Academic Article

# When Therapy Goes Wrong – A Case for Increasing Focus on the Negative Effects of Counselling and Psychotherapy in Training Programmes

*By Suzanne Mitchell*

*Training programmes are often geared around bolstering the belief, albeit true in most instances, that therapy has positive outcomes for clients. However, research has shown that up to 10 per cent of clients are worse off as a result of therapy and that some therapists underestimate the frequency of negative outcomes. It is crucial that trainees are aware of the risks involved with this caring profession*

## Introduction

Counselling and psychotherapy have repeatedly been shown to be effective in helping people who are experiencing emotional and psychological distress (Rozantal, Kottorp, Boettcher, Andersson & Carlbring, 2016). More than ever, therapists' work practices must be based on current research and, as a result, counsellor training programmes are evolving to meet this demand (Cooper, 2008). There appears to be a belief that talking therapies carry little risk to clients (Berk & Parker, 2009), yet evidence to the contrary exists.

The body of evidence demonstrating the efficacy of counselling and psychotherapy is expanding. We know now that up to 10 per cent of people may deteriorate because of psychotherapy (Boisvert & Faust, 2003). Despite practitioners having an ethical responsibility to do no harm, research into the potentially harmful effects of this potent intervention is lacking.

The aim of this article is to make the case for a heightened focus on the negative effects of therapy in undergraduate training programmes. Students must be made aware of the risks associated with talking therapies and be offered the tools to help identify and measure negative outcomes, while at all times respecting client autonomy.

## Existing research

In his 2008 research, Cooper found that eight out of 10 people benefited from therapy as opposed to not having therapy at all. There was no statistically significant difference in outcomes between the main therapeutic orientations. Justifiably,

researchers are trying to identify the elements that make therapy effective, with a view to enhancing outcomes. However, "little is known about the occurrence and characteristics of possible negative effects, reflecting a major shortcoming in clinical research" (Bystedt, Rozental, Andersson, Boettcher & Carlbring, 2014, p. 319). Bystedt et al (2014) argue that most of the emphasis on negative effects has been on fringe therapies such as rebirthing and recovered memory techniques, with less attention given to "negative effects that might be associated with evidence-based care" (p. 314). Some evidence suggests that clinicians have a propensity to underestimate negative effects (Castonguay, Boswell, Constantino, Goldfried & Hill, 2010; Leitner, Martens, Koschier, Gerlich, Liegl, Hinterwallner & Schnyder, 2012; Slade, Lambert, Harmon, Smart & Bailey, 2008). Furthermore, some practitioners are unable to predict when clients will get worse. In one study involving 48 therapists, some 20 per cent noticed that their clients were deteriorating (Hannan, Lambert, Harmon, Nielsen, Smart, Shimokawa and Sutton, 2005). Lambert (2010, as cited in Leitner et al 2012) found that just half of the therapists surveyed reported deterioration in their own clients. Whilst these studies have relatively small samples sizes, a worrying trend in practitioners' inability to notice adverse effects appears to be emerging.

**Obstacles**

Why this reticence to exploring the shadow side of psychotherapy? Linden and Schermuly-Haupt (2014) offer several reasons. Firstly, they argue that because the therapist provides the treatment, they are responsible for all negative outcomes "which results in a perceptional bias towards positive rather than negative effects"

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(p. 306). Secondly, the range of negative effects is very broad as there is a focus on social behaviour of clients as well as symptoms. Thirdly, there is no consensus on what to call negative. For example, crying in therapy can be unpleasant, but is often positive therapeutically. Fourthly, there is no delineation between side effects, failure of therapy and deterioration of illness. Finally, they note that as yet there has been no agreement on how to measure and assess negative effects or rules on how to plan scientific studies to monitor these.

Nutt and Sharpe (2008) also argue that many trials have not entertained the idea that therapy could cause harm. They suggest that researchers, and indeed the public, assume that because it is only talking, it is innocuous. There is stiff competition for limited funding to further the field of mental health. The Improving Access to Psychological Therapies programme in the UK will only allocate funding to "those therapies for which there is clear evidence of effectiveness" (Cooper, 2008, p. 9). The author believes this competition could incentivise researchers to produce evidence that therapy works, rather than highlighting when it does not.

