UNSUCCESSFUL PSYCHOTHERAPIES: WHEN AND HOW DO TREATMENTS FAIL?

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UNSUCCESSFUL PSYCHOTHERAPIES: WHEN AND HOW DO TREATMENTS FAIL?

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EDITORIAL
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Editorial: Unsuccessful Psychotherapies: When and How Do Treatments Fail?

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Editorial on the Research Topic

Unsuccessful Psychotherapies: When and How Do Treatments Fail?

As humans, but also as researchers and clinicians, we can learn a lot from our failures. The issue of failures in psychotherapeutic treatments is extremely important, as from them we can infer the signs that precede them, and the strategies to deal with them. In psychotherapy we are also aware of the important fact that the amount of unwanted effects is very similar to fields such as pharmacotherapy, and the number of patients reporting unwanted effects of psychotherapy is between 3 and 15% of cases (Berk and Parker, 2009). In 2012, a meta-analytic study by Swift and Greenberg (2012) suggested that approximately one in every five clients still chooses to end treatment prior to its completion. Similarly, Lambert (2013) has demonstrated that 5 to 10% of patients deteriorate in therapy, and 35 to 40% of participants in clinical trials do not improve. This Research Topic asks how we can address this situation.

Technical mistakes by psychotherapists or the particular mental conditions of patients are typical variables that lead to unsuccessful and negative outcomes. In early pioneering clinical studies, both variables can be observed, for example, the transference/countertransference phenomena in Breuer's case of Anna O and Dora's drop out from treatment with Freud. Subsequently, several difficulties have arisen in the study of unsuccessful psychotherapies: (1) the methodological proposals for studying positive effects often obscure negative effects; (2) the complexity of the therapeutic process; and, (3) a lack of agreement on the definition of treatment failures. Indeed, treatment failure has been used as an umbrella term for a broad array of unwished-for effects of psychotherapy, such as attrition, lack of change, relapse, and a worsening of patient conditions. Additional challenges when measuring outcome and defining therapeutic success and failure include: which perspective is being used (patient, therapist, or researcher), what types of outcomes are measured with which methods, and the appropriate time point of outcome monitoring.

Over the last decade, psychotherapy was considered to be a complex form of interaction, which is in many ways different from relationships in ordinary life. Regardless of the specific therapeutic method, the role of the therapist is to facilitate change in a patient and to improve their functioning. From the researcher's perspective, treatment failures have been related to negative interpersonal processes in psychotherapy. Furthermore, unrepaired ruptures are connected to the unilateral interruption and drop out of patients (Safran et al., 2011; Gülüm et al., 2018; Colli et al., 2019). There is significant evidence of substantial variance in treatment outcomes between different therapists. Therapists may be more important for therapeutic success than the type of intervention they deliver. Furthermore, while therapists differ in their average outcomes, most therapists have at least some successful case outcomes. On the other hand, even the most effective therapists have experienced unsuccessful treatments when patients did not improve.

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The articles presented in this Research Topic show how complex the topic is. In an evidence-based case study, Block-Elkouby et al. suggest the combination of at least three groups of factors. A first group refers to factors related to the patient, a second to those related to the psychotherapist, and a third to those attributable to the expected treatment modality. A tentative process model of the development of suboptimal psychotherapy with young adults, presented by von Below, focuses on when therapists underestimate patient problems, patient pseudo-mentalizing, and no development toward agency. Adopting another perspective, Carcione et al. investigate the role of mentalization in the process of change and demonstrate that changes in metacognition predict improvements in personality disorders. The work of Braga et al. shows that an analytic procedure based on coding ambivalence can predict subsequent symptomatology, thus helping therapists to promote moments of communication between the opposing positions of the patient's self.

Several of the studies included in this Research Topic address different aspects of dropout. Maggio et al. study cases of premature termination and hypothesize that the particular emotional responses of the therapist may be prognostic. O'Keeffe et al. investigate types of dropout from the perspective of adolescent clients: "dissatisfied" dropouts experienced the therapy as not helpful, "got-what-they-needed" dropouts experienced sufficient benefits from therapy, whereas "troubled" dropouts lacked stability in their lives. Smith et al. conclude that war veterans with more PTSD symptomatology and those who did not receive trauma-focused therapy were less likely to complete residential treatment. A meta-analysis of non-response in internet-based CBT conducted by Rozental et al. focuses on patient variables and found that higher symptom severity and male gender increase the odds of a patient not responding.

In a grounded theory study, De Smet et al. found that non-improved depressed patients experienced a stalemate in therapy, stuck between knowing and doing. Nevertheless, "no change" in outcome scores involved, from the patients' perspective, a "partial change." Werbart et al. studied contrasting cases from the caseloads of three therapists. In successful treatments, the patients and the therapists shared a joint view of the therapy and their relationship, whereas in unsuccessful treatments their views diverged and the therapists had difficulty in reflecting on their contributions. Curran et al. undertook a meta-synthesis of service user experiences, revealing potentially harmful factors at each stage of the therapy process that may require adequate remedial action.

Taken together, the 11 articles included in this Research Topic demonstrate that researchers and clinicians can learn a great deal from further studies of unsuccessful treatments. To do so, we need to look not only for patient factors, but also the therapist contributions, as well as the therapeutic relationship. As proposed by the third APA task force, we have to "identify effective elements of the therapy relationship and to determine effective methods of adapting or tailoring therapy to the individual patient on the basis of transdiagnostic characteristics" (Norcross and Wampold, 2019, p. 3). The therapist's ability to recognize and manage ruptures is decisive in the repair process and the prevention of treatment failure (Eubanks-Carter et al., 2011). A focus on the emotional reactions of the therapist determined by their specific personality traits, for example, narcissism (Oasi et al., 2019), is of fundamental importance. A further crucial issue is a patient-therapist match in terms of personality orientation, and an early adjustment by the therapist, in terms of their orientation on relatedness or self-definition, to the patients' predominant personality configuration, might enhance treatment outcomes (Werbart et al., 2018). Even the well-known construct of therapeutic alliance can receive (and give) further strength if it is placed in a relational context. Taking up the groundbreaking statement by Horwitz et al. (1996), we run fewer risks if we are able to tailor our way of working to the patient.

AUTHOR CONTRIBUTIONS

All authors listed have made a substantial, direct and intellectual contribution to the work, and approved it for publication.

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ORIGINAL RESEARCH
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'I Just Stopped Going': A Mixed Methods Investigation Into Types of Therapy Dropout in Adolescents With Depression

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What does it mean to 'drop out' of therapy? Many definitions of 'dropout' have been proposed, but the most widely accepted is the client ending treatment without agreement of their therapist. However, this is in some ways an external criterion that does not take into account the client's experience of therapy, or reasons for ending it prematurely. This study aimed to identify whether there were more meaningful categories of dropout than the existing dropout definition, and to test whether this refined categorization of dropout was associated with clinical outcomes. This mixed-methods study used a subset of data from the IMPACT trial, which investigated psychological therapies for adolescent depression. Adolescents were randomly allocated to a treatment arm (Brief Psychosocial Intervention; Cognitive-Behavioral Therapy; Short-Term Psychoanalytic Psychotherapy). The sample for this study comprised 99 adolescents, aged 11–17 years. Thirty-two were classified as having dropped out of treatment and participated in post-therapy qualitative interviews about their experiences of therapy. For 26 dropout cases, the therapist was also interviewed. Sixty-seven cases classified as having completed treatment were included to compare their outcomes to dropout cases. Interview data for dropout cases were analyzed using ideal type analysis. Three types of dropout were constructed: 'dissatisfied' dropout, 'got-what-they-needed' dropout, and 'troubled' dropout. 'Dissatisfied' dropouts reported stopping therapy because they did not find it helpful. 'Got-what-they-needed' dropouts reported stopping therapy because they felt they had benefitted from therapy. 'Troubled' dropouts reported stopping therapy because of a lack of stability in their lives. The findings indicate the importance of including the perspective of clients in definitions of drop out, as otherwise there is a risk that the heterogeneity of 'dropout' cases may mask more meaningful distinctions. Clinicians should be aware of the range of issues experienced by adolescents in treatment that lead to disengagement. Our typology of dropout may provide a framework for clinical decision-making in managing different types of disengagement from treatment.

Keywords: attrition, dropout, premature termination, psychotherapy, adolescents, depression, mixed-methods, ideal type analysis

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INTRODUCTION

Dropout from psychological treatment is a significant concern across mental health services, including services for children and young people. The study of dropout has been hindered by a lack of consensus about how dropout should be operationalized. The most widely accepted definition in the contemporary dropout literature is based on the therapists' judgment that the client ended therapy prematurely without their agreement (Warnick et al., 2012). It is acknowledged that dropout can occur after any number of sessions (Wierzbicki and Pekarik, 1993; de Haan et al., 2015), so a strength of this operational definition is that it does not presuppose a treatment duration required to classify a client as a completer or dropout. Another strength is its face validity, as the concept of dropout stems from therapists' observations that some clients end treatment inappropriately (Wierzbicki and Pekarik, 1993). However, concerns about the reliability of this operational definition have been raised, as it has been acknowledged that therapists may differ in the criteria they use to judge the appropriateness of the ending of treatment (Wierzbicki and Pekarik, 1993). Therefore this approach to defining dropout is subjective, dependent on the clinician's own views and possibly their therapeutic orientation.

Other definitions of dropout are less subjective. In several studies, dropout was defined based on treatment duration, such that clients are considered to have dropped out if they fail to attend a specific number of sessions or proportion of the planned treatment (Baruch et al., 2009; Warnick et al., 2012). This avoids therapist bias and subjectivity, yet is essentially a dichotomized measure of therapy duration (Hatchett and Park, 2003), which is problematic. Setting a minimum number of sessions does not account for individual differences in how long it takes for a client to benefit from a given treatment, fails to consider the clinical appropriateness of the ending of treatment, and seems inadequate for open-ended therapies, where the number of sessions has not been pre-determined.

Other studies have classified dropouts as clients who do not attend their last scheduled appointment or who repeatedly fail to attend appointments, resulting in no further contact with the therapist (Swift et al., 2009; Warnick et al., 2012). This operationalization is likely to lead to doubtful classifications in several ways. A client who does not schedule another appointment, even though the ending of treatment may have been inadvisable in the therapist's view, would be classified as a completer (Wierzbicki and Pekarik, 1993). On the other hand, a client who was due to complete treatment, but did not attend their final session, would be classified as a dropout. Moreover, the appropriateness of the treatment ending is not taken into account.

Finally, some studies have defined dropout based on a client ending treatment prior to recovering from the issues that motivated them to seek treatment (Bados et al., 2007; Swift et al., 2009). This approach seeks to provide a more objective judgment on the appropriateness of the ending of treatment, based on clinical outcomes according to standardized outcome measures. However, standardized measures of symptom reduction may not capture the reasons the client sought treatment, or the treatment goals agreed between the client and the therapist. Furthermore, not all clients in psychotherapy and mental health services will return to normal functioning or attain their treatment goals (Edbrooke-Childs et al., 2018).

Thus, currently the most widely accepted definition of dropout in the literature is based upon whether the ending of therapy is mutually agreed between the client and therapist (Wierzbicki and Pekarik, 1993; Hatchett and Park, 2003). Using this definition, a recent meta-analysis of dropout from child and adolescent mental health care estimated the dropout rate in efficacy studies (i.e., randomized controlled trials) at 26%, while average dropout rates were higher (45%) in effectiveness studies conducted in naturalistic settings (de Haan et al., 2013).

It is difficult to estimate the dropout rate specifically in young people receiving therapy for depression, due to the inconsistency in how dropout has been reported. For instance, the TADS trial compared fluoxetine, CBT and their combination for adolescent depression and reported the consent withdrawal rate at 10.9% (Treatment for Adolescents with Depression Study Team, 2004). However, some young people may stop attending treatment without formally withdrawing consent for treatment, which likely explains the difference in the consent withdrawal rate in TADS compared with the dropout rates reported in de Haan et al.'s (2013) meta-analysis. More recently, the "Improving Mood with Psychoanalytic and Cognitive Therapies" (IMPACT) trial investigated psychological treatment for adolescent depression (Goodyer et al., 2011, 2017). In the IMPACT trial, when dropout was defined as ending treatment without the agreement of the therapist, 37% of adolescents were classified as having dropped out of treatment, and a further 11% did not take up the treatment on offer (O'Keeffe et al., in press). Treatment dropout in adolescent depression is an important area for research, given the high dropout rates in this population, and moreover, given that depression is regarded as the leading cause of disability for adolescents (World Health Organization, 2014); yet this is an area that has been neglected in the literature to date.

Kazdin (1996) introduced a risk-factor model of treatment dropout, based on work with children experiencing conduct problems. Risk factors are conditions that are present at the point of intake and cumulatively increase risk of dropout. Studies have generally found the most disadvantaged young people to be at greatest risk of dropout, including those with socio-economic disadvantage, greater parental stress and symptom severity (Kazdin, 1996; de Haan et al., 2013). However, effect sizes are generally small (de Haan et al., 2013) and some studies have found contradictory findings. For instance, some studies have not found symptom severity (Wergeland et al., 2015; O'Keeffe et al., 2018), being from a single parent family (Pina et al., 2003; Gonzalez et al., 2011; Wergeland et al., 2015) and parental wellbeing (O'Keeffe et al., 2018) to be associated with increased risk of dropout. These inconsistent findings may be the result of studies being in different clinical populations or using different definitions of dropout. Although there is some evidence for associations between pre-treatment client characteristics and dropout risk, these are not sufficiently strong to permit reliable prediction of dropout (de Haan et al., 2013). A more diverse range

of methods for seeking to improve our understanding of dropout is needed.

The risk-factor model does not consider within-treatment factors, but subsequently Kazdin et al. (1997a,b) developed the barriers to treatment model to address this. This model proposed that families experience multiple barriers when attending treatment which increase the likelihood of them dropping out (Kazdin et al., 1997a,b). Barriers to treatment may include stressors or practical obstacles in attending appointments (such as transportation), not perceiving the treatment as relevant to their problems, finding treatment too demanding or having a poor relationship with their therapist (Kazdin et al., 1997a,b; Nock and Ferriter, 2005). Empirical research has found support for the barriers to treatment model in families attending treatment for a child's conduct problems, with more reported barriers being associated with greater risk of dropout (Prinz and Miller, 1994; Kazdin et al., 1997b; Kazdin and Wassell, 1998; Stevens et al., 2006). While these studies tell us about issues experienced by families when attending treatment that are associated with dropout, they do not specifically tell us about the reasons families may have for stopping therapy.

