't want to read […] how is this looking after me?"* Barbara said that her therapist would suggest to "*accept…your health, you're doing the best you can. No… I don't want to".*

Adam said that the therapist used technical language which was hard to understand. Jason thought the therapist quietly discharged him when "*he didn't feel he could help me…kind of quietly shifted me off"*.

3) Negative internal patterns

The authors identified internal patterns in participants' interviews which seemed to have interfered with their engagement. These patterns included: unrealistic expectations, self-criticism and negative focus.

<u>Unrealistic Expectations</u>

Seven clients were identified as having unrealistic expectations of CBT. Three clients set their expectations at a high, potentially unattainable level. Marie said "*I thought it was this really great thing that was going to help me get better"*. Michael set a goal "*of not to* [wanting] *to feel like this anymore"* but he realised on reflection this was unrealistic and "*it*

is not the way…it works". Jenny had an expectation that the change would start immediately "*I needed to go in and get on with it straightaway".*

Self-critical

The authors identified that seven clients were voicing self-criticism with Carl and Barbara directly making self-critical references. Barbara added that not only had she failed but "*I give in and surrender".* Michael said the therapy not working was his own failure "*It hasn't worked again, I failed again".* In the interviews clients said they had not tried hard enough, for example Michael said "*it could have been a lot better if I'd tried harder".* Not completing goals or tasks reinforced the sense of failure, Jason said "*I couldn't even succeed at doing my therapy homework correctly".*

Negative Focus

We identified five clients with a negative focus. Michael stated "*I realised I was getting a positivity even amongst the absolute depression... but then I was focusing on the negative"*. Jenny said *"you feel a bit like pfff, what's the point"*. Other examples of negative focus included that the 'good' experience was a one off. Michael for example said *"there's coincidence you know, it happened to be a nice good group"*. Jason stated *"this had helped before… I've moved on in my life"*. One client stated they approached CBT with a

negative expectation that it was not going to be effective while another approached it with resistance to change, for example Jason stated *"look don't tell me I haven't tried you know".*

4) Physical health, mental health and psychosocial barriers

Only three clients commented on health and psychosocial issues but it seemed important to include this as the research focused on clients based in a deprived area.

Three clients noted that severe depression and anxiety interfered with CBT. Marie's low mood hindered her reflective ability and Clare found anxiety made exposure work difficult. Stability of social and health issues were highlighted. Two participants stated it was difficult to engage when fundamentals were not settled. Maurice commented "*if you're trying to put roofs on etc, and you haven't put the foundation, it's going to collapse".* Ongoing medical investigations interrupted therapy and physical illness resulted in low energy and mood. Involvement of social services, childcare, redundancy and loss of relationships also got in a way of engaging with CBT.

5) Unhelpful IAPT processes

Participants discussed NHS/IAPT issues as barriers to engaging in CBT. Although these issues are not related to CBT per se it seemed important to report them as they were

mentioned by most participants. They reported difficulties with outcome measures, assessments, administrative issues and therapy structure. Participants also commented on the long waiting lists and that only CBT was available to them.

Difficulties with outcome measures

Seven participants discussed difficulties with the outcome measures they had to fill in each week. Clients said they did not feel comfortable filling them in. Clare said it felt *"disheartening… because … it brings it home…just how bad you've been feeling".* Clients also said that the scales felt disrespectful to their experience. For some, it was difficult to pinpoint the accurate answer and for others the measures did not reflect the nuances. For example, Jenny said about the self-harm question on PHQ9 "...*to harm myself? No, but I know I wasn't eating ...well".* Also Jason said "*there's a difference between wishing you were dead and wanting to die … the question really is: do you think you should kill yourself rather than do you think you'd be better off dead?"* Participants also commented that they learnt how to score the measures to get more services or sessions. Jenny said about the self-harm question "*If I' said 'yes' then they … 'right, shit', but because you don't put that they do 'OK, see you next week'*." Jenny also worried that "*if you put it was only one day this week, does that mean you don't get any more sessions?"* Measures were also reported as focusing on the negative side and did not catch positive change.