**Defining harm**

Classifying harmful treatments has generated controversy (Dimidjian & Hollon, 2010). Methodologically, it can be difficult to differentiate between negative effects from therapy itself, normal life events and the progression of a mental illness (Bystedt et al, 2014). Traditionally, deterioration effects and negative effect sizes from meta-analyses of therapeutic outcomes have been used to assert that psychotherapy can be harmful (Lilienfeld, 2007). Deterioration can be described as "not only worsening symptoms, but lack of significant improvement when it is expected" (Lambert, Bergin & Collins, 1977, as cited in Berk & Parker, 2009). Barlow (2010) discusses the example of critical incident stress debriefing (CISD). This is offered to people immediately after experiencing a traumatic event, such as a natural disaster or car crash. People who scored high on a measure of the impact of a traumatic event actually experienced more severe symptoms after four months and a three-year follow-up than those who scored lower.

Dimidjian and Hollon (2010) argue that harmful outcomes of therapy are those that are more than simply unhelpful, but are those interventions that cause injury or damage. May and Franks (1980, as cited in Bystedt et al, 2014) coined the term 'negative outcome'. This is when a person's functioning declines after beginning therapy, and continues to decline for a significant length of time (which is not specified) after termination. Linden and Schermuly-Haupt (2014) believe that similarly to pharmacotherapy, "a distinction must be made between side effects, unwanted events, adverse treatment reactions, treatment failure, malpractice effects, side effect profile, and contraindications" (p. 306).

**Why pay attention to harmful effects?**

Given that therapists already work in a profession described by Freud as "impossible" (1937, as cited in Barnett, 2007, p. 258), the existence of a multitude of obstacles is insufficient reason

to neglect a critical aspect of this caring profession. It is the author's view that ignoring the evidence surrounding potential client deterioration could potentially and unnecessarily put clients at risk - a sentiment echoed by Dimidjian and Hollon (2010) who believe that "failure to detect harm can have serious consequences" (p. 21). Furthermore, "a duty to avoid harm to any client" is one of the underpinning principles of the IACP Code of Ethics ('IACP Code of Ethics', 2019).

**What do we already know?**

Lilienfeld (2007) believes that the emphasis on the gathering of evidence for the efficacy of empirically supported therapies is misplaced. Empirically supported therapies are those interventions that have been found in controlled trials to be effective for specific disorders, for example, major depressive disorder, obsessive-compulsive disorder and bulimia. He argues that because a practitioner's prime responsibility is to do no harm, identifying therapies that are potentially harmful should be afforded a higher priority. To that end, by examining current research findings, he created a list of potentially harmful therapies that includes items such as CISD, rebirthing therapies, grief counselling for normal bereavement and relaxation treatments for panic-prone clients (Lilienfeld, 2007). He expects the list to be updated and revised continuously. Importantly, he refers to these as 'potentially' harmful.

The evidence suggesting they have adverse effects is not definitive and they are not harmful for all individuals exposed to them. Lilienfeld (2007) believes that there is an attitude of complacency in the field towards the harmful effects of counselling and psychotherapy. He argues that exposure to research in this area should be an integral ingredient in the training of mental health professionals, stating that "students in training also need to understand that even well-intentioned interventions can sometimes produces harm" (Lilienfeld, 2007, p. 66).

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**Tools to assess negative outcomes**

We cannot learn from our mistakes if we do not know we are making them. Sapyta, Riemer and Bickman (2005) posit that practitioners need to be aware of client outcomes if they are to learn from clinical experience. According to Mearns, Thorne and McLeod (2013), an increasing number of counselling services require their staff to use brief surveys to collect client feedback. A popular tool used for this is the CORE outcome measure (CORE Information Management Systems, 2019). Providing clinicians with regular feedback on client progress has been shown to improve outcomes for those predicted to leave therapy worse off (Harmon, Lambert, Smart, Hawkins, Nielsen, Slade & Lutz, 2007). Slade et al (2008) point out that if clinicians can identify clients who are at risk of deterioration earlier in the therapeutic process, then they would be in a better position to prevent this.

Despite the lack of consensus in relation to defining and measuring negative effects of therapy, there are instruments available to practitioners and researchers alike to monitor negative therapeutic outcomes. The Inventory for the Assessment of Negative Effects of Psychotherapy, devised by Ladwig, Rief and Nestoriuc in 2014, is a self-assessment tool clients complete at the conclusion of therapy to determine whether it had a positive or negative effect. With Linden's (2012) Unwanted Events to Adverse Treatment Reactions checklist, therapists can assess side effects of therapy at fixed intervals.