Regarding the implications of dropout, it is generally assumed that that dropout is an indicator of treatment failure (Kazdin et al., 1994). Studies with pre-adolescent child and adult clients found dropout to be associated with poorer clinical outcomes (Kazdin and Wassell, 1998; Cahill et al., 2003; Boggs et al., 2005; Saatsi et al., 2007). However, in one study, after pre-treatment differences were controlled for, there was no longer a difference in clinical outcomes between dropouts and completers (Kazdin et al., 1994). Similarly, in the IMPACT trial, no strong evidence was found for poorer outcomes for those adolescents who dropped out of treatment compared with those who completed treatment (O'Keeffe et al., in press). Thus, while dropout is often assumed to be a negative way for therapy to conclude, studies have not always found dropout to be associated with poorer clinical outcomes. This raises questions about the reasons that adolescents stop treatment. Understanding why adolescents stop going to therapy is therefore an important area for research as it can inform clinical practice about the implications of dropout and how disengagement from treatment may be managed.

The limited available literature has focused on parents' perspectives on the reasons as to why their child dropped out of therapy. Reasons for stopping therapy reported by parents included not perceiving the need for further treatment, the child not liking the clinic and problems in the therapeutic relationship (Kendall and Sugarman, 1997; Garcia and Weisz, 2002). Similarly, in studies with adult clients, reasons for dropping out of treatment include dissatisfaction with the therapy, such as feeling that strategies or advice did not meet their needs, as well as dissatisfaction with the therapist, such as lack of rapport, lack of trust or issues in the fit between the client and therapist (Wilson and Sperlinger, 2004; Roe et al., 2006; Khazaie et al., 2016). One study also reported that clients stopped treatment due to it giving rise to painful feelings or not feeling ready to engage in treatment (Wilson and Sperlinger, 2004). However, positive reasons for stopping treatment have also been cited, with one study of 84 clients finding that almost half reported stopping treatment having made sufficient progress with the problems that led them to seek treatment (Roe et al., 2006). However, no known study has asked adolescents about their reasons for dropping out of therapy, or their therapists about how they make sense of their clients' decision to stop coming to treatment.

Empirical research into risk factors and within-treatment predictors of dropout has identified some correlates of dropout, but findings from the plethora of studies conducted do not always agree. The views of adolescents on dropout are absent from the literature. There is thus a dearth of knowledge about *why* adolescents drop out of therapy (Ormhaug and Jensen, 2016). Some of the contradictory findings in the literature to date may be the result of issues regarding how dropout is defined, given the limitations of the operational definitions of dropout. In particular, existing definitions of dropout do not take into account the reasons that adolescents give for stopping therapy.

This study therefore aims to identify whether there are more meaningful categories of dropout than the existing dropout definition, based on narratively expressed reasons for dropout given by both therapist and adolescent, in the context of treatment for adolescent depression. The focus is on depression as one of the most commonly occurring presentations for which adolescents seek mental health treatment (Essau, 2005), and among adult clients, dropout rates have been found to be highest for clients with depression (36.4%) compared with other client groups, such as those with anxiety disorders (19.6%) and psychosis (20.1%) (Fernandez et al., 2015). Given the importance of identifying moderators, this study also aimed to test whether there were pre-treatment differences for adolescents in each of the dropout categories, and whether these dropout categories were better at predicting clinical outcomes compared with the existing definition of dropout.

MATERIALS AND METHODS

Design

This study is based on data from the IMPACT trial, a randomized controlled trial comparing three interventions in the treatment of depression in adolescents (Goodyer et al., 2011, 2017). Adolescents (aged 11–17 years) with a diagnosis of moderate/severe unipolar depression were recruited and randomized to a psychological interventions for depression. The multi-center trial was conducted across three regions in the United Kingdom. Four hundred and sixty-five adolescents were recruited and randomized to receive one of the following manualized interventions, in similar numbers (BPI = 155; CBT = 154; STPP = 156):

(i) Brief Psychosocial Intervention (BPI) is a psychosocial program, including a focus on sleep hygiene, exercise and monitoring risk; planned duration of up to 12 sessions delivered over 20 weeks (Kelvin et al., 2010).
(ii) Cognitive-Behavioral Therapy (CBT) focuses on identifying distorted cognitions, and using explicit, shared goals;

planned duration of up to 20 sessions delivered over 28 weeks (Impact Study Cbt Sub-Group, 2010).

(iii) Short-Term Psychoanalytic Psychotherapy (STPP) focuses on uncovering the feelings or thoughts that interfere with the young person's relationships, communication and daily functioning; planned duration of 28 weekly sessions (Cregeen et al., 2016).

Outcome assessments were carried out during treatment (6 and 12 weeks after the start of treatment), post-treatment (36 weeks) and at long-term follow up (52 and 86 weeks).

IMPACT-My Experience (IMPACT-ME) was a qualitative, longitudinal study linked to the IMPACT trial. In the IMPACT-ME study, the participants (including adolescents, parents and therapists) from the North London Centre of IMPACT trial were invited to participate in qualitative interviews about their expectations and experiences of therapy (Midgley et al., 2014).

Drawing on data from the IMPACT and IMPACT-ME studies, the study reported here used a mixed-method, sequential design (Creswell et al., 2003), where qualitative methods were used to construct a typology of dropout, and quantitative methods were then used to investigate whether characteristics and outcomes of adolescents differed between the types of dropout.

Sample

The sample for this study draws on participants from the North London site of the IMPACT trial (N = 127). Of those, seven cases were excluded from this study as they did not take up the therapy on offer and 21 cases who had dropped out of therapy were excluded, either because they did not take part in the IMPACT-ME study (N = 17) or because their data could not be used for the purpose of this study (N = 4). In such cases, this was because they did not describe their therapy in sufficient detail for them to be classified as a dropout type. The sample for this study thus comprised 99 adolescents from the North London region of the IMPACT trial, 32 of whom dropped out of treatment, while 67 completed treatment (see **Figure 1**). The 67 completers were not included in the qualitative part of this study, but were used as a comparison group in statistical analyses.

Dropout cases were selected who participated in the IMPACT-ME interviews and were reported as having dropped out of therapy by their therapist. Dropout was defined as the adolescent ending treatment without the prior agreement of their therapist, regardless of when in treatment the ending occurred. For dropout cases, broadly speaking, the sample characteristics appeared similar for those who did and did not participate in the IMPACT-ME study, in terms of average age and depression severity (see **Table 1**). Although all of those who did not participate in the IMPACT-ME study were female this might be expected as there was a higher prevalence of girls in the sample. The percentages of cases that did and did not participate in the IMPACT-ME study were very similar between the three treatment arms.

The dropout sample for this study comprises the 32 dropout cases where qualitative data was collected and could be used to address the aims of this study (see **Figure 1**). Of these 32 cases, 9, 9, and 14 participants were in the BPI, CBT and STPP arms, respectively. The sample consisted of 23 females (72%) and 9 males (28%). Their ages at baseline ranged between 11 and 17 years (M = 15.84, SD = 1.87). Fifteen participants (47%) described their ethnicity as White British, and 16 (50%) described their ethnicity as any other ethnic background (any other white background, mixed, Asian/Asian British, Black/Black British, ant other ethnic group). Ethnicity was unknown for one case.

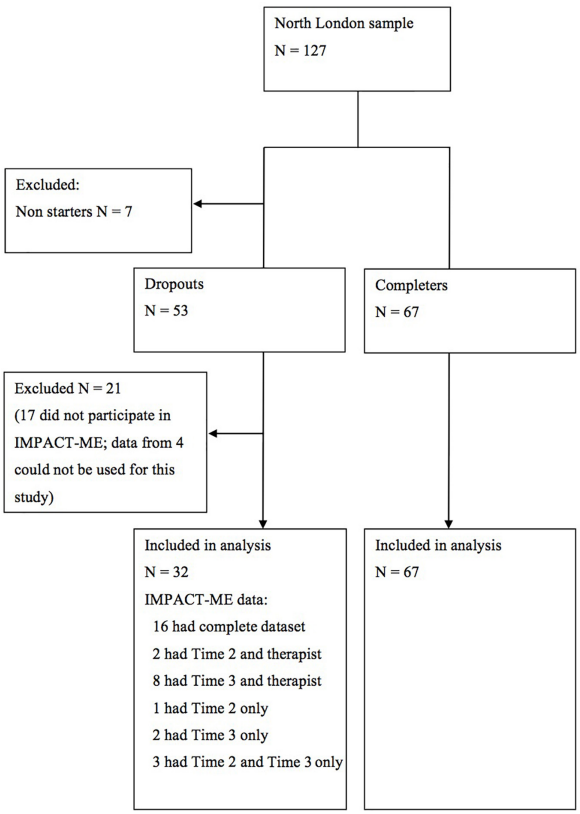

FIGURE 1 | Time 2 refers to the Experience of therapy interview with adolescent (conducted after therapy ended); Time 3 refers to the Thinking back about therapy interview with adolescent (conducted one year after the end of therapy); Complete dataset refers to the adolescent completing a Time 2 and Time 3 interview and their therapist also completing a post-therapy interview.

TABLE 1 | Descriptive statistics for those who dropped out of therapy and did or did not participate in the IMPACT-ME interviews.

	Completed IMPACT-ME interview (N = 36)	Did not complete IMPACT-ME interview (N = 17)
Age	M = 16.02, SD = 1.83	M = 16.43, SD = 1.16
% Female	72%	100%
% White British	49%	64%
MFQ at baseline	M = 47.19, SD = 1.36	M = 47.15, SD = 2.62
Treatment arm		
BPI	68%	32%
CBT	69%	31%
STPP	67%	33%

MFQ, Mood and Feelings Questionnaire; BPI, Brief Psychosocial Intervention; CBT, Cognitive Behavioral Therapy; STPP, Short Term Psychoanalytic Psychotherapy.

Adolescents were invited to be interviewed at both time points, and data from both interviews were used in the present study. Not all participants completed both interviews, but available data for each participant was used (see **Figure 1**). The therapists were not able to be interviewed for six cases, but the therapist interviews were included for all other cases.

Data

Interviews

The data used in this study consisted of interviews with the adolescents and their therapists:

(i) Experience of therapy interviews (Midgley et al., 2011a). Semi-structured interviews were carried out separately with the adolescent and their therapist after the therapy had ended. The interviews with adolescents sought to explore their experiences of therapy and change, including helpful and hindering aspects of therapy and how therapy ended; and interviews with therapists explored the therapy from the clinician's perspective.
(ii) Thinking back about therapy interviews (Midgley et al., 2011b). Semi-structured interviews were carried out with the adolescent, approximately 1 year after their previous interview, in which their further reflections on the therapy experience were explored.

Measures

(i) Depression severity. The Mood and Feelings Questionnaire (MFQ; Angold et al., 1987).
(ii) Anxiety severity. The Revised Children's Manifest Anxiety Scale (RCMAS; Reynolds and Richmond, 1997).
(iii) Obsessionality. The Short Leyton Obsessional Inventory (LOI; Bamber et al., 2002).
(iv) Anti-social behavior. The Antisocial Behavior Questionnaire (ABQ; St Clair et al., 2017).
(v) Psychosocial functioning. The Health of the Nation Outcome Scale for Children and Adolescents (HoNOSCA; Garralda, 2000).
(vi) Risk taking and self-harm. The Risk-Taking and Self-Harming Inventory for Adolescents (RTSHIA; Vrouva et al., 2010).

Data Analysis

The aim of this study was to try to identify whether there were more meaningful categories of dropout than the existing definitions allowed for. Ideal type analysis was chosen, as this allows cases to be compared to form clusters of cases, toward the aim of identifying different categories of dropout. The concept of 'ideal types' was introduced by Max (Weber, 1949) to describe a composite case that embodied the key attributes of a set of similar cases. Ideal types are defined as a way of representing the characteristics and features of a social phenomenon (Weber, 1949). Ideal types may be thought of as "analytical constructs for use as yardsticks for measuring the similarity and difference between concrete phenomena" (Kvist, 2007). In this context, 'ideal' is referring to an idea that presents as a useful way of thinking about clusters of cases, rather than something conceived as perfect (Philips et al., 2007; McLeod, 2011).

As this study was drawing on the perspectives of both adolescents and their therapists, it was expected there would be differences and discrepancies between the accounts given by an adolescent and their therapist. Where their accounts mirrored or contradicted each other became an interesting aspect of the analysis. In the results, the extent to which the account of the adolescent and therapist was similar or different is reported.

Data analysis comprised three key stages: developing the typology, testing the typology; and coding the remaining dataset.

Stage 1: Developing the Typology

The typology was initially developed on the first half of the dataset using the stages of ideal type analysis outlined by Gerhardt (1994). This involved listing all themes, categories or statements from the transcript(s) for each case and using this to construct a summary for each case. These summaries were systematically compared with every other case to explore their similarities and differences. Cases were grouped to form discrete types of dropout, whereby each case was represented in one of the types. Cases in each cluster were re-examined, to ensure that they shared key features and did not overlap with other types. A description of each ideal type was written, as well as a coding frame which outlined the necessary conditions that a case must meet to be coded to a type. The typology that was constructed consisted of ideal types, which comprised necessary conditions (i.e., the conditions that a case must meet in order to be coded into that type) and typical characteristics (i.e., characteristics that tended to fit with a type, but were not a requirement to be coded into that type, to reflect variation within the types).

Stage 2: Testing the Typology

Two independent researchers used the coding frame to each categorize six cases, using the interview transcripts, into the ideal types. The first was a qualitative post-doctoral researcher, who had experience of ideal type analysis. Agreement with the lead researcher on all but one cases was established. This led to some refinement of the coding frame. A postgraduate researcher without experience of ideal type analysis then used the revised coding frame to code six different cases. There was 100% agreement with the lead researcher on the typological classification. This served as a credibility check for the ideal types.

Stage 3: Coding the Remaining Dataset

The coding frame was then used to code the remaining cases. All fitted into the types constructed in the previous stage. Another postgraduate researcher, without experience of ideal type analysis, then double coded all cases that had not yet been double coded, using the coding frame (**Table 2**). This served as a reliability check, and agreement with the lead researcher was found on all but one case. In the results, the necessary conditions and the typical characteristics are presented, followed by an illustrative case for each type. This provides an example of that type in its optimal form. Where there was significant variation within a type, this is reported in the results.