Difficulties with assessment

Six clients discussed issues they had with the assessment process. Clients said that they were not assessed for the right type of therapy. For example, Adam said "*if I had been…assessed better, that therapist doing CBT could have been helping another person".* Clients also said that CBT was not explained to them and Michael commented that he "*didn't know exactly what CBT things were going to entail".* Clients said that assessment involved a lot of paperwork and form filling and did not focus on their needs. Jason commented that he had to fill in a measure first and the score decided that he was depressed rather than a discussion first supported by a measure. Maurice talked a lot about the phone assessment and said it was "*uncaring, robotic and intrusive".* He was concerned that people will not engage in therapy following telephone assessments.

Difficulties with administrative issues

Four clients discussed administrative issues that got in the way of engaging in CBT. Maurice felt the service had no sensitivity when he cancelled his session as he needed to go to a funeral, he said "*if you're not going to have empathy around that, how are you going to have empathy around anything else, really?"* Barbara said "*I'm going to ask for...help …get the answering machine and then no one bothers to ring you back".* She added that it took her a lot to ask for help and she would not do it again. Clients also

commented about the problems with referrals. Carl said that his referral was dropped and he asked to be referred by a different GP. Jason's therapist went off sick and he did not get reassigned to another therapist. Carl commented on the unwelcoming language on the letters which for him sounded like "*don't waste our time…or…you'll be removed"*. He added that if he felt more ambivalent about the therapy he would have let his appointment go.

Difficulties with therapy structure

Four clients commented on the structure of therapy that prevented full engagement with CBT. Maurice and Jenny said that the therapy felt too short and Carl commented that he was not able to spread his sessions fortnightly even though it felt more beneficial to him. Jason said that he was not able to engage in CBT as he was not able to access therapy outside working hours. Jenny also felt that the therapist did not prepare for the sessions and did not remember what they talked about which she put down to the lack of time.

Waiting list is too long

Six participants said that as they waited for therapy their mood plummeted and difficulties increased which made it more difficult to engage in CBT. Maurice added that "*they leave*

you to it" and there is no support available while waiting. Long waiting times also affected therapy per se as Jenny, for example, did not want to ask for what she needed as she "*didn't want to rock-the-boat".*

Only CBT available

Five clients commented that only CBT was available to them and Maurice described it as a *state "monopoly of CBT"*. Adam was *referred "… to an inhouse therapist …who did CBT"* and there were no other therapists. Carl was referred for counselling but the waiting list was so long that he accepted CBT which was available. Michael said that he was told he had to have CBT first before getting the right therapy. Jason commented that he had to "*either get on with it or you won't get anything else".* Five clients thought CBT was chosen for their therapy as it was a cheap option. Jenny said "*I feel it's a bit of a 'go-to' therapy that's thrown at people. I don't know if it's the cheapest kind and that's part of the reason*."

6) Consequences of unhelpful treatment

All clients talked about the consequences of unhelpful CBT including not addressing core underlying issues, not addressing feelings, feeling worse and aggravated following CBT.

Overall CBT did not feel convincing. Clients stated that previous negative experience of CBT affected therapy.

Not addressing core underlying issues

For seven participants CBT did not address core underlying issues. Carl said that "*it didn't feel like it was approaching any kind of underlying problems...I felt like a train had gone off the tracks...and rather than figuring out why...CBT felt like...put it back on tracks and set it on it's way again".* For Adam the therapy was "*chipping away, but not actually breaking through".* Barbara and Claire said CBT did not address childhood issues which were at the core of their difficulties. Jason commented that CBT focused on the here and now and Jenny concluded that CBT was simply stating the obvious.

Not addressing feelings

Four clients said that CBT did not address feelings. Barbara said for example that CBT "*opened Pandora's Box"* and she was left to deal with feelings by herself. Similarly for Adam, he said that his feelings were stirred up during sessions but the therapist did not address or explore them. Carl found it difficult to articulate his feelings during sessions, leaving him self-critical. He commented that he was not encouraged and supported to discuss his feelings during CBT.