In 2016, Rozental et al designed the Negative Effect Questionnaire. This 32-item instrument is used throughout therapy to assist in the identification of clients who are at risk of a negative outcome so that alternative interventions can be offered.

Having a credible framework to learn from and proficiency in specific skills can help trainees feel more confident in their abilities (Hill, Roffman, Stahl, Friedman, Hummel and Wallace, 2008). It is the author's view that exposure to instruments such as those listed above, in a supportive learning environment, would not only give invaluable feedback on their progression, but also help overcome reluctance to use such tools in professional practice.

**Why focus on training programmes?**

It is apparent to the author that in order to address the aforementioned shortcomings, training programmes must increase their focus on identifying potential harmful and negative effects. Mearns, Thorne and McLeod (2013) expect graduates to be able to use instruments that evaluate the effectiveness of their work.

Castonguay et al (2010) assert that "one of the mandates of graduate training in clinical and counselling psychology should be to raise awareness of and to prevent, to the extent possible, predictable sources of harm in psychotherapy" (p. 35). Sapyta et al (2005) state that "therapists are trained, are supervised, and practice in the absence of information about client treatment response from objective sources" (p. 147). In most training programmes, emphasis is on teaching results of studies where the evidence supports the efficacy of therapy. Less attention is given to the fact that not all outcomes are positive (Castonguay et al, 2010).

**Recommendations**

In light of this knowledge gap, Castonguay et al (2010) make a number of recommendations for training programmes. Many of these already exist in most programmes as they are theorised to contribute to positive therapeutic outcomes. However, Castonguay and colleagues underscore the importance of emphasising the avoidance of doing harm when training therapists. They clustered their recommendations into a set of overarching principles, plus five general guidelines.

**Overarching principles**

Castonguay et al (2010) argue that students should be exposed to Lilienfeld's list of potentially harmful therapies and kept up to date with any expansions as it provides "clear warning signals of harm for certain populations or contexts" (p. 35). Furthermore, trainees should be encouraged to critically assess the evidence that supports the claim that a particular intervention is potentially detrimental. For example, just because relaxation techniques have been shown to induce panic attacks in some clients, they should not be applied to everyone. Some deleterious effects only occur in certain contexts. For that reason, training clinicians in how to monitor changes and a lack of improvement is of the utmost importance. It is also prudent to invite trainees to identify commonalities amongst potentially harmful therapies. For example, grief counselling for normal bereavement, boot camp interventions and CISD may all induce intense emotions.

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**General guidelines**

**1. Enhance therapeutic relationship**

A vast body of research demonstrates that a healthy therapeutic alliance is a good predictor of positive therapeutic outcomes (Yalom, 1980; Mearns Thorne & McLeod, 2013; Duff & Bedi, 2010). This is not a new concept in counsellor training. Castonguay et al (2010) propose that these findings can also inform training guidelines to avoiding harm. They advocate explicitly focusing on teaching skills that enhance the therapeutic relationship such as communicating empathy and setting collaborative goals.

**2. Skilful and appropriate use of technique**

Students must be made aware of the potential negative impact of techniques employed, even if they are used in an empirically supported therapy (Castonguay et al, 2010). It is not necessarily the techniques themselves that may be detrimental, but the strict adherence to their use. To illustrate, when faced with resistance from a client, cognitive behaviour therapists often increase their adherence to an intervention. This in turn may lead to more opposition to the technique from the client. Additionally, frequent interpretations by psychodynamic therapists were associated with poor therapeutic outcomes (Castonguay et al, 2010). Boisvert and Faust (2003) also caution again insisting on using a particular intervention, despite resistance from the client as this may threaten the relationship.

**3. Prevent and repair toxic relational and technical processes**

There is an abundance of empirical evidence on the importance of relational factors, such as the therapeutic alliance to advocate for a clear focus on interpersonal skills in therapist training. (Castonguay et al, 2010). Fostering self-awareness amongst trainees and increasing countertransference managements skills are important considerations for training programmes. So too are teaching technical processes, such as identifying when a client is not responding to an intervention, and responding in a flexible way. Ackerman and Hilsenroth (2001) also argue that positive therapeutic outcomes rely heavily on the therapist's "capacity to recognize and effectively control negative process" (p. 171).