TABLE 2 | Ideal types coding frame.

Type	Summary	Necessary conditions
(1) 'Dissatisfied' dropout	The adolescent reported stopping therapy because it failed to meet their needs.	Adolescent reported stopping therapy because they did not find it helpful.
		Adolescent was critical of the therapy they received.
		Therapist reported that adolescent had difficulty attending or engaging in the sessions.
(2) 'Got-what-they-needed' dropout	The adolescent reported stopping therapy because they felt better.	Adolescent reported not seeing a need to keep going to therapy, as they felt better or it was due to end soon.
		Adolescent attributed positive change, to some extent, to the therapy.
		Therapist did not appear to be worried about the adolescent stopping therapy.
(3) 'Troubled' dropout	The adolescent reported stopping therapy because they felt it was not the right time for them to engage in therapy.	Adolescent presented with complex difficulties (e.g., homelessness, history of abuse)
		Adolescent linked (or implied) stopping therapy to external difficulties.
		Therapist suggested that the adolescent could not have engaged in any type of therapy at that time, because of the lack of stability in their life.

Stage 4: Quantitative Analysis

Having constructed the types of dropout, Kruskal–Wallis tests were conducted to test whether there were differences between the cases in each dropout type and completers with respect to baseline characteristics. Where the Kruskal–Wallis test statistic was statistically significant ($p < 0.05$), *post hoc* pairwise comparisons were conducted using Dunn's tests, with Benjamini–Yekutieli adjustment for multiple comparisons to control the false discovery rate (Benjamini and Yekutieli, 2001). Hypotheses about differences in clinical outcomes between the dropout types were formed. The final stage of data analysis was to test whether there was a difference in outcomes between the types. Mixed effect models were used to test differences between MFQ scores for each type at baseline, long-term follow-up, and change over time. The dependent variable was MFQ scores, as this was the primary outcome measure in the IMPACT RCT (Goodyer et al., 2011). The independent variables were Time × Therapy Ending Type interaction effects, with the types included as categorical variables. Three models were tested: predicting change in MFQ scores at 36, 52, and 86 weeks in Stata version 14.1. Models included a random intercept and random slope for participant, and a random intercept for therapist.

Ethics Statement

The study protocol was approved by Cambridgeshire 2 Research Ethics Committee (Reference: 09/H038/137). Fully informed written consent was sought from participants at the baseline assessment. For those under the age of 16, fully informed written parental consent was also sought. To ensure the confidentiality of participants, participants were assigned a pseudonym and any identifiable details have been removed or changed.

RESULTS

Three types of dropout were constructed, using ideal type analysis: 'dissatisfied' dropout, 'got-what-they-needed' dropout and 'troubled' dropout. In the BPI arm, the 'got-what-they-needed' type was most common, with five cases fitting into this type. The remaining BPI cases were classified as 'dissatisfied' ($N = 3$) and 'troubled' ($N = 1$). As in the BPI arm, the most common type in the CBT arm was the 'got-what-they-needed' type, with four CBT dropouts fitting this type. The remaining CBT cases were 'dissatisfied' ($N = 3$) and 'troubled' ($N = 2$). In the STPP arm, the most common type was the 'dissatisfied' type, with twelve STPP dropouts fitting this type. Of the remaining two STPP dropouts, one was classified as a 'got-what-they-needed' dropout and one as a 'troubled' dropout.

Ideal Type 1: 'Dissatisfied' Dropout

Description

'Dissatisfied' dropouts reported stopping therapy because they did not find therapy helpful and it failed to meet their needs. Eighteen cases represented this type (BPI = 3, CBT = 3, STPP = 12).

Necessary Conditions

'Dissatisfied' dropouts were critical of the therapy they received and described various things about the therapy they did not like or find helpful, such as the therapists' approach to therapy, and issues regarding their relationship with their therapist. They reported stopping therapy because they did not feel they were benefitting from it. The therapist of 'dissatisfied' dropouts reported that the adolescent showed some reluctance to engage, either in the sessions, or through missed sessions.

Typical Characteristics

'Dissatisfied' dropouts may have referred to practical issues associated with attending therapy, but did not cite these as reasons for stopping therapy. They sometimes spoke about not feeling able to tell their therapist how they felt about therapy, particularly the aspects of therapy they were dissatisfied with. Their therapists tended to report that they believed the ending of therapy was the result of the adolescents' inability to engage in the therapy. The therapists appeared to be unaware of many of the adolescents' criticisms of therapy. Their narrative of the therapy therefore tended to be distinctly different from that of the adolescents.

Significant Variation

While in all three treatment arms, adolescents expressed dissatisfaction with the therapy, there were differences in the nature of their dissatisfaction. In the BPI and CBT arms, adolescents described dissatisfaction with the therapy being too structured or not understanding the rationale for some of the activities in therapy, such as keeping a diary. In contrast, dissatisfaction in the STPP arm tended to focus on the lack of structure, not knowing what to talk about, feeling uncomfortable with silence in the sessions or the therapist offering interpretations that didn't make sense to them.

Illustrative Case: Fiona

Fiona was a 13-year-old girl who received STPP.

Adolescent's perspective

Fiona was critical of the therapy she received. Fiona's main criticism was with the way in which the therapist interacted with her. She described how the therapist would ask her questions, but when she answered, the therapist wouldn't respond, and they could spend 5 minutes in silence, which Fiona described as "awkward." Fiona described her therapy:

> *"I went to this therapist and they just sat there and hummed for an hour at everything that I said. I hated it. [My therapist] made me really angry because it just felt like I was talking to a brick wall and I wasn't. I didn't even want to talk because [my therapist] didn't engage with me at all. It just felt like it was completely pointless."*

Fiona described finding the therapy "disappointing" and also reported not feeling comfortable telling the therapist how she felt. Fiona described how her decision to stop going to therapy came about:

> *"Well I wasn't enjoying it, well not enjoying it because it's not something you're going to have fun in doing, but I wasn't benefiting from it and it just seemed really pointless because it was quite far away and I didn't feel like I was getting anything out of it. And I was missing time off school to actually get there on time."*

While Fiona referred to the inconvenience of attending therapy, she implied this was not the reason for stopping: therefore, it is possible she may have kept going, had she felt she was benefitting from it.

Therapist's perspective

The therapist reported that at the start of therapy, Fiona had expressed reservations about therapy. Despite this, the therapist described seeing a side to Fiona that could engage in the therapy, as she was at times "animated," but she then felt Fiona withdraw. The therapist reported that Fiona then said she did not want to continue with therapy. The therapist speculated that things had already started to improve for her at an early stage in the therapy and the therapist suggests this may have impacted on her willingness to engage:

> *"I think the session sort of stirred stuff up and the fear was that she'd feel worse again."*

The therapist reported that Fiona believed she was better when she decided to stop therapy, whereas the therapist stated that they did not believe things were truly resolved for Fiona.

Ideal Type 2: 'Got-What-They-Needed' Dropout

Description

'Got-what-they-needed' dropouts reported stopping therapy because from their perspective, they had got what they needed and did not feel a need to continue in therapy. Ten cases represented this type (BPI = 5, CBT = 4, STPP = 1).

Necessary Conditions

'Got-what-they-needed' dropouts appeared to find therapy helpful and attributed positive change in their life, at least to some extent, to the therapy they received. They reported their reason for stopping therapy to be that they felt they had got the help they needed. The therapists likewise reported that they thought their clients had got what they needed from therapy but viewed the ending as premature in that they believed continued therapy could have yielded further benefits. The therapist did not appear to be left clinically concerned about 'got-what-they-needed' dropouts, as they reported seeing some improvements for the adolescent by the time therapy ended.

Typical Characteristics

'Got-what-they-needed' dropouts may have been critical of specific aspects of the therapy or may have referred to the inconvenience of attending sessions, but did not cite these as reasons for stopping therapy. The therapists tended to report signs of disengagement for 'got-what-they-needed' dropouts, either through missing sessions or their reluctance to engage when they did attend.

Illustrative Case: Connor

Connor was a 17-year-old boy, who received CBT.

Adolescent's perspective

Connor gave a balanced account of his therapy, as he discussed aspects he found positive about it, as well as some criticisms of the therapy. Connor reported that it was "helpful to talk to someone." He spoke positively about his therapist and the relationship they had:

> *"[My therapist] wanted to help. Not judgmental or anything. You know, like a nice person. So it was a good relationship."*

Connor also spoke about some reservations regarding the approach to therapy, as he questioned "why can't we just talk about stuff?" instead of focusing on a specific goal. Overall, Connor gave the impression that he had got something out of the therapy, despite his reservations. Connor linked his decision to stop therapy to external circumstances. He suggested that the main trigger to his depression was school, and once he finished school, he reported feeling ready to stop therapy:

> *"I just wanted to kind of, get that kind of phase of my life over with. I didn't really want to, like, it was almost like doing the stuff put me in a worse mood, because it would put me in a mind-set of, oh ok,*

I'm going to a therapy meeting now, that means I have, something to talk about, about why I'm feeling bad."

Connor described feeling better by this point, so reported not feeling a need to continue with therapy.

Therapist's perspective

Connor's therapist described him as compliant with the treatment, in that he attended most of the sessions, although also described how he seemed "reluctant" to be there. The therapist described how they focused on Connor's sleep patterns in the sessions, and reported that this seemed helpful for Connor. Connor's therapist described how Connor "stopped coming" to therapy, and connected this to his ambivalence toward therapy. However, the therapist reported that Connor had benefitted from therapy by the time he decided to stop, and did not seem concerned about him ending therapy, despite not agreeing to the ending. The therapist suggested that the practical level of support that therapy offered him seemed to be the right approach for him, at that point in his life, yet speculated that Connor may need more therapy in the future.

Ideal Type 3: 'Troubled' Dropout

Description

'Troubled' dropouts reported stopping therapy because of a lack of stability in their life which made it difficult for them to engage in therapy. Four cases represented this type (BPI = 1, CBT = 2, STPP = 1).

Necessary Conditions

'Troubled' dropouts described significant difficulties beyond their low mood (including homelessness, history of abuse and trauma, and financial and caring responsibilities). 'Troubled' dropouts and their therapists gave similar accounts; both described how a lack of stability in the adolescent's life impacted on their session attendance and led to their decision to stop therapy. The therapists suggested this lack of stability needed to be addressed before these adolescents would be able to engage in therapy.

Typical Characteristics

The therapists of 'troubled' dropouts tended to report that the adolescents engaged in the sessions when they attended, but they missed a lot of sessions, as a result of the external difficulties in their lives. The therapists suggested these external difficulties were the main reasons for them stopping therapy.

Significant Variation

'Troubled' dropouts varied in how they spoke about their experience of therapy. While some reported not finding it helpful, others spoke about finding aspects of it helpful, such as being offered advice and the relief of talking to someone. Regardless of whether 'troubled' dropouts spoke about therapy being helpful or unhelpful, they did not tend to link this to their decision to stop therapy.

Illustrative Case: Asha

Asha was a 17-year-old girl, who received BPI.

Adolescent's perspective

Asha described how she initially attended the therapy sessions, but then decided to stop going:

"I went for a while and then and then [sic] I just stopped going. Just because I felt like I wasn't changing anything and my life was all over the place and I just like oh, yeah, just stopped going."

While Asha described stopping therapy because she didn't feel she was gaining from it, she also linked it to external factors in her life, suggesting that the complex difficulties made it difficult for her to engage in therapy, as she did not have a stable home.

Therapist's perspective

Asha's therapist reported that Asha's therapy attendance had been "intermittent." The therapist linked Asha's difficulty attending the sessions to demands in her home life, and reported that the focus of the sessions was on helping Asha to manage her living situation. The therapist speculated that with the instability in her life, Asha may not have been able to engage in any kind of treatment:

"So I'm not sure, you know, as far as an individual therapy is concerned, whether that, whether anything would've worked at that time."

Therefore, the therapist seemed doubtful that any talking therapy could have worked at that point in Asha's life, and suggested that Asha needed to find stability in her life before she could attend treatment regularly.

Comparison of the Cases in the Ideal Types

Having constructed a typology of dropout, further exploration of the types was conducted, comparing the cases in the ideal types. This was to test whether the refined categorization of dropout was more meaningful compared with the generic 'dropout' definition in identifying baseline characteristics associated with dropout and association with outcome. There was an insufficient sample size to conduct statistically reliable analyses for 'troubled' dropouts with respect to clinical outcomes. However, some specific hypotheses regarding 'got-what-they-needed' dropouts and 'dissatisfied' dropouts were formed, and there was a sufficient sample size to conduct statistical analyses comparing 'got-what-they-needed' dropouts and 'dissatisfied' dropouts with those who completed therapy.

Hypotheses

(i) 'Got-what-they-needed' dropouts will have been less severely depressed at baseline, compared with 'dissatisfied' dropouts.
(ii) 'Got-what-they-needed' dropouts will have had better outcomes, compared with 'dissatisfied' dropouts.
(iii) 'Got-what-they-needed' dropouts will have had better outcomes, compared with completers.
(iv) 'Dissatisfied' dropouts will have had poorer outcomes, compared with completers.

The first hypothesis was formed on the basis that 'got-what-they-needed' dropouts may have been less severely depressed to

TABLE 3 | Baseline descriptive statistics for dropout types and completers.