Clients left feeling worse

Seven clients expressed that CBT left them feeling worse. Adam said that "*everything gets brought up"* but then the session ends "*that's just sort of messed everything up".* Barbara used the metaphor of "*Pandora's* Box" being opened which also left her in a worse place. Barbara said she felt overwhelmed as the therapist was *"trying to put it across to me in a 10-minute conversation"*. Jason was concerned about having false confidence "*I've…got in social situations where I've gone in with confidence and been smashed down".* Maurice was critical that CBT could be setting clients up to fail "*you've had your CBT now for 10 weeks, bang. And, relapse happens again"*. Jenny felt judged and she felt "*like a horrible person"* which left her feeling worse. Jenny also criticised the process of completing the rating scales as after filling them in she *was "actually distressed and struggled".* Claire said she felt responsible for CBT not working I've *done "all that and nothing's changed. If anything, I'm worse".* Jason also said the homework tasks made him feel worse as he felt he could not do them correctly.

Feeling aggravated with CBT

We identified six clients who reported feeling aggravated with CBT. Clients felt disillusioned, irritated and dismissive. There was a sense of wasted time with therapy

feeling pointless. Jenny stated she felt annoyed "*walking out of there thinking I had got nothing done. I felt really disappointed quite regularly".*

CBT did not feel convincing

Five clients were not convinced by CBT. Marie shared that CBT was too clinical. Carl said that "*there is no room for the kind of silences that would force you to… properly reflect".* Carl said the structure of CBT meant *"it was more artificial".* For Barbara "*it threw up more things than actually resolved",* and she did not feel that CBT put difficulties into perspective.

Previous negative experience of CBT affecting therapy

Four clients stated that previous negative experience of CBT affected their current CBT.

Carl said *the fact I've been through a couple of "…different, assessments, different workers and sort of feeling like I've had a, not a complete vision".* Jenny said a previous therapist did not understand her which led her to not trusting her current therapist. Jason said the lack of success in his first experience of CBT meant "*now I have avoided going down the CBT route".*

Table 2

Results section

1) Difficulties with CBT itself
Difficulty challenging thoughts and finding alternative evidence (5) Examples/ explanations too general for the client (5) Difficulties with homework (5) Difficulty identifying negative thoughts and feelings (4) Difficult to apply herself/himself (3) Difficulty using thought records (3)
2) Negative perception of therapists
Queried if therapist committed (4) Limited empathy (4) Relational skills issues (3) Carrying on even though therapy not working (3) Did not follow up homework (3) CBT not explained properly (2)
3) Unhelpful internal patterns
Unrealistic expectations (7) Feeling self-critical (7) Negative focus (5) Lack of motivation (3) Avoidance (3) Feeling a burden (2)
4) Physical health, mental health and psychosocial barriers
Feeling too depressed to be reflective or to undertake CBT (3) Anxiety (3) Family issues (3) Exposure/ completing thoughts records too anxiety provoking (3) Deprivation/ Lack of stable physical/ financial/ social structure (2) Health issues/ medical investigations (2)
5) Unhelpful IAPT processes
Difficulties with outcome measures (7) Difficulties with assessment (6) Waiting list is too long (6) Only CBT available (5) Difficulties with therapy structure (4)
6) Consequences of unhelpful treatment

Not addressing core underlying issues (7)
Clients left feeling worse (7)
Feeling aggravated with CBT (6)
CBT did not feel convincing (5)
Not addressing feelings (4)
Previous negative experience of CBT affect therapy (4)
Feelings stirred up and not addressed (4)
Not feeling cared for (3)
Patronising and simplistic (2)

Discussion

The results of this study demonstrate there are aspects of CBT that do not meet client needs. This will be discussed in the same order as the results above.

1) Difficulties with CBT itself

Clients identified difficulties with the process of CBT itself, undertaking the practical exercise of homework or the theoretical exercises of identifying negative thoughts and feelings and challenging these (cognitive restructuring). Nilsson et al.. (2007) also found that it was difficult for clients to focus on negative thoughts and Westra et al (2010) said that a lot of clients found learning techniques and doing homework difficult. The results indicate the rationale given for these difficulties could vary. Clients identified struggling to undertake exercises on their own or found the process in itself overwhelming and negative. Nilsson et a.l (2007) also said that clients did not find learning techniques or discussing homework helpful as they wanted to talk about things they wanted to talk about in therapy and they wanted to focus more on reflection and understanding . Homework

and cognitive restructuring are key aspects of CBT (Mansell, 2018) so it seems concerning that most clients had difficulties with these and did not find them helpful.