**4. Adjusting treatment to client characteristics**

Castonguay and his colleagues highlight the importance of ensuring that trainees are aware that

different clients react differently to various interventions. For example, clients with depression have a tendency to externalise their issues. These clients are often more responsive to cognitive-behavioural approaches rather than insight-oriented approaches. Practitioners must adapt to client needs and Castonguay et al (2010) suggest that therapists be trained to integrate a variety of evidence based interventions in their work. Trainees must be reminded that not all interventions work with all clients and if a client does not respond to therapy, it is not necessarily an indication of their incompetence.

**5. Recognising practitioner traits that may be less effective**

Wampold (2006, as cited in Castonguay et al, 2010) suggests that 'therapist effect' may be more predictive of outcomes than the therapeutic relationship. In other words, some practitioners are more likely to cause harm than others. For example, therapists with anxious attachment styles may have less empathic exchanges with clients. Though existing research into harmful therapist characteristics is inconclusive, Castonguay et al (2010) offer examples such as a tendency to be authoritarian, passive, detached, an excessive need to be liked, an inability to receive criticism and perfectionism. To counteract the potentially damaging effects of therapist traits, trainees must be encouraged to become aware of their vulnerabilities, as well as their strengths.

**Client responsibility**

Despite numerous challenges defining and researching negative therapeutic effects, there are tools and guidelines available to begin to overcome these hurdles. We must remember, however, that therapy is not a solitary endeavour undertaken by therapists. Our clients are equally part of the process.

> *Our clients "are not inert objects upon which techniques are administered"*
>
> *(Bergin & Garfield, 1994)*

It is tempting to conclude that therapists bear all responsibility for any negative outcomes that occur. This was even suggested by Linden and Schermuly-Haupt (2014). By that rationale, are therapists also responsible for all positive outcomes? The author argues that by taking full responsibility for all results, we risk undermining client autonomy and subverting clients' capacity for personal responsibility. These are the very qualities we are supposed to help our clients cultivate (Kinsella, 2018; Mearns, Thorne & McLeod, 2013, Yalom, 2011).

Our clients "are not inert objects upon which techniques are administered" (Bergin & Garfield, 1994, as cited in Bohart & Tallman, 2010, p. 84). As practitioners, we must be responsible *to* our clients, but we cannot be responsible *for* them (Mearns, Thorne and McLeod, 2013). The significance of a client taking personal responsibility for their own therapy cannot be understated. According to Overholser (2005), "clients are more likely to benefit from treatment when they are willing to assume their share of responsibility for good and bad events" (p. 370).

Therapists, of course, have an ethical responsibility to do no harm, however we cannot accept all responsibility for how clients react to interventions, even those that are empirically supported. Yalom (2011) urges therapists to explain to clients the importance of being responsible for themselves, calling it an "essential first step in the therapeutic process" (p. 144).

Kinsella (2018) states that "autonomy sits at the epicentre of counselling and psychotherapy" (p. 5). From the author's perspective, therapists must be aware of therapies that have potential for harm. They must be willing to reflect on, and manage, personal traits that may produce unwanted effects. Practitioners must be vigilant, on the look-out for any deleterious effect. However, it is critical that we collaborate with clients when these occur and ultimately allow them to decide what is the best course of action for them.

**Conclusion**

With an increasing focus on evidence-based practice, the field of counselling and psychotherapy is undergoing a paradigm shift. However, as has been shown, not enough attention has been paid to negative outcomes. Lilienfeld's pioneering research illustrates that there are a significant number of interventions that have the potential for harm.

We have seen that practitioners are not always aware when their clients are deteriorating. Obstacles to defining and researching harmful effects abound, yet this does not relieve us of our duty to make advances in this overlooked area. There are tools available to help practitioners monitor and identify deleterious outcomes that can be taught in training programmes, so as to encourage their use in professional practice.

Castonguay and colleagues have offered guidelines for the incorporation of research on negative effects into counsellor and psychotherapy training programmes. Therapists cannot be responsible

for all negative effects as client responsibility plays a central role in outcomes. Like medical practitioners, counsellors and psychotherapists have an obligation to abide by the credo *primum non nocere* (first, do no harm). We can continue to fulfil this obligation by instilling the significance of paying attention to the shadow side of counselling and psychotherapy in trainees.


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In 2018, Suzanne was awarded the Martin Kitterick award. This is presented annually by PCI College to a final year student who produces a relevant and engaging thesis of outstanding academic quality in memory of Martin Kitterick, a former director who passed away in 2012. This article is an abridged version of her winning submission. Suzanne can be contacted at: mitchellsuzanne1@gmail.com

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