	Completers *N* = 67	'Got-what-they-needed' dropouts *N* = 10	'Dissatisfied' dropouts *N* = 18	'Troubled' dropouts *N* = 4		
Sex (% female)	69%	60%	72%	100%		
Ethnicity (% White British)	59%	40%	65%	0%		
Comorbidity (% with >1 comorbid disorder)	48%	50%	33%	100%		
	M (*SD*)	*M* (*SD*)	*M* (*SD*)	*M* (*SD*)	Kruskal–Wallis χ^2 (*df* = 3)	*p*-value
Age	15.63 (1.63)	14.97 (1.82)	16.12 (1.95)	16.73 (0.65)	4.69	0.20
Depression (MFQ)	45.69 (11.32)	47.12 (6.21)	47.67 (9.72)	45.98 (6.16)	0.53	0.91
Anxiety (RCMAS)	41.47 (7.68)	44.66 (5.89)	40.37 (7.20)	44.50 (3.11)	2.61	0.46
Obsessionality (LOI)	10.77 (5.25)	10.81 (5.08)	9.78 (5.55)	8.20 (3.58)	1.35	0.72
Antisocial Behavior (ABQ)	2.95 (2.66)	5.50 (2.80)	3.67 (2.06)	8.00 (4.24)	13.85	0.003
Psychosocial functioning (HoNOSCA)	18.55 (6.63)	15.55 (6.29)	20.90 (7.88)	21.11 (6.19)	3.32	0.35
Risk taking (RTSHIA)	5.13 (5.04)	5.25 (4.20)	6.77 (4.83)	12.75 (4.03)	8.47	0.04
Self-harm (RTSHIA)	11.24 (8.71)	12.68 (7.64)	17.97 (12.92)	17.81 (11.89)	4.87	0.18

M = mean; SD = standard deviation; MFQ = Mood and Feelings Questionnaire; RCMAS = Revised Children's Manifest Anxiety Scale; LOI = Leyton Obsessional Inventory; ABQ = Antisocial Behaviors Questionnaire; HoNOSCA = Health of the Nation Outcomes Scales Child and Adolescent; RTSHIA = Risk Taking and Self Harm Inventory.

begin with than 'dissatisfied' dropouts and therefore required a brief number of sessions to feel sufficiently improved to stop therapy. The hypotheses regarding outcomes were formed on the basis that 'got-what-they-needed' dropouts reported finding therapy helpful and 'dissatisfied' dropouts reported finding therapy unhelpful, so it was expected that 'dissatisfied' dropouts would have poorer outcomes than 'got-what-they-needed' dropouts. As the completers had not been grouped into types, it was expected that they would comprise a heterogeneous group. It was therefore expected that completers would have poorer outcomes compared with 'got-what-they-needed' dropouts and better outcomes than 'dissatisfied' dropouts.

Comparison of Pre-treatment Characteristics for Completers, 'Dissatisfied' Dropouts, 'Got-What-They-Needed' Dropouts and 'Troubled' Dropouts

Baseline descriptive statistics are shown in **Table 3** for adolescents for each dropout category and completers, to explore whether there were differences between the dropout types and completers. Kruskal–Wallis tests indicated that there was not a statistically significant difference (at the 5% level of significance) between the dropout types and completers with respect to age, depression and anxiety severity, obsessionality, psychosocial functioning and self-harm. There was a statistically significant difference in antisocial behavior between the groups (Kruskal–Wallis $\chi^2 = 13.85$, $p = 0.003$). Based on Dunn's pairwise tests with Benjamini–Yekutieli adjustment for multiple comparisons, completers were found to have statistically significantly lower scores of antisocial behavior at baseline compared with 'got-what-they-needed' dropouts ($p = 0.03$) and 'troubled' dropouts ($p = 0.04$). All other pairwise comparisons of anti-social behavior baseline scores yielded *p*-values larger than 0.05.

The Kruskal–Wallis test also indicated a statistically significant difference between groups in baseline scores of risk taking (Kruskal–Wallis $\chi^2 = 8.47$, $p = 0.04$), although Dunn's pairwise tests found no statistically significant difference between any pair of groups (at the 5% level of significance). All 'troubled' dropouts presented with at least one comorbid disorder, whereas comorbidity rates were lower in the other three groups. Statistical testing comparing groups and rates of comorbidity was not conducted due to the presence of zero values in some cells, which meant it was not possible to conduct chi-squared tests. This was also the case for the other categorical variables. Overall, the 'troubled' dropouts seemed to present with more difficulties at baseline, especially compared with the completers.

Testing Outcomes for Completers, 'Dissatisfied' Dropouts and 'Got-What-They-Needed' Dropouts

Figure 2 shows the mean MFQ scores at each time point, for 'got-what-they-needed' dropouts, 'dissatisfied' dropouts and completers. MFQ scores reduced for all groups over time, with 'got-what-they-needed' dropouts making the greatest gains. Hypotheses were tested using mixed effects models, with MFQ scores as the dependent variable, and Time × Therapy Ending

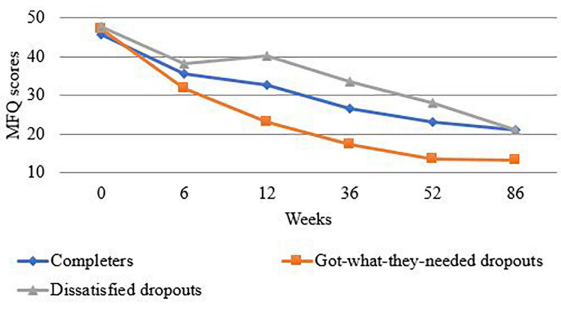

FIGURE 2 | Mean MFQ scores at each time point, for 'got-what-they-needed' dropouts, 'dissatisfied' dropouts and completers.

TABLE 4 | Mixed effect models predicting MFQ scores from Time and Therapy Ending Type, with completers as the reference group.

Variable	Model 1 36 weeks β (*SE*)	Model 2 52 weeks β (*SE*)	Model 3 86 weeks β (*SE*)
Constant	45.69 (1.28)	45.69 (1.28)	45.69 (1.28)
Time	−19.51* (2.07)	−22.52* (2.25)	−25.39* (1.97)
Group (reference: completers)			
'Got-what-they-needed' dropouts	1.44 (3.55)	1.44 (3.55)	1.44 (3.55)
'Dissatisfied' dropouts	1.98 (2.78)	1.98 (2.78)	1.98 (2.78)
Time × 'got-what-they-needed' dropouts	−10.37 (5.62)	−10.93 (6.55)	−8.91 (5.43)
Time × 'dissatisfied' dropouts	5.41 (4.89)	3.17 (4.82)	−1.87 (4.27)
Residual variance	90.66	101.40	82.56
Participant variance	5.63	0.67	12.13
Participant slopes	7.63	6.84	2.78
Therapist variance	5.66	0.70	12.10

*MFQ, Mood and Feelings Questionnaire. * < 0.001.*

Type interaction effects as the independent variables. Therapy ending type was coded as dummy variables for completers, 'got-what-they-needed' dropouts, and 'dissatisfied' dropouts. The model statistics are presented in **Table 4**.

The estimated MFQ scores at each time point are presented in **Table 5**. No evidence was found for a significant difference in depression severity at baseline between completers, 'got-what-they-needed' dropouts and 'dissatisfied' dropouts. Thus, the first hypothesis that 'got-what-they-needed' dropouts would be less severely depressed at baseline compared to 'dissatisfied' dropouts was not supported.

In line with the hypotheses, the greatest improvement was observed for 'got-what-they-needed' dropouts, followed by completers, with 'dissatisfied' dropouts having the poorest outcomes, at 36, 52, and 86 weeks. At 36 weeks, the hypothesis that 'got-what-they-needed' dropouts would have better outcomes compared with 'dissatisfied' dropouts was supported, although there was not a statistically significant difference between the two groups at the later follow-ups (**Table 5**).

Despite trends in the expected direction, the hypothesis that 'got-what-they-needed' dropouts would have better outcomes compared with completers was not supported, as there was not a statistically significant difference between the two groups at any time point. Similarly, despite trends in the expected direction for 'dissatisfied' dropouts compared with completers, there was not a statistically significant difference between the two groups at any time point.

DISCUSSION

This study aimed to identify categories of dropout that, in contrast to previously proposed definitions of dropout, took into account the perspective of both the client and their therapist. A further aim was to test whether this refined categorization of dropout was better at predicting clinical outcomes than the generic 'dropout' definition, in adolescents who received therapy for depression. Three distinct types of dropout were constructed. 'Got-what-they-needed' dropouts were those who reported stopping therapy because they felt better. 'Dissatisfied' dropouts were those who reported stopping therapy because they did not find it helpful. 'Troubled' dropouts reported stopping therapy because of a lack of stability in their lives that made it difficult for them to engage in therapy.

'Got-what-they-needed' dropouts reported that they did not perceive a need to continue in therapy and their therapists were not left concerned about them. The 'got-what-they-needed' dropout category fits with qualitative studies that cite clients reporting not perceiving the need for further treatment as a reason for stopping treatment (Garcia and Weisz, 2002; Block and Greeno, 2011). A substantial minority of cases in this sample (31%) were 'got-what-they-needed' dropouts, suggesting that adolescents stopping therapy without agreement of their therapist is not necessarily a negative way for therapy to conclude. While we could speculate these adolescents were justifying their decision to end therapy by saying they didn't need to keep going, this study found a trend toward them having better outcomes compared with 'dissatisfied' dropouts and completers, supporting their reported perception that they did not need to continue in therapy. However, the study was underpowered and there was only a statistically significant difference between 'got-what-they-needed' dropouts and 'dissatisfied' dropouts at 36 weeks with regards to depression severity – but not at the later follow ups. This finding must be viewed cautiously but may suggest a direction for future research to rigorously test the link between dropout types and clinical outcomes in a sufficiently powered study. Importantly, baseline scores indicated that 'got-what-they-needed' dropouts did not appear to be less severely depressed compared with completers or 'dissatisfied' dropouts. These findings suggest that a significant minority of adolescents with moderate to severe depression may benefit from a brief intervention and be able to decide to end therapy appropriately, even when this has not been agreed with the therapist. Their therapists viewed the ending as premature, yet did not have clinical concerns about these adolescents. Overall, 'got-what-they-needed' dropouts appeared to have stopped therapy for positive reasons, in contrast to the other types of dropout.

'Dissatisfied' dropouts were critical of the therapy they received, and described a range of things they didn't like about the therapy or that they found unhelpful, including issues with the therapists approach and their relationship with the therapist. 'Dissatisfied' dropout is consistent with some aspects of the barriers to treatment model, which outlines difficulties experienced by families in attending treatment (Kazdin et al., 1997a,b). Such difficulties include perceptions that treatment is not relevant or is too demanding and issues in the relationship with the therapist, which are particularly relevant to 'dissatisfied' dropouts. 'Dissatisfied' dropouts frequently referred to practical issues in attending therapy, such as the cost of bus fares, which fit with 'obstacles to coming to therapy' from the barriers to treatment model. Research has found more obstacles experienced by families to be associated with greater risk of dropout (Prinz and Miller, 1994; Kazdin et al., 1997a,b; Kazdin and

Wassell, 1998; McCabe, 2002; Stevens et al., 2006). However, 'dissatisfied' dropouts did not cite practical issues as reasons for stopping therapy. Rather, for these adolescents, the costs of therapy seemed to outweigh the benefits. Thus, it seems that adolescents' perceived lack of helpfulness of treatment was central to their decision to stop treatment. At baseline, there did not appear to be any notable differences between 'dissatisfied' dropouts and the completers with regards to presenting symptoms, indicating of the measured variables, there were not factors that could have predicted the outcome of 'dissatisfied' dropout.

Therapists of 'dissatisfied' dropouts showed little awareness of the adolescent's dissatisfaction with treatment, which fits with previous findings that clients often avoid expressing their dissatisfaction to their therapist (Henkelman and Paulson, 2006; von Below and Werbart, 2012; Gibson and Cartwright, 2013). This mirrors what was found in our study, as the adolescents expressed many criticisms of therapy in the research interviews, yet often did not seem to have shared these criticisms with their therapists, with some adolescents explicitly stating that they did not feel comfortable expressing their negative views about therapy to their therapist.

'Troubled' dropouts reported stopping therapy because of a lack of stability in their lives, which made it difficult for them to engage in the therapy, at that time. These adolescents reported complex difficulties that had interfered with therapy (such as not having a stable home or having responsibilities to support their family). Moreover, at baseline, 'troubled' dropouts appeared the most impaired in terms of symptom severity, compared with the other dropout types and completers. This included having statistically significantly higher scores for antisocial behavior, compared with completers, as well as presenting with more comorbidity. This type fits with Kazdin's (1996) groundbreaking risk-factor model, which suggests that it is the most disadvantaged youth at greatest risk of dropping out of treatment (Kazdin, 1996; de Haan et al., 2013). 'Troubled' dropouts most certainly would have met the criteria for a number of risk factors, and therefore according to Kazdin's risk-factor model, would have been considered at high risk of dropout. A recent systematic review revealed that intercurrent life events and contextual factors that interfere with treatment have been largely overlooked in the child psychotherapy literature (Blackshaw et al., 2018). 'Troubled' dropouts represent a group of young people for whom there were contextual factors that impeded their ability to engage in treatment, reflecting the need for greater attention to be paid to such contextual complexity for delivering effective mental health care. The reasons 'troubled' dropouts reported for stopping therapy focused on issues outside of the therapy room, contrasting with the other types of dropout, whose reasons for stopping therapy centered around what happened in the therapy and whether or not they found it helpful.

Kazdin's (1996) risk-factor model has received a great deal of attention in the literature on treatment dropout. While we must be cautious about the claims that can be made from our small sample, the risk-factor model appeared relevant to 'troubled' dropouts, but not the other types of dropout in this study. It is possible that the risk-factor model is primarily important for understanding one type of dropout only, and may be less helpful in explaining other types of dropout ('dissatisfied' and 'got-what-they-needed' dropouts), who appeared similar to completers prior to the start of treatment. Within-treatment factors may be a more productive line of enquiry for understanding 'dissatisfied' dropouts among adolescents in therapy for depression, while 'got-what-they-needed' dropouts reflect cases that drop out of treatment for more positive reasons. Together, these findings illustrate issues when using the generic 'dropout' definition. Future research should use a more refined categorization of dropout, due to the heterogeneity of cases classified as dropouts when using existing definitions of dropout.

Of the dropout cases included in this study, the most common type of dropout in the BPI and CBT arms was 'got-what-they-needed' dropout, with 42% and 45% of dropouts in these treatments fitting with this type. This finding may be understood in the context of the BPI and CBT treatment models, which focus on the presenting symptoms, which may have resulted in early symptom relief, resulting in these adolescents considering themselves to be sufficiently improved to stop therapy. The most common type in the STPP arm was 'dissatisfied' dropout, with 79% of STPP dropouts fitting with this type, compared to 25% of BPI and 33% of CBT cases. This raises questions about the specific aspects of STPP that adolescents seemed particularly dissatisfied with. These included the adolescents disliking the lack of structure, not knowing what to talk about and finding silence uncomfortable. Therapists may need to look out for warning

TABLE 5 | Estimated mean MFQ scores at 36, 52, and 86 weeks, showing group comparisons for completers, 'dissatisfied' dropouts and 'got-what-they-needed' dropouts.