2) Negative perception of therapists

Clients expressed concern about whether therapists were committed to helping them which was also expressed by Nilsson et al. (2007). Several clients saw therapists as not empathic. Clients commented that therapists followed a CBT protocol rather than attending to them individually which felt unhelpful. Bystedt et al. (2014) also found that when therapists followed CBT protocol rigidly, clients felt not understood and validated. Nilsson et al (2007) added that in these situations clients considered the therapist intrusive and oppressive. They felt that the therapist was withdrawn, disengaged and aloof and not providing support the client needed. Interestingly during this study a therapist who applied CBT in response to the client's needs (Adam) was seen as helpful. Whalley (2018) confirmed this and said that CBT can be helpful but it needs to be applied in a flexible and responsive way depending on and following clients' needs. The above findings show that therapy process needs to be adjusted to the clients rather than following a therapy protocol which will have a significant impact on the therapeutic relationship and the outcome of therapy. The findings have potential implications for an increased empathy training within therapy courses as this could help therapists to be able to be more understanding and responsive to clients' needs.

3) Unhelpful internal patterns

While interviewing clients about unhelpful factors in CBT we noticed that clients discussed internal patterns such as having high or unrealistic expectations, being critical of self and negative focus. Although clients did not express explicitly that these patterns got in the way of engaging in CBT we thought that it would be useful to consider these. We discuss them here only tentatively hypothesizing their importance in clients' perception of helpfulness of CBT.

This research identified a high level of expectation regarding CBT that was potentially unattainable or could not be met with either resources or in the timeframe. Both clients and therapists set goals that were unrealistic with the outcome that they were either not attempted or left the client feeling frustrated. If the therapy was subsequently not producing results clients became self-critical blaming themselves as failures. This pattern of setting unrealistic expectations leading to negative outcome in CBT was also noticed by Westra et al. (2010). Clients ended up blaming themselves for therapy not being helpful and consequently feeling worse. We concluded that it is essential for any form of therapy to discuss client's expectations from the outset, so they are realistic. . In terms of self-criticism it appeared from the interviews that the pattern of self-criticism and blaming self was present in other areas of clients' lives and it was possible that it contributed to the clients' difficulties in the first place. It would have been helpful if the therapists were able to address this with clients.

We also noticed that although clients spoke about the CBT in negative terms describing it as unhelpful, they commonly said that they felt better and were doing more activities.

We concluded that perhaps there might have been a discrepancy between the clients' perception of helpfulness and the helpfulness of therapy. Therefore, asking about CBT might have activated negative internal patterns whereas gently challenging these allowed the clients to reflect further on the positive aspects of the process.

4) Physical health, mental health and psychosocial barriers.

A small proportion of participants reported that they could not use CBT as they were too depressed, anxious or had health issues. Only two clients said that if their physical, financial or social positions were more stable then at that point CBT would be more appropriate for them. The interviews took place in one of the most deprived areas of the UK with one of the highest Mental Health Needs Index scores in in the country. NHS Digital (2016) reported that the recovery rate in IAPT in the deprived area was 35% (in comparison to 46.3% in more affluent areas) with local data suggesting that the recovery rates in the deprived area can be even lower than that. Delgadillo et al. (2015) also identified that there is a link between deprivation and recovery scores. It is possible that the participants of this research did not want to or did not see that their economic and psychosocial positioning potentially could have an impact on their mental health. Also it is possible that the participants of this research felt fairly stable and secure and perhaps the results of this research might have been different if we interviewed clients in crisis without economic or psychosocial stability. We did not collect demographic information indicating the participants' deprivation level and this might be an important social justice issue requiring further research.

5) Unhelpful IAPT processes

Most clients expressed concerns and dissatisfaction with outcome measures namely PHQ9 and GAD7. Clients felt that the provision of services was decided on the scores, but the measures did not reflect accurately how they felt or what they needed. Clients said they learnt to exaggerate or distort what they reported in order to get what they needed. The service funding is dependent on outcome measures and reflecting on what clients said about the measures raises ethical and economic questions and requires further research. Another concerns clients expressed was waiting lists, in some instances waiting as long as two years for therapy. Clients said that they were left without support whilst they were waiting, and they were not able to access other forms of therapy during that time. Clients said that their mental health deteriorated in that time and also their motivation to engage in therapy decreased which made engagement in therapy more difficult. Again, this has ethical and economic implications.