	Completers *N* = 67	'Dissatisfied' dropouts *N* = 18	'Got-what-they-needed' dropouts *N* = 10	Completers vs. 'dissatisfied' dropouts	Completers vs. 'got-what-they-needed' dropouts	'Dissatisfied' dropouts vs. 'got-what-they-needed' dropouts
Weeks	**Mean (*SE*)**	**Mean (*SE*)**	**Mean (*SE*)**	***p*-value**	***p*-value**	***p*-value**
0	45.69 (1.55)	47.67 (2.99)	47.12 (4.01)	0.48	0.69	0.90
36	26.17 (1.67)	33.56 (3.62)	17.24 (4.21)	0.27	0.07	0.02
52	23.17 (1.75)	28.32 (3.32)	13.68 (4.82)	0.51	0.10	0.06
86	20.30 (1.62)	20.40 (3.10)	12.82 (4.14)	0.66	0.10	0.26

Estimates and group comparisons derived from mixed effect models predicting MFQ scores from Time and Therapy Ending Type.

signs of disengagement, and in some cases, aspects of the STPP model may need to be adapted to better meet their needs.

Strengths and Weaknesses of This Study

This mixed-methods study allowed an in-depth exploration of the concept of dropout. The qualitative analysis was strengthened by credibility and reliability checks in developing the types. However, there were too few cases to allow comparison of 'troubled' dropouts with other groups with respect to outcome, and the sample size for 'got-what-they-needed' and 'dissatisfied' types meant the statistical analyses had low power to detect differences in both baseline characteristics and outcome. There were too few cases to control for potential confounders, and the length of time between the end of treatment and the follow up assessments varied between participants. Thus, the statistical analyses were exploratory and failure to reject the null hypothesis should not be interpreted as evidence that the groups did not differ with respect to clinical outcomes. We hope that larger studies in the future will build on these exploratory results. As participants had been randomized to a treatment arm, the method of treatment assignment was not naturalistic, so dropout could potentially have been the result of violation of client preferences for the type of treatment, although none of the participants stated that they stopped therapy for this reason. Additionally, the study sample comprised adolescents with depression. It is unknown how generalizable these findings are to adolescents with other presenting problems. Future studies can test how these types apply to naturalistic settings and with adolescents with other presenting difficulties.

We also note that the sample for this study comprised those adolescents and therapists who were contactable and agreed to be interviewed after the therapy ended, so it is unknown whether these types would generalize to those who did not participate in the study. This study used semi-structured interviews, which provided a rich account of the participants' experiences of therapy, yet there may be bias in what was reported. The data used in this study was based on what the participants were able to remember, willing to share and aware of. It is possible that there may have been reasons for dropout that the adolescent and therapist were not aware of or had forgotten by the time they were interviewed. Finally, ideal type analysis shares limitations with many inductive analyses of qualitative data. The types identified in this study may not be the only types of dropout, and other types may be found in other samples and settings. The typology was constructed from the first author's point of view, as a researcher. It cannot be said whether the same types would have been constructed by another researcher. Nonetheless, once the typology was defined, there was good agreement in classification of cases to the types between the lead author and independent researchers.

CONCLUSION

Debates about how dropout should be defined have spanned across several decades. The aim of this study was to try to identify more meaningful categories of dropout in the context of adolescents receiving psychological therapy for depression. In this study, three types of therapy dropout were constructed. While the adolescents decided to stop therapy without their therapists' agreement, they had somewhat different reasons for doing so and reported several key influences as to whether they kept going to therapy: whether the therapy was helping or had helped them, their satisfaction with the treatment and external influences.

'Dissatisfied' dropouts had significantly poorer outcomes compared with 'got-what-they-needed' dropouts at 36 weeks. The study had low statistical power and these findings should be viewed as preliminary, yet provide some indication that the effect of dropout on outcome may differ by dropout type. This study raises issues with studying dropout as a unitary concept and may help to explain some of the inconsistent findings in the existing dropout literature. Existing definitions of dropout do not capture or take into account the way in which adolescents experience therapy, nor do they consider the reasons they give for stopping therapy. Future research should seek to differentiate between different types of dropout given the heterogeneity of cases when using the generic 'dropout' definition.

The types of dropout in this study may provide a framework for clinicians working in CAMHS to think about ending treatment with adolescents receiving therapy for depression. 'Got-what-they-needed' dropouts may to a certain extent be thought of as having dropped out of therapy appropriately, given that the adolescents reported that they did not perceive a need to continue in treatment. Dropping out of therapy may not always be a negative way for therapy to end, so in clinical practice, shared decision making (Cheng et al., 2017) about treatment durations and endings may be warranted. 'Dissatisfied' dropouts reported stopping therapy because of issues they had with the therapy. These findings are important for providing awareness to clinicians about the range of issues experienced by adolescents in treatment that lead to their dissatisfaction and disengagement. Through awareness of such issues, therapists can be more in tune with the way in which adolescent's experience treatment, and interventions can be adapted to improve their acceptability to adolescents. Therapists often were not aware of the issues adolescents had with treatment. Future research into the therapeutic process should seek to investigate whether there are detectable warning signs of adolescents' dissatisfaction with treatment. Finally, the 'troubled' dropouts illustrate the difficulty some adolescents are likely to have engaging in treatment when experiencing complex difficulties, such as homelessness or responsibilities in the family. This raises questions about how such adolescents, possibly those most in need of it, can be supported.

AUTHOR CONTRIBUTIONS

NM and MT were Principal Investigators of the IMPACT-ME study, responsible for securing funding for the project and the overall management of the project. SO'K contributed to data collection. SO'K carried out this study, including analyzing the data and writing the initial draft of this manuscript, under the

supervision of NM and PM. All authors contributed to manuscript revision, read and approved the submitted version.

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Metacognition as a Predictor of Improvements in Personality Disorders

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Personality Disorders (PDs) are particularly hard to treat and treatment drop-out rates are high. Several authors have agreed that psychotherapy is more successful when it focuses on the core of personality pathology. For this reason, therapists dealing with PDs need to understand the psychopathological variables that characterize this pathology and exactly what contributes to maintaining psychopathological processes. Moreover, several authors have noted that one key problem that characterizes all PDs is an impairment in understanding mental states – here termed metacognition – which could also be responsible for therapy failures. Unfortunately, a limited number of studies have investigated the role of mentalization in the process of change during psychotherapy. In this paper, we assume that poor metacognition corresponds to a core element of the general pathology of personality, impacts a series of clinical variables, generates symptoms and interpersonal problems, and causes treatment to be slower and less effective. We explored whether changes in metacognition predicted an improvement among different psychopathological variables characterizing PDs; 193 outpatients were treated at the Third Center of Cognitive Psychotherapy in Rome, Italy, and followed a structured path tailored for the different psychopathological variables that emerged from a comprehensive psychodiagnostic assessment that considered patients' symptoms, metacognitive abilities, interpersonal relationships, personality psychopathology, and global functioning. The measurements were repeated after a year of treatment. The results showed that changes in metacognitive abilities predicted improvements in the analyzed variables.

Keywords: metacognition, mentalization, personality disorders, psychotherapeutic process, psychotherapy outcome

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INTRODUCTION

Psychotherapists and psychiatrists agree that Personality Disorders (PDs) are particularly troublesome to treat. Although psychotherapy is considered to be the treatment of choice for all PDs (Verheul and Herbrink, 2007; Livesley, 2012; Bamelis et al., 2014), the rate of treatment being prematurely interrupted is high (McMurran et al., 2010; Barnicot et al., 2011; Swift and Greenberg, 2012; Gamache et al., 2018; Gülüm, 2018). Unfortunately, research largely focuses on the treatment

of borderline personality disorder (BPD), which may be an unjustified bias, since individuals with BPD represent a minority of PD sufferers requiring treatment (Dimaggio et al., 2013b).

Systematic research on factors associated with premature treatment interruption has not yet produced conclusive results; however, it is well known that the drop-out rate in PDs is particularly high. In an accurate metanalysis conducted by Swift and Greenberg (2012), the general treatment drop-out rate of 19.7% increased to 25.6% in the case of PDs. Furthermore, McMurran et al. (2010) discovered that the median drop-out rate in PD patients was 37%, while in a recent study by Gamache et al. (2018) the drop-out rate amounted to 40.8%. These data suggest that it might be particularly relevant to study the therapeutic process when treating PDs, since this would help to identify the main factors underlying personality pathology that might need to be addressed during treatment. Studies have generally investigated large sets of several pre-treatment variables without focusing on specific variables selected for treatment prognosis prediction (Gamache et al., 2018). These observations call for a remarkable effort in analyzing the treatment process and understanding the possible mechanisms of change during psychotherapy.

Additionally, several authors have agreed that therapeutic intervention should be centered on aspects of general personality pathology shared in different PDs; among these, a reduced ability to understand the minds of others seems to be particularly relevant (Fonagy, 1991; Semerari et al., 2003, 2007, 2014, 2015; Bateman and Fonagy, 2004, 2009; Minzenberg et al., 2006; Dimaggio et al., 2007; Gullestad et al., 2013). Moreover, the DSM 5 stresses the key role of reflective abilities, since in Section III and establishes that in order to diagnose a PD, it is crucial to consider the evaluation of the functioning level of the individual's personality through their capacity to (1) self-reflect, thus promoting a stable sense of self and self-directivity and (2) understand others' minds in order to establish and maintain empathetic and good relationships (American Psychiatric Association [APA], 2013).

The ability of understanding mental states has different denominations, but in the field of PDs it is often termed "mentalization" (Bateman and Fonagy, 2004; Bouchard et al., 2008; Choi-Kain and Gunderson, 2008) or "metacognition" (Semerari et al., 2003, 2007; Dimaggio and Lysaker, 2010; Carcione et al., 2011). These two terms have been used in numerous studies as similar concepts, and there is a broad consensus indicating that they refer to almost the same psychological function (Bo et al., 2014; Semerari et al., 2014; Fonagy and Bateman, 2016).

In this paper, we use the term *metacognition* to refer to a set of abilities that are crucial to: (1) identify mental states and ascribe them to oneself and others on the basis of facial expressions, somatic states, behaviors, and actions; (2) reflect and reason on mental states; (3) use information about mental states to make decisions, solve problems or for psychological and interpersonal conflicts and to cope with subjective suffering (Carcione et al., 2010, unpublished).

Only a limited number of studies have investigated the role of different metacognition abilities in the process of change during psychotherapy (Levy et al., 2006; Vermote et al., 2010; Maillard et al., 2017). Some studies have provided data about the role of mentalization as a moderator of the clinical outcomes of psychotherapeutic treatment for PDs (Gullestad et al., 2013). Other studies have investigated the predictive role of a series of constructs related to metacognition, such as psychological mindedness (PM; Appelbaum, 1973; Conte et al., 1990; McCallum et al., 2003; Ogrodniczuk et al., 2011), alexithymia (Nemiah and Sifneos, 1970), especially in creating major difficulties in identifying the aim of treatment, (Leweke et al., 2009; Ogrodniczuk et al., 2010; Nicolò et al., 2011) and affect-consciousness (AC – Monsen and Monsen, 1999), whose high pre-treatment levels predict improvements in Cluster C pathology (Gude et al., 2001).

Within this framework, in this study we assumed that poor metacognition corresponded to a core element of the general pathology of personality, the functioning of which impacts a series of clinical variables (and treatment). Therefore, we expected that improvements in metacognition would be associated with improvements in personality pathology.

We explored changes in metacognition and in a series of clinical variables (i.e., personality dysfunction, symptom distress, and interpersonal and psychosocial functioning) in a sample of patients treated for 1 year with a treatment specifically structured to improve metacognition (i.e., the Metacognitive Interpersonal Therapy, MIT; Semerari, 1999; Dimaggio et al., 2007, 2011; Fiore et al., 2008; Dimaggio et al., 2015; Carcione et al., 2016).

To comprehensively evaluate the changes of all the considered variables, we firstly compared the mean scores at the beginning of the treatment (T0) and after 1 year (T1). We expected that the mean scores of personality severity (the number of dysfunctional traits), symptom distress and interpersonal problems would decrease, while global functioning and metacognition would increase after 1 year of treatment. Secondly, we compared the associations between metacognition and the clinical variables considered at the beginning of the study and after 1 year of treatment. If low metacognition is a variable that could be conceived of as a core aspect across different PDs, then an improvement in metacognition should predict a reduction in personality pathology. Specifically, considering that poor metacognition is related to the severity of personality pathology measured through the number of PD criteria (according to the DSM IV-TR; Dimaggio et al., 2013a; Semerari et al., 2014), we hypothesized that improvements in metacognition are associated with improvements in personality pathology (i.e., a reduction in the number of dysfunctional traits). Furthermore, considering that an understanding of mental states is a requirement to regulate and master those same states (Carcione et al., 2011), we also hypothesized that an increase in metacognition is associated with a reduction in symptom distress among patients with PDs. Since it is also assumed that understanding the mental states of oneself and others is fundamental to the regulation of interpersonal relationships and helps individuals to overcome interpersonal problems (Dimaggio et al., 2007), our third hypothesis was that an increase in metacognition would be associated with a decrease in interpersonal problems. Additionally, we expected that improvements in metacognition

were associated with improvements in global psychosocial functioning. We tested the hypotheses of an association between changes in metacognition and changes in all of the above considered clinical variables after 1 year of treatment through the use of a structural equation model with latent variables.

MATERIALS AND METHODS

Participants

The sample consisted of 193 individuals who completed a 1-year treatment schedule in an Italian outpatient clinic between 2011 and 2017. The mean age of the sample was 33.37 years (SD = 9.54), ranging from 18 to 65. 59 participants (44.7%) were male and 73 (55.3%) were female. All participants met DSM-IV-TR (American Psychiatric Association [APA], 2000) diagnostic criteria for PD; DSM-IV Axis I diagnoses were assessed using the Structured Clinical Interview for the DSM-IV, Axis I Disorders (SCID-I; First et al., 1996). The inclusion criteria embraced patients with at least one PD (including those with histories of suicidal attempts or self-harm). On the other hand, the exclusion criteria were substance dependence, psychotic disorders, bipolar I disorder, delirium, dementia, mental retardation, severe medical conditions which precluded psychiatric medications, and medical conditions requiring hospitalization. Individuals who were enrolled in the study provided written informed consent.

Table 1 illustrates the demographic and diagnostic characteristics of the study sample and the percentage of PD diagnoses.