Clients also had concerns over clinical assessments. They said that assessments involved lots of paperwork and form filling but did not focus on what clients needed. Clients were offered CBT as a first line of treatment, but they said they actually wanted a different type of therapy.

Clients worried that CBT was not appropriate for them but were offered it as a “go to therapy” without consideration of their individual difficulties. Clients expressed a fear of losing services or therapists and therefore undertook and completed CBT as a means to assuage that even when they knew CBT was not the appropriate for them. Some clients

undertook CBT as a means to an end i.e. achieving their desired therapy. This indicates that the triage and resource allocation system in IAPT may benefit from a review. This seems particularly pertinent as local data suggests that 45% of clients are referred to another therapy following 2-6 sessions of CBT. This is also mentioned in literature, for example, following sessions of CBT, clients are referred to DBT (Childs-Fegredo et al. 2018) and to Counselling (Goldman et al., 2016). Therefore referring clients as a first line of treatment to therapies other than CBT should be considered as research demonstrates they are as effective as CBT (e.g. Pybis et al. (2017).

6) Consequences of unhelpful treatment

A key issue that arose was that CBT actually made the clients feel worse which which may be similar to the CBT "side effects" that Schermuly-Haupt et al. (2018) reported. Bystedt et al. (2014) also found that several clients reported feeling worse following CBT experiencing insomnia, low-self-esteem and the reinforcement of the 'sick role' including feeling suicidal. These findings are or concern given the level of provision of CBT within the NHS.) Clients identified they went into CBT either seeking to resolve specific goals or without a clear understanding of what CBT entailed and then during therapy emotions or feelings were stirred or raised. This was also mentioned by Westra et al. (2010) and Young (2019) who said that clients often considered CBT as too intellectual, cognitive and technical which did not address their feelings. A concern identified in our findings was the lack of address or follow up given to these emotions, or the practical lack of time available to discuss them.. Similarly most clients commented that CBT did not address

their core underlying issues which clients considered as waste of time and resources leaving them feeling worsewhich was also echoed in Westra et al. (2010) and Bystedt et al. (2014). Nilsson et al. (2007) reported that clients said that they were not supposed to think about what caused their problems but to focus on the problem per se. Clients said they felt patronised and felt CBT was simplistic . Clients also commented that they felt aggravated with CBT and they did not find CBT convincing. Nilsson et al. (2007) said that clients wanted deeper therapeutic process for change to occur.

An important area from our research was clients' previous experience of CBT. Clients expressed undertaking and having difficulties with CBT in the past. These clients then found it difficult to engage in the CBT again either approaching the therapy with preconceived criticisms or feeling they were being set up to repeatedly fail. Bystedt et al. (2014) also mentioned this as unhelpful as it could generate perception that one is beyond help and clients would potentially be less likely to seek further help. These findings have been confirmed by Cooper et al. (2017) who found that client's preferences were predictors of therapy outcomes. Clients' preferences and previous therapy experiences need to be taken into account in order for clients to successfully engage in therapy.

Limitations

As with most qualitative research the sample size in the research is small and therefore the ability to generalise is limited. The researchers' subjective biases will have impact on the findings, and as it was mentioned above we attempted to bracket our assumptions in the research team through reflection and discussion as we were analysing the data. A further limitation is that the results are dependent on the clients' recall and clients might not remember what was unhelpful for them. It is also important to say that the findings emerged from the participant's subjective perception but there might be other factors at play that clients were not aware of. Due to confidentiality we did not report ethnic backgrounds of our participants. The sample was predominately White British and it would have been helpful to have more diverse participants' group.

Conclusions

The current research identified a range of unhelpful aspects of CBT which include more general NHS/IAPT issues as well as mental health, health and psychosocial issues which can become barriers to CBT. Clients also discussed issues that are related to therapists' attitudes and behaviours and their own internal patterns that would get in the way of engaging in CBT. Difficulties with CBT itself were also mentioned and included difficulties with identifying thoughts and feelings as well as challenging thoughts. Clients also had difficulties with homework and relating to general examples used in therapy.