Measures

The *Structured Clinical Interview for DSM-IV* (SCID-II; First et al., 1997) was used to obtain diagnostic Axis-II profiles on the basis of the criteria of the DSM-IV (American Psychiatric Association [APA], 2000), which yielded 11 different categories of PD diagnoses. In this study, satisfactory inter-rater reliability was found in the application of the SCID-II. 20 SCID-II were rated twice; the internal consistency of the PDs traits ranged from 0.71 to 0.89 for the majority of the PD diagnoses; only four PDs (obsessive-compulsive, dependent, schizotypal, and passive-aggressive) achieved alphas above 0.60. The inter-rater reliability was adequate for both trait scores (a two-way mixed absolute agreement model for the Intraclass Correlation Coefficients (ICC) ranged from 0.87 to 0.99, mean = 0.94) and categorical diagnoses (average $\kappa = 0.89$).

TABLE 1 | Sample description.

N	Gender	Age M(SD)
193	83 M (43%) 110 F (57%)	32.9 (10.1)

Percentage of Diagnosis for PDs										
AV	DEP	OBS	PA	DE	PAR	ST	HIS	NAR	BDL	AS
7.3	10.4	23.8	10.4	10.4	5.2	0.5	2.6	7.8	14.4	1.6

M, Male; F, Female; AV, Avoidant PD; DEP, Dependent PD; OBS, Obsessive PD; PA, Passive-Aggressive PD; DE, Depressive PD; PAR, Paranoid PD; ST, Schizotypal PD; HIS, Histrionic PD; NAR, Narcissistic PD; BDL, Borderline PD; AS, Antisocial PD.

The *Symptom Checklist-90-R* (SCL-90-R; Derogatis, 1977; $\alpha = 0.96$) is a 90-item self-report inventory designed to reflect the psychological symptom patterns of psychiatric and medical patients. It is a measure of the current (state) psychological symptom status of a patient. The SCL-90-R measures nine primary symptom dimensions and generates an estimate of global psychopathology, the Global Severity Index (GSI), which has been adopted in the current study as a measure of symptoms.

The *Inventory of Interpersonal Problems*-47 (IIP-47; Italian version Ubbiali et al., 2011; $\alpha = 0.93$) is a 47-item self-report scale which assesses interpersonal problems, and consists of five subscales: Interpersonal Sensitivity, Interpersonal Ambivalence, Aggression, Need for Social Approval, and Lack of Sociability.

The *Global Assessment of Functioning* (GAF; American Psychiatric Association [APA], 2000) is a valid measure of social functioning and is currently placed on the fifth axis of the DSM-IV-TR. It has shown reasonable psychometric properties (inter-rater reliability of approximately 0.80; Dworkin et al., 1990). For this study, the inter-rater agreement was good (ICC, $r = 0.80$, $p < 0.001$).

The Metacognition Assessment Interview (MAI). The MAI (Semerari et al., 2012; Pellecchia et al., 2015) is a semi-structured clinical interview designed to elicit and evaluate the metacognitive abilities of the participant during a brief narrative of a psychologically significant experience or event. During the interview, the participant is requested to describe the most troubling interpersonal experience they had experienced in the previous 6 months, a time frame selected in order to facilitate recall and to permit test-retest, avoiding recall biases, in the evaluation of changes during psychotherapy. The reported experience must be autobiographical, personal and involve another person, so that the individual's ability to understand the mental state of others can be evaluated. Once the description of the episode is completed, the interviewer asks a list of questions, divided into four modules, to elicit and evaluate the 16 basic facets constituting metacognitive sub-functions (four facets are allocated to each sub-function). The interviewer assigns each of the 16 basic facets a score ranging from 1 to 5 using a Likert scale. The metacognitive functions assessed by the MAI are: Monitoring (MON), Integration (INT), Differentiation (DIF), Decentration (DEC), and Global score. MON is the ability to identify and label the components of our mental states in terms of emotions, thoughts, motivations and desires. People who can effectively monitor find it easy to give appropriate answers to questions such as "What do you think?" and "How do you feel?". Impairments of this function compromise both the individual's ability to describe his/her internal state and their ability to explain the reasons and motivations underlying his/her behavior. INT refers to the more general capacity of individuals to reflect upon different mental states and identify internal contradictions, conflicts and patterns. This metacognitive function allows us to adaptively organize mental content in terms of significance and subjective priority and thus to maintain behavioral coherence. An INT disorder causes mental processes and behaviors to be

contradictory and unstable. DIF indicates the individual's ability to recognize the representational nature of their mental states, distinguishing clearly between the internal psychological content and external reality. In the presence of impaired differentiation, imagination takes on the properties of the real world. In this perspective, if the patient is unable to recognize the subjectivity of his/her mental representations, he/she is also unable to maintain a critical distance from his/her own representations. DEC refers to the ability to assume other people's perspectives and to make plausible hypotheses about their mental states. Specifically, it means being able to reflect on others' intentions, thoughts and desires, independently of one's own personal point of view.

The MAI was tested in two preliminary studies. In the first study, factor analysis was used to investigate 175 non-clinical subjects and revealed the presence of two higher order domains, which can be described, respectively, as the awareness of one's own mental state and the awareness of others' mental states (Semerari et al., 2012). In the second study, conducted with the same sample as this study, factor analysis indicated four factors, consistent with the structure of the MAI sub-functions, but which also confirmed the higher "two factor" structures identified in the first study (Pellecchia et al., 2015). Additionally, this study demonstrated a significant association between the MAI and alexithymia measured with Toronto Alexithymia Scale (TAS-20) (Bagby et al., 1994). In particular, MON scores and MAI global scores were associated with all TAS-20 dimensions and total scores (with correlation coefficients ranging from 0.24 to 0.39, $p < 0.01$). Moreover, MAI sub-functions and global scores resulted in an association with the global evaluation of interpersonal problems measured with the IIP-47 (Pilkonis et al., 1996), with a correlation coefficient ranging from 0.19 to 0.27 ($p < 0.01$).

In the present study, the MAI was administered and scored by three senior interviewers blind to the clinical diagnosis of the participants. A preliminary inter-rater reliability evaluation was carried out on 20 interviews. The ICC was used to estimate the correlation for every single function rated by different judges. A two-way mixed absolute agreement model was applied to conduct the ICC for each dimension of the MAI. The ICC for the MAI's functions ranged from 0.55 to 0.72 for MON; from 0.50 to 0.67 for INT; from 0.49 to 78 for DIF; and from 0.45 to 0.61 for DEC; all analyses were significant ($p < 0.001$) and provided good inter-rater reliability. The internal consistency of the MAI dimensions was estimated with Cronbach's alpha, which ranged from 0.85 to 0.89.

The Treatment: Metacognitive Interpersonal Therapy (MIT)

The Metacognitive Interpersonal Therapy (MIT is an integrated approach, developed by the Third Center of Cognitive Psychotherapy in Rome, to treat PDs (Carcione et al., 2016). It aims to improve metacognitive abilities and to master problematic mental states. This treatment model derives from a) the analysis of clinical and research literature on PDs and (2) intensive research investigating the therapeutic process starting from a descriptive model of psychopathological functioning (Dimaggio et al., 2007, 2015; Semerari et al., 2014).

Metacognitive interpersonal therapy was developed within the framework of CBT, but it integrates the different procedures and techniques developed, even from a non-CBT approach (i.e., Mentalization Based Treatment-MBT, Dialectical Behavior Therapy-DBT), for the treatment of PDs. In particular, MIT shares with MBT the constant attention and focus on the patient's reflective abilities and their efforts to increase these abilities as its principal aim.

Metacognitive interpersonal therapy can be schematically divided into five phases focused on different metacognitive functions:

(1) In the first phase, the principal aim is to develop the patient's ability to monitor problematic states. The therapist attempts to make the patient aware of (a) the primary emotion, which is the basis of these states and (b) the intentions, motivations and goals underlying the most dangerous behaviors for the patient and which prevent a good therapeutic alliance from developing.
(2) The aim of the second phase is to develop an integrated view (i.e., the INT ability) of the current trends in the patient's mental state. The therapist tries to: (a) focus on the transition of the states; (b) highlight the contradictions and conflicts and (c) reconstruct the modifications of the problematic states in conjunction with the patient. The awareness of the dynamics of the states is the basis for the greater tolerance of suffering which itself is increased using mindfulness and experiential techniques.
(3) The third phase is focused on the patient's ability to consider the representational nature of thoughts. The therapist uses CBT techniques to promote the patient's differentiation abilities, helping them to distinguish between representation and reality and to consider the subjectivity of one's own point of view. In these two phases, the mastery of problematic states is achieved through behavioral modifications using cognitive behavioral and DBT techniques.
(4) In the fourth phase, the aim is to increase the awareness of dysfunctional interpersonal cycles (according to Safran and Segal, 1990; Safran and Muran, 2000). The therapist has to (a) focus on the self and interpersonal schemas (self/other representations) and (b) promote differentiation and decentration abilities using cognitive therapy procedures.
(5) The aim of the fifth phase is to develop a sense of self-agency. The therapist helps the patient to build autobiographical continuity in which the troubles and how he/she coped with them emerge in a coherent narrative.

The therapist, throughout the duration of the psychotherapy, must, at the right moment, debate with the patient the behavioral and problem solving (i.e., mastery) strategies spontaneously adopted, encouraging those which are more adaptive to cope with distress and interpersonal problems.

In addition to individual therapy, MIT can also provide group intervention aimed at improving metacognition

using psychoeducation and role-playing techniques, with particular attention paid to the impact of metacognition on relational aspects.

Procedure

All measures were administered at baseline (pre-treatment) and after 1 year of treatment. SCL-90-R and IIP-47 were self-reported by the patients; GAF was reported by a clinician, SCID-II interviews and MAI at T0 and T1 were administered by a clinical team of psychologists and psychiatrists from the Third Center of Cognitive Psychotherapy in Rome, Italy. Each patient was rated by the same clinician at both T0 and T1.

The therapists were psychiatrists and psychologists, all trained in CBT, with an expertise in PDs and an experience ranging from 5 to 35 years. The sample comprises outpatients who sought the services of a private clinical center (Third Center of Cognitive Psychotherapy). Patients followed a thorough assessment procedure: first, patients are interviewed by a senior psychiatrist and psychotherapist (at least 20 years of experience); thus, several diagnostic and clinical tests are administered and a diagnosis is established; then, in a team meeting, the patient is assigned to a psychotherapist, taking into consideration the peculiarities of the specific case and the expertise of the psychotherapist in treating similar cases. The center's organizational procedure includes weekly team meetings for the discussion of the most complex cases, and to monitor the ongoing therapies.

The study was extensively explained to each participant, who signed a written consent form before entering into the study. Following the informed consent, all participants completed each of the self-report measures, and were then assessed during interviews. After the first evaluation (T0), participants were assigned to a therapist and attended the sessions every week for 1 year before being evaluated again (T1).

Statistical Analyses

To test our hypotheses, the statistical analyses were divided into two phases. We firstly computed the number of SCID-II criteria met by each individual participating in the study; the resulting score was considered to be a global measure of the severity of personality pathology. An analysis of internal consistency supported the view that a general severity composite may be represented this way (at T0 $\alpha = 0.74$; at T1 $\alpha = 0.88$; Hopwood et al., 2011; Semerari et al., 2014).

During the first phase, a series of repeated ANOVA measures were computed in order to evaluate changes on all measures between early and late treatment. All results were evaluated against Holm's sequential Bonferroni correction (Holm, 1979), and adjustments to alpha values were made to protect against inflated family-wise error rates.

Secondly, to investigate the role of metacognition in predicting changes in the severity of clinical variables we specified a structural equation model with latent variables, conceptually summarized in **Figure 1**. We modeled a latent criterion (or dependent variable), here termed "*Clinical Variable*,", that summarized the observed variables relating to an array of clinical indicators (SCL90R-GSI, IIP-47, SCID II criteria, and GAF scores) at T1 (i.e., after 1 year of treatment). The latent predictor of improvements in metacognition was then linked to *Clinical Variable* at T1. To control for spurious effects, a latent variable *Clinical Variable* at T0 (using the same indicators as in T1) was also specified and linked with *Clinical Variable* at T1. Thus, any effect for metacognition on the T1 *Clinical Variable* cannot be traced back to spurious associations through *Clinical Variable* at T0. We expected that, over and above the association between *Clinical Variable* across the T0 and T1 time-lag, improvements in metacognition would be negatively associated (i.e., decrease) with the level of *Clinical Variable* at T1. A statistical analysis of the data was performed using SPSS 20.0 and LISREL 8.8.

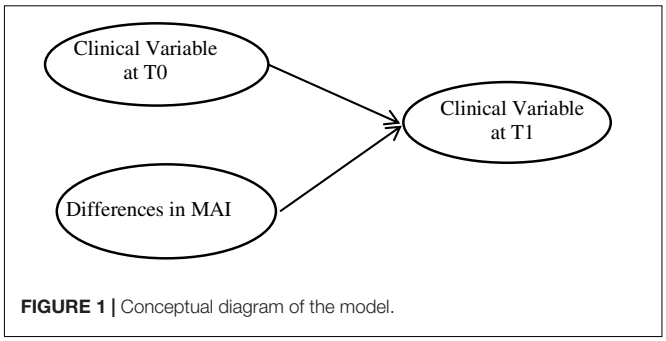

FIGURE 1 | Conceptual diagram of the model.

RESULTS

Changes Between Early and Late Treatment on Clinical and Functioning Measures

Table 2 presents the means and standard deviations for both outcome and predictor variables at T0 (the beginning of the treatment) and T1 (1 year later). Additionally, **Table 2** summarizes the results for the repeated measures ANOVA for each variable. At T0, data showed generally high levels of severity and distress, and low scores of general functioning. At T1, the means showed significant changes compared with T0, indicating a general improvement in personality severity, symptom distress and levels of psychosocial and interpersonal functioning. Turning to levels of metacognition, a significant improvement was observed from T0 to T1. Such an improvement was detectable in both the MAI Global Score and the four MAI facets (**Table 2**).

Changes in Metacognition and Clinical Variables

We tested the structural equation model with the latent variables depicted in **Figure 2** (the obtained parameter estimates are summarized in the figure). A latent factor indexed by the observed scores at T1 (i.e., after 1 year of treatment) in the PD severity scores (the number of PD criteria met during SCID II) and also in the SCL90R-GSI scores, interpersonal problems (IIP-47) and GAF scores played the role of the dependent (or endogenous) variable. This *Clinical Variable* at T1 latent factor was predicted in the model by two independent latent factors.

TABLE 2 | Outcome and predictor measure changes between early and late treatment (Repeated-measures ANOVA results of included variables).

Measures	Early Mean (SD)	Late Mean (SD)	Mean Difference	Fs	Partial Eta Squared
PD Severity	16.30 (6.59)	9.34 (6.39)	6.96	F(1,190) = 291.49**	0.61
GSI	1.38 (0.59)	0.83 (0.55)	0.55	F(1,182) = 184.74**	0.50
IIP-47	1.74 (0.65)	1.35 (0.64)	0.40	F(1,184) = 80.57**	0.31
GAF	65.55 (10.15)	75.36 (11.41)	−9.81	F(1,149) = 138.50**	0.48
MAI					
Monitoring	12.37 (2.71)	14.51 (2.12)	−2.14	F(1,182) = 122.86**	0.41
Integration	11.13 (2.52)	13.21 (2.08)	−2.08	F(1,182) = 121.20**	0.40
Differentiation	10.92 (2.74)	13.39 (1.93)	−2.47	F(1,182) = 146.43**	0.45
Decentration	10.91 (2.73)	12.81 (2.38)	−1.90	F(1,182) = 103.23**	0.36
Total score	45.33 (9.26)	53.92 (7.19)	−8.59	F(1,182) = 182.10**	0.50

*PD Severity, number of criteria met at the SCID-II (N = 191); GSI, SCL90-R Global Severity Index (N = 183); IIP-47, Inventory of Interpersonal Problems (N = 185); GAF, Global Assessment of Functioning (N = 150); MAI, Metacognition Assessment Interview (N = 183). **p < 0.001.*

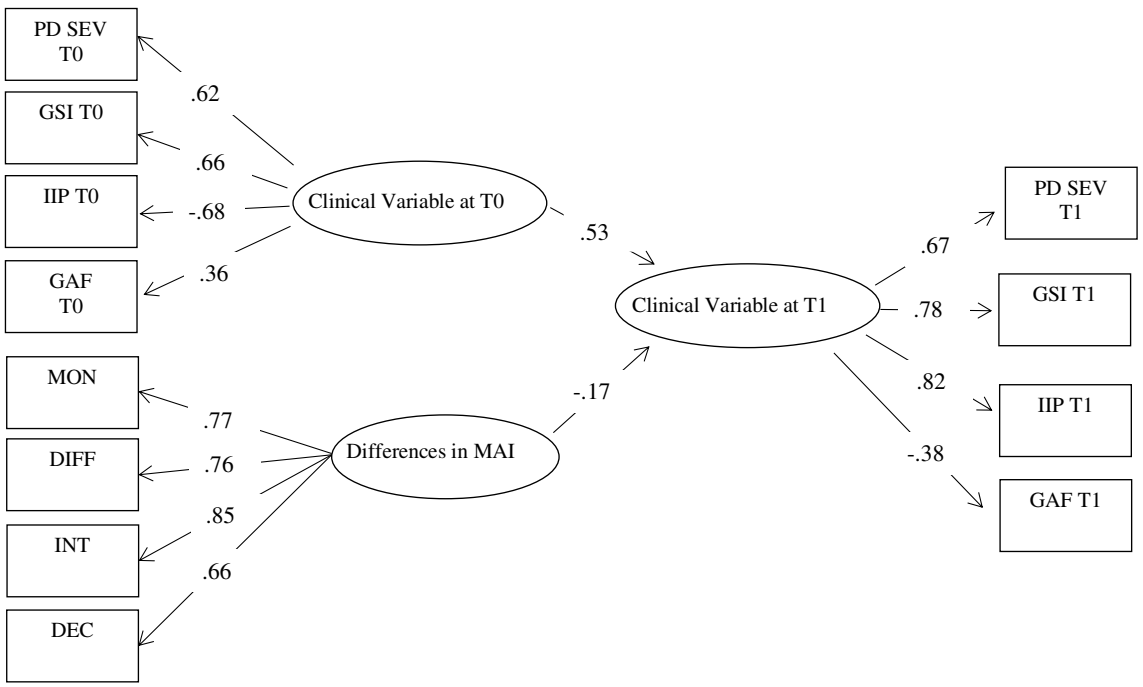

FIGURE 2 | Structural equation model: Parameter estimates. Note: All parameters are significant. GSI, SCL90-R-Global Severity Index; IIP, Inventory of Interpersonal Problems; GAF, Global Assessment of Functioning; PD SEV, number of criteria met at the SCID-II; MON, Monitoring; DIFF, Differentiation; INT, Integration; DEC, Decentration; MAI, Metacognition Assessment Interview.

A first predictor, which mainly played a control role, was a latent factor *Clinical Variable* at T0, indexed by the PD severity scores, SCL90R-GSI, IIP-47 and GAF scores measured at T0 (at the beginning of the treatment). The second latent predictor was a "*Change in Metacognition*" factor, indexed by four difference-score indicators (T1-T0), one for each metacognition facet of the MAI. Utilizing the latent variables enables the study to more accurately predict the regression coefficients (because the measurement error is explicitly modeled and does not attenuate regression parameter estimates). This confirmative model also allows the testing of the global fit in terms of the ability of the model parameters to reproduce the observed data (Bollen, 1989). A Maximum Likelihood estimation was used to obtain the parameter estimates and standard errors. The ability of the model to reproduce the data is directly evaluated by a chi-square statistic; however, the chi-square statistic is excessively restrictive for large samples (Bollen, 1989), and therefore we would also evaluate the model fit by assessing the root mean square error of approximation (RMSEA), the comparative fit index (CFI), the non-normed fit index (NNFI), and the standardized root mean square residual (SRMR), as suggested by Hu and Bentler (1999). These latter indices are generally unaffected by sample size and provide a more comprehensive view of the model fit.

The model fitted the data satisfactorily. Although the chi-square statistic was significant [$\chi^2(47, N = 218) = 84.11$, $p = 0.0007$], the other fit indexes pointed to a reasonable

fit: RMSEA = 0.060 [90% C.I. 0.039; 0.081]; CFI = 0.97; NNFI = 0.96; SRMR = 0.059. The RMSEA value was statistically undistinguishable from the so-called "close fit" hypothesis (RMSEA = 0.05), indicating negligible deviations in the reproduced data. CFI and NFFI were above the threshold of 0.95 generally associated with good fit, and the SRMR was below 0.08 (Hu and Bentler, 1999). The model appeared therefore fairly satisfactory.

Figure 2 summarizes the main parameter estimates. The measurement models (factor loadings) demonstrated satisfactory values, with significant loadings with the expected sign. Turning to the structural parameter estimates linking the latent variables, as should be expected, *Clinical Variable* at T0 were significantly and strongly linked with *Clinical Variable* at T1. Interestingly, once the cross-lag association between *Clinical Variable* across T0 and T1 was controlled for, increases in the metacognition scores were associated with decreases in *Clinical Variable* at T1.

DISCUSSION

Our study entered into the research field surrounding the existing relations between metacognition and its role in the outcome of treatment for PDs. Our purpose was to measure the specific functions of metacognition, their changes during treatment and their role as a predictor of personality severity changes and other outcome measures.

This study does not aim to assess the effectiveness of a specific treatment. Nevertheless, we believe that, given the lack of a broad range of sensitive measures of cognitive and affective dysfunctions found in PDs (Luyten et al., 2012; Chiesa and Fonagy, 2014), our study could add empirical evidence about the role of specific variables that are important to reduce therapeutic failures.

We firstly evaluated the mean differences in personality severity, symptom distress, interpersonal problems, global functioning, and metacognition both at the beginning of a treatment based on metacognition (MIT) and after 1 year of treatment. The results showed a general improvement in all the variables considered.

In the second hypothesis, we supposed that those improvements could be predicted by improved metacognition functioning developed by the patient during 1 year of MIT treatment. The results appeared consistent with these expectations.

These results can be discussed from two points of view: what they indicate with respect to the pathology of the individual's personality, and what they indicate with respect to the psychotherapeutic process of PD patients.

From the point of view of personality pathology, if the initial general hypothesis that low metacognition is one of the general factors underlying this pathology is true, a metacognitive improvement would consequently be associated with a general improvement in the clinical variables associated with the disorder. Our data, through a structural equation model with latent variables, lent support to this argument, constituting indirect support to the central role played by low metacognition in PDs. The reported results are consistent with previous findings (Semerari et al., 2003, 2007, 2014, 2015; Bateman and Fonagy, 2004; Minzenberg et al., 2006; Dimaggio et al., 2007; Gullestad et al., 2013) that considered difficulties in understanding one's own and others' minds as core aspects of PDs. For example, Herpertz and Bertsch (2014) considered impairments in social cognition (i.e., facial emotion recognition, cognitive and emotional empathy, and theory of mind) to be a core concept that characterizes PDs. Other authors (Antonsen et al., 2016; Hayden et al., 2018) found an association between Reflective Function (RF) and the intensity of symptom distress and psychosocial impairment. Semerari et al. (2014) supported evidence that (1) metacognition is specifically impaired in PDs if compared to a clinical sample of non-PD patients, (2) the dysfunction is significantly correlated to the severity of personality pathology (measured as the number of criteria met in the SCID II) and (3) difficulties in metacognition are specific to different PDs (Semerari et al., 2007), for example in BPD (Semerari et al., 2005, 2015) and in Avoidant PD (AvPD) patients Pellecchia et al. (2018).

Furthermore, Pellecchia et al. (2018) compared patients with Social Phobia (SP), with AvPD, with both AvPD and SP and with other PDs without SP or AvPD criteria on metacognitive abilities, interpersonal functioning and global symptomatic distress. They found that patients with AvPD and AvPD+SP groups demonstrate poorer metacognition compared with SP patients; moreover, no differences were found in metacognition capacity between the groups with an AvPD diagnosis (AvPD+SP and AvPD) and the PD group without an AvPD diagnosis, which is consistent with the notion that poor metacognitive functioning is an element that differentiates personality pathology from anxiety disorders.

From the point of view of the impact on psychotherapeutic treatment, our data support the hypothesis that an increase in metacognitive abilities is a factor of change in personality pathology. Similarly, Chiesa and Fonagy (2014) found the mediator role of mentalization between early adverse experiences and PD diagnoses and between adversity and psychiatric distress. Our results are consistent with Gullestad et al. (2013), which provided data about the role of mentalization in psychotherapeutic treatment for PDs, and with other studies that have investigated the predictive value of related concepts, like psychological mindedness (PM) (Appelbaum, 1973), alexithymia (Nemiah and Sifneos, 1970) and affect-consciousness (Monsen and Monsen, 1999). Higher pre-treatment levels of PM have been found to predict favorable outcomes (Conte et al., 1990; McCallum et al., 2003; Ogrodniczuk et al., 2011). Additionally, convergent evidence shows that alexithymia impacts treatment, for example by creating major difficulties in identifying treatment aims or in generating negative reactions in the therapists (Leweke et al., 2009; Ogrodniczuk et al., 2010; Nicolò et al., 2011). Finally, in a study that examined the relationship between Affect Consciousness (AC) and cluster C personality pathology, a high pre-treatment level of AC predicted a reduction in avoidant personality pathology, but not in dependent or obsessive-compulsive PD-traits. One exception is the data of Gude et al. (2001), where an increase in AC during therapy was not

associated with improvements in personality pathology. This difference could be due to the fact that AC covers only some aspects of reflective abilities, as the ability to perceive and organize specific affects, while metacognition includes several other abilities in understanding one's own and others' minds (including not only emotional but also cognitive awareness). This difference could mean that metacognition, as measured through the MAI, clinically captures more relevant functioning.

Together, the data encourage the investigation of aspects of functioning underlying the various PDs and the refinement of the intervention focusing on these dimensions, in line with the suggestion of Bateman and Fonagy (2009).

Limitations

The present study has a number of limitations that should be acknowledged. Firstly, data are mostly based on self-report measures (i.e., symptom distress and interpersonal problems). However, it should also be emphasized that the main variable of the present study (i.e., metacognition) was measured through a semi-structured interview, assuaging concerns of inflated associations due to common method biases. Moreover, other variables of interest, such as alexithymia levels, should be added in future studies concerning metacognition.

To obtain a fairly-sized sample, we did not distinguish among different PDs. Further studies could be extended in larger groups representing specific diagnoses. Nonetheless, our study was mainly concerned with the severity of personality functioning and distress, therefore our sample and methods appeared to be consistent with our research perspective. Moreover, we did not include a follow-up measurement, so we could not verify whether the improvement we depicted would change or remain constant after 1 year of treatment.

Finally, the design of our study was not aimed at testing the effectiveness of MIT treatment on PDs or to measure the drop-out rate. What our study does provide is corroborating evidence that improvements in metacognitive abilities go hand-in-hand with improvements in the severity of personality pathology and its associated symptoms. Future research should consist of clinical trials in order to determine whether a possible causal relationship exists between improvements in metacognition and a series of outcome variables, and to test if a psychotherapy for PDs focused on metacognition would actually reduce the drop-out rate compared with other psychotherapies.

CONCLUSION

Our data supported the hypothesis that changes in metacognitive functioning would explain a significant portion of personality pathology, together with an improvement in symptoms and interpersonal and social functioning after 1 year of treatment. The reduction in distress levels can be explained by the fact that metacognition abilities might increase individuals' ability to cope with mental states as a source of subjective suffering, showing that the metacognition construct is able to capture clinically relevant phenomena.

ETHICS STATEMENT

The protocol was approved by the Scientific and Research Ethic Committee at School of Cognitive Psychotherapy, Rome, Italy. All participants signed written consent forms before participating in the study.

AUTHOR CONTRIBUTIONS

AC, IR, and AS conceived the study. EB, IR, and RP curated the data. EB and LL performed the formal analysis. AC, IR, EB, and AS investigated the study. AC, GN, MP, and AS administered the project. LaC, LiC, DF, and GP contributed to resources. AC and AS supervised the study. AC, EB, IR, and AS wrote the original draft of the manuscript.

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Predictors of Dropout From Residential Treatment for Posttraumatic Stress Disorder Among Military Veterans

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Background: Successful psychotherapy for posttraumatic stress disorder (PTSD) necessitates initial and sustained engagement. However, treatment dropout is common, with rates of 50–70% depending on the setting, type of treatment and how dropout is calculated. Dropout from residential treatment is less understood and could be impacted by participation of more symptomatic patient populations and reduced day-to-day barriers to engagement. Gaining insight into predictors of treatment dropout is critical given that individuals with greater symptoms are the most in need of successful treatments but also at higher risk of unsuccessful psychotherapy episodes.