This research demonstrated that analysing unhelpful factors in CBT is helpful, not as a critical stance, but as a means to allow therapists to identify particular themes relating to these factors and therefore to understand how and why something has not been helpful. This will improve the therapeutic process for both therapist and client.

Regarding future research, further exploration of disorder specific unhelpful factors may allow professionals to adapt a more tailored approach to working with these conditions. Also it might be useful to research unhelpful factors in BME populations to be more responsive to the needs of this group of clients.

It seems important to conclude that the above unhelpful factors are likely to be present in most therapies and it is important to engage in a thorough assessment prior to therapy and regular therapy reviews asking clients what is helpful and unhelpful in therapy. It is also crucial to respond and be flexible to clients' needs as well as being sensitive to clients' preferences and internal patterns. The participants clearly identified that other approaches should be offered alongside CBT as the first line of treatment. Interestingly, in 2010 Swedish government decided to fund other approaches then CBT. They found that 'CBT monopoly' is not helpful as people need to have choice for their therapy to be effective. (Miller, 2012). Will we be brave enough to listen to this evidence in the UK?

.

Acknowledgements

We wish to thank the clients for participating and the BACP for funding the project. We are also grateful to our colleagues who supported the research.

References

Bohart, A., & Tallman, K. (2009). *How clients make therapy work*. Washington DC: American Psychological Association.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. Qualitative Research In Psychology, 3(2), 77-101. doi: 10.1191/1478088706qp063oa

Bystedt, S., Rozental, A., Andersson, G., Boettcher, J. and Carlbring, P. (2014).Clinicians' Perspectives on Negative Effects of Psychological Treatments. *Cognitive Behaviour Therapy*, 43(4), pp.319-331.

Cooper, M. (2008). *Essential research findings in counselling and psychotherapy*. London: Sage.

Cooper, M. Messow, C.M., McConnachie, A., Freire, E. Elliott, R., Heard, D., Morrison, J. (2017). Patient preference as a predictor of outcome in a pilot trail of person-centered counselling versus low-intensity cognitive behavioural therapy for persistent subthreshold and mild depression. *Counselling Psychology Quarterly,*1-17.

Childs-Fegredo, J. & Fellin, L. (2018) 'Everyone should do it': Client experiences of receiving adapted Dialectical Behaviour Therapy, an interpretative phenomenological analysis. *Counselling and Psychotherapy Research* 18(3)

Delgadillo, J., Asaria, M., Ali, S., Gilbody, S. (2016). On poverty, politics and psychology; the socio-economic gradient of mental healthcare utilization and outcome. *The British Journal of Psychiatry* 209, 429-430

Elliott, R. (1985). Helpful and nonhelpful events in brief counseling interviews: An empirical taxonomy. *Journal Of Counseling Psychology*, *32*(3), 307-322. doi:10.1037//0022-0167.32.3.307

Elliot R. (1999). Client Change Interview protocol. Retrieved from Network for Research Experiential Psychotherapies website http://experiential-researchers.org/instruments/elliott/changei.html

Foa, E. B., Zoellner, L. A., Feeny, N. C., Hembree, E. A., & Alvarez-Conrad, J. (2002). Does imaginal exposure exacerbate PTSD symptoms? *Journal of Consulting Clinical Psychology, 70*(4), 1022–102.

Goldman, S., Brettle, A., McAndrew, S. (2016). A client focused perspective of the effectiveness of Counselling for Depression (CfD). *Counselling and Psychotherapy Research*, 16(4): 288–297

Jarrett, C. (2008). When therapy causes harm. *The psychologist*, 21(1), pp.10-12.

Kvale, S. & Brinkmann, S. (2009). *Interviews (2nd ed).* London: Sage.

Henkelman, J., & Paulson, B. (2006). The client as expert: Researching hindering experiences in counselling. *Counselling Psychology Quarterly*, *19*(2), 139-150. doi: 10.1080/09515070600788303

Layard, R. (2004) Mental Health: Britain's Biggest Social Problem. Retrieved On 27thJanuary 2007 from http://www.cabinetoffice.gove.uk/strategy/downloads/files/mh_layard.pdf.

Layard, R . & Clark, D.M. (2014). Thrive: the power of evidence based Psychological therapies. London: Allen Lane.

Mansell, W. (2018) What is CBT really and how can we enhance the impact of effective psychotherapies such as CBT. In Loewenthall, D. & Proctor, G. (Eds) Why not CBT? Against and for CBT revisited. PCCS Books: Exeter

Mayou, R. A., Ehlers, A., & Hobbs, M. (2000). Psychological debriefing for road traffic accident victims: Three-year follow-up of a randomized controlled trial. *British Journal of Psychiatry, 176*(6), 589–593. https://doi.org/10.1192/bjp.176.6.589.

Miller, S.D. (2012) *Revolution in Swedish mental health practice: the cognitive behavioural therapy monopoly gives way.* [Blog] www.scottdmiller.com/revolution-in-swidish-mental-health-practice-the-cognitive-behavioral-therapy-monopoly-gives-way (accessed 3rd February 2018)

Nilsson, T., Svensson, M., Dandell, R., Clinton, D. (2007) Patients' experiences of change in cognitive-behavioural therapy and psychodynamic therapy: a qualitative comparative study. *Psychotherapy Research.* 17(5): 553-566

NICE (2009) *Depression in adults: recognition and management. NICE Clinical Guideline 90. Retrieved from* https://www.nice.org.uk/guidance/cg90 on 27th February 2018

NHS Digital (2016) *Psychological Therapies: Annual report on the use of IAPT services*.

Health and Social Care Information Centre. Retrieved from www.digital.nhs.uk on 15th January 2017

Parry, G., Kothari, G., Saxon, D., Curran, J., Barkham, M., Bishop-Edwards, L., Hardy, G. & Dent-Brown, K. (2014). AdEPT: Understanding and preventing the adverse effects of psychological therapies. UK NIHR Research for Patient Benefit (RfPB) Programme (Grant Reference Number PB-PG-0408-15144).

Proctor, G. (2005) Should therapy make you worse? *Clinical Psychology*, 45, pp.7-9

Pybis, J., Saxon, D., Hill, A., Barkham, M. (2017) The comparative effectiveness and efficiency of cognitive behaviour therapy and generic counselling in the treatment of depression: evidence from the 2nd UK National Audit of psychological therapies. *BMC Psychiatry 17:215 Doi 10.1186/s12888-017-1370-7*

Scheeringa, M. S., Weems, C. F., Cohen, J. A., Amaya-Jackson, L., & Guthrie, D.(2011). Trauma-focused cognitive-behavioral therapy for posttraumatic stress disorder in three-through six year-old children: A randomized clinical trial. Journal Of Child Psychology and Psychiatry, 52(8), 853–860. https://doi.org/10.1111/j.1469-7610.2010.02354.x.

Schermuly-Haupt, M., Linden, M., & Rush, A. (2018). Unwanted Events and Side Effects in Cognitive Behavior Therapy. Cognitive Therapy And Research, 42(3),219-229. doi: 10.1007/s10608-018-9904-y

Schwandt, T. A. (1994). Constructivist, interpretivist approaches to human inquiry. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 118-137). Thousand Oaks, CA, US: Sage Publications, Inc.

The National Collaborating Centre for Mental Health. (2018). *The Improving Access to Psychological Therapies Manual*. NHS.

Westra, H.A., Aviram, Ad, Barness, M., Angus, L. (2010) Therapy was not what I expected: a preliminary qualitative analysis of concordance between client expectations and experience of cognitive-behavioural therapy, *Psychotherapy Research* 20(4): 436-446

Whalley, S., Florence, I. (2018) Every time I sit down with a client, I am privileged to learn something new. The Psychologist. May 2018.

Young, C. (2019) The possible harmful ‘side-effects’ of psychotherapy. Researchgate

Retrived from

https://www.researchgate.net/publication/235982198_The_Possible_Harmful_'Side-Effects'_of_Psychotherapy_ 1_COURTENAY_YOUNG

Retrieved on 25th April 2019

Disclosure Statement: no financial interest or benefit has arisen from the direct application of this research.