Aim: The aim of the current study was to examine predictors of treatment dropout among veterans receiving residential treatment for PTSD.

Methods: The study included 3,965 veterans who initiated residential PTSD treatment within a Department of Veterans Affairs program during Fiscal Year 2015 and completed self-report measures of demographics and psychiatric symptoms at admission.

Results: In our sample (N = 3,965, 86.5% male, mean age = 45.5), 27.5% did not complete the residential program (n = 1,091). Controlling for age, marital status, combat/non-combat trauma, and facility, generalized estimating equation modeling analysis indicated greater PTSD symptoms and physical functioning at admission were associated with reduced likelihood of completing the residential program. There were significant differences in trauma-focused psychotherapy received by individuals who dropped out of residential treatment and those who did not. Among veterans who dropped out, 43.6% did not get any trauma-focused psychotherapy; 22.3% got some, but less than 8 sessions; and 34.1% got at least 8 sessions; compared to 37.3%, 4.8%, and 57.9%, respectively, among program completers.

Conclusion: Dropout rates from residential PTSD programs indicate that at least one in four veterans do not complete residential treatment, with more symptomatic individuals and those who do not receive trauma-focused therapy being less likely to complete.

Keywords: treatment failure, PTSD, veterans, residential, psychotherapy, drop-out, program completion

INTRODUCTION

Rates of posttraumatic stress disorder (PTSD) are considerably high among United States military veterans (e.g., Hoge et al., 2004; Kok et al., 2012; Fischer, 2015). In response to these high rates of PTSD, there has been attention paid to the delivery of evidence-based treatment to veterans with PTSD, particularly at the Department of Veterans Affairs (VA). There are many evidence-based treatments for PTSD that are efficacious among veterans. Recent clinical practice guidelines identified trauma-focused psychotherapies (TFP) as the first-line treatment for PTSD (Veterans Affairs Department of Defense, 2017), which can be delivered in a variety of settings (e.g., outpatient, residential). To date, much of the extant literature has focused on examining treatment outcome in outpatient settings, leading to ongoing questions regarding treatment success or failure in residential treatment settings. It is imperative to understand predictors of unsuccessful treatment for this population so that the field may more effectively intervene to maximally facilitate successful outcomes.

A given course of treatment can be considered unsuccessful if (1) a patient does not engage in the treatment, such as not attending a first session after being assessed, referred, and consented to treatment; (2) a patient initially engages in treatment but prematurely discontinues before completing a full course or dose of treatment; or (3) a patient engages in treatment but it is not effective for symptom severity and functional outcomes even when delivered at an adequate dose and with good fidelity (Sippel et al., 2018). This current examination will focus on (2): premature termination of PTSD treatment delivered in residential treatment settings through the examination of rates of residential program completion and whether completion is predicted by the receipt of trauma-focused (i.e., evidence-based) psychotherapy.

Treatment dropout has gained attention in both randomized clinical trials and real-world clinical care, with some individuals beginning but not completing a full course of treatment and therefore not having the opportunity to maximally benefit. Meta-analytic findings indicate that, across psychological disorders, roughly 20% of patients prematurely terminate psychotherapy (Swift and Greenberg, 2012), with higher odds of dropout from pharmacotherapy than psychotherapy (Swift et al., 2017).

Extant research on treatment dropout in PTSD is based on randomized clinical trials of specific psychotherapies typically delivered in outpatient settings or effectiveness data from outpatient clinics (Goetter et al., 2015). Rates of dropout from psychotherapy for PTSD vary widely, with meta-analytic findings identifying an average dropout rate of 18% in randomized clinical trials (Imel et al., 2013). Rates tend to be higher in naturalistic clinic-based studies, with a pooled average of 42.0% in these settings (Goetter et al., 2015). However, dropout rates are not higher in trauma-focused vs. non-trauma-focused therapies (Imel et al., 2013). Patient-related predictors of dropout have included younger age (e.g., Erbes et al., 2009; Garcia et al., 2011; Kehle-Forbes et al., 2016; Goodson et al., 2017; Niles et al., 2018) and higher PTSD symptom severity (Garcia et al., 2011; Grubbs et al., 2015), though some studies have not found that PTSD severity is associated with dropout (Kehle-Forbes et al., 2016; Niles et al., 2018). When dropout occurs, it tends to be early in treatment, around sessions two to four (e.g., Garcia et al., 2011; Davis et al., 2013; Mott et al., 2014; Kehle-Forbes et al., 2016).

To our knowledge there are no existing published studies examining dropout from residential treatment programs for PTSD. However, there have been examinations of associations between length of stay in residential treatment and clinical outcomes among veterans. For example, homeless women veterans who received greater than 30 days of residential treatment exhibited more improvement in mental health symptoms and functional outcomes at one-year follow-up than veterans who received fewer than 30 days of treatment (Harpaz-Rotem and Rosenheck, 2011). Longer length of stay has also predicted better outcomes for common comorbidities such as alcohol misuse (Harpaz-Rotem and Rosenheck, 2011; Coker et al., 2016). A recent study revealed that longer length of stay in residential treatment programs at five VA facilities was associated with more severe PTSD symptoms at baseline and less severe PTSD symptoms at discharge (Banducci et al., 2017). Among individuals who did not complete an inpatient PTSD program, a shorter stay was related to less symptom improvement (Szafranski et al., 2014). Taken together, it appears that longer courses of residential treatment may be associated with better outcomes among veterans, though there is limited evidence focused specifically on PTSD and significant heterogeneity in the clinical programming and duration of residential programs.

Examination of dropout from a residential setting is critical, as it is considered a higher level of care and thus oftentimes attracts a more symptomatic population. As indicated previously, more symptomatic individuals may be more likely to drop out of treatment delivered in outpatient settings (Garcia et al., 2011; Grubbs et al., 2015), making this a particularly vulnerable population. However, residential treatment is associated with fewer logistical barriers to completion such as reduced day-to-day stressors at home/work, transportation, and housing. Thus, it is critical to determine potential risk factors for premature termination from both residential treatment and trauma-focused psychotherapy in order to address these factors and enhance treatment completion and outcome.

This is the first study to our knowledge to examine rates and predictors of premature termination (i.e., dropout) from

VA residential PTSD programs. The overarching goal of this study was to better understand this form of treatment failure so that the field may better address these predictors to bolster treatment completion. Our first aim was to characterize rates of dropout in this population and to determine differences between individuals who prematurely terminate and those who complete treatment. We hypothesized that the rate of dropout would be lower than rates published with samples from outpatient settings, potentially due to reduced logistical barriers. Our second aim was to determine bivariate correlates as well as predictors (e.g., demographics, clinical characteristics) of residential treatment dropout in multivariate analyses after accounting for data nested within sites. We hypothesized that more severe symptoms would be associated with dropout, consistent with prior research in outpatient settings. Our third aim was to examine receipt of TFP among individuals who dropped out of residential treatment in order to enhance our understanding of whether engagement in first-line treatment is associated with reduced risk of dropout.

MATERIALS AND METHODS

Participants and Procedure

The study included 3,965 veterans who initiated residential PTSD treatment within a Department of Veterans Affairs residential treatment program during Fiscal Year 2015 (FY15) and completed self-report measures of demographics and psychiatric symptoms at admission. Program clinicians and staff completed measures indicating a veteran's completion of the residential program, as well as information regarding the dose of trauma-focused psychotherapy each veteran received, at discharge. This study was approved by the VA Connecticut Healthcare System Institutional Review Board.

Measures

Demographic Information

Demographic information was collected, including: age, sex, race, ethnicity, and marital status. Experience of combat trauma was also assessed, as well as the site at which the veteran participated in residential treatment.

Treatment Completion

Clinicians indicated whether each veteran completed residential treatment or if they dropped out. Clinician-rated premature termination has been employed in previous studies examining discontinuation of treatment (e.g., Garcia et al., 2011). Program length and services offered vary by site; thus, treatment completion was determined by clinical staff at each site. This variable was dichotomized (dropped out: 0; completed: 1).

Receipt of Trauma-Focused Psychotherapy

Clinicians also indicated the extent to which individuals received trauma-focused treatment defined by the protocol-based number of sessions. Individuals who received eight or more sessions were considered to have completed TFP, whereas those who completed less than 8 were characterized as not receiving a TFP. Eight sessions in 14 weeks is a rough metric intended to capture participation in an evidence-based treatment such as TFPs in previous studies (VA Office of Inspector General, 2012) and many participants meet end-state criteria by session 8 (e.g., Galovski et al., 2012); thus, this number of sessions was selected as indicating receipt of TFP. For our third aim, this variable was dichotomized (less than 8 sessions: 0; 8 or more sessions: 1) to better understand dropout from TFP.

PTSD Symptoms

At admission, veterans completed the PTSD Checklist-5 (PCL-5; Weathers et al., 2013), a 20-item self-report measure that assesses severity of PTSD symptoms according to the Diagnostic and Statistical Manual of Mental Disorders-Version 5 (DSM-5; American Psychiatric Association, 2013) diagnostic criteria. Higher scores reflect greater PTSD scores. It had good reliability in the current sample ($\alpha = 0.91$).

Substance Use

At admission, veterans completed the Brief Addiction Monitor (BAM; Cacciola et al., 2013), a 17-item, multi-dimensional questionnaire designed to assess frequency of substance (alcohol and drug) use. In this study, we used the three items that sum the total amount of substances used in the past 30 days (alcohol, illegal drugs, and prescribed medication). A score of 0 reflects 0 days; 1 = 1–3 days; 2 = 4–8 days; 3 = 9–15 days; and 4 = 16–30 days, with higher scores reflecting more frequent substance use.

Physical and Mental Health

At admission, veterans completed items of the Short Form Health Survey (SF-12; Ware et al., 1996); these components were used to assess various domains of mental and physical health. Physical functioning and role-physical were components of physical health that were included, while role-emotional represented mental health, as these were the components that appear to best predict physical and mental health. Scores on the SF-12 were transformed to z-scores using means and standard deviations from the general population to account for population-based norms (Ware et al., 1996). Higher scores reflected better health.

Data Analytic Strategy

Prior to all analyses, descriptive statistics were run to identify means and standard deviations for the study variables. To address aim 1, we conducted descriptive statistics and tests of difference (*t*-tests and chi-squared tests) for completers and non-completers (i.e., those who dropped out). To address aims 2 and 3, we ran bivariate correlations to identify significant associations between predictor variables (e.g., demographics and clinical characteristics) and outcome variables (aim 2: treatment completion; aim 3: receipt of TFP) for all veterans. We then used multivariate Generalized Estimating Equation (GEE) modeling to examine the relation between significant demographic and clinical characteristics and program completion vs. dropout in the first analysis and receipt of TFP in the second. GEE was used to adjust for correlated observations (Liang and Zeger, 1993), such as data nested within residential sites. The PROC GENMOD procedure of SAS was used for these analyses and probabilities

were modeled for those who dropped out and those who did not receive TFP, respectively.

RESULTS

Our sample (N = 3,965) was predominantly male (86.5%), with a mean age of 45.54 (standard deviation = 13.38). **Table 1** includes demographic and clinical characteristics of study participants.

Our first aim was to characterize dropout among veterans in residential PTSD treatment. In our sample, 27.5% did not complete the residential program (n = 1091). **Table 1** displays group differences between residential program completers and those who dropped out. Individuals who dropped out were younger, had more severe PTSD symptoms, and reported better physical functioning. There were significant differences in receipt of TFP by individuals who dropped out of residential treatment and those who did not, $\chi^2(2) = 338.17$, $p < 0.001$. Among veterans who dropped out, 65.9% got less than eight sessions; and 34.1% got at least eight sessions; compared to 42.1% and 57.9%, respectively, among program completers.

Our second aim was to identify correlates and predictors of program completion. Bivariate correlations indicated significant relations between program completion and age (r = 0.09, $p < 0.001$), marital status (r = 0.05, p = 0.001), PTSD symptoms (r = −0.05, p = 0.002), and physical functioning (r = −0.05, p = 0.001). Including these significant variables in the model and after controlling for data nested within sites, GEE analyses indicated that age, PTSD symptoms, and physical functioning were significantly related to program completion, such that younger age, greater PTSD symptoms, and better physical functioning were associated with reduced likelihood of completing the program. See **Table 2** for a summary of the GEE analysis.

Our third aim was to examine receipt of TFP among those who dropped out. Among individuals who did not complete residential treatment, bivariate correlations indicated significant relations between TFP completion and ethnicity (r = −0.066, p = 0.033) and alcohol use (r = −0.082, p = 0.008). Results of GEE indicated that neither variable (ethnicity: B = −0.20, 95% Confidence interval = −0.03, 0.05, p = 0.35) or alcohol use: (B = 0.01, Confidence interval = −0.62,.22, p = 0.64) was significantly associated with outcome when in the multivariate analysis when accounting for nesting with sites.

DISCUSSION

This was the first study to examine predictors of treatment dropout among a national sample of veterans who engaged

TABLE 1 | Demographic and clinical characteristics of the total sample and each group (Program completers and non-completers).

	Total	Completers	Non-completers	Test of difference
	***N* = 3,965**	***n* = 2,874**	***n* = 1,091**	
Age, *M* (*SD*)	45.54 (13.38)	46.23 (13.43)	43.65 (13.07)	$t = -5.51$, $p < 0.001$
Ethnicity: white, *n* (%)	2,340 (59)	1,698 (59.1)	652 (58.8)	$\chi^2(1) = 0.02$, $p = 0.89$
Military trauma, *n* (%)	3,746 (94.5)	2,710 (94.3)	1,036 (95)	$\chi^2(1) = 0.67$, $p = 0.41$
Married, domestic partner *n* (%)	1,580 (39.8)	1,189 (41.7)	391 (36.1)	$\chi^2(1) = 10.53$, $p = 0.05$
Sex: male, *n* (%)	3,430 (86.5)	2,488 (89)	942 (89.6)	$\chi^2(1) = 0.27$, $p = 0.61$
TFP (8+ sessions), *n* (%)	2,019 (50.1)	1,663 (57.9)	356 (34.1)	$\chi^2(1) = 173.15$, $p < 0.001$
Substance use[1], *M* (*SD*)	2.46 (3.04)	3.01 (0.56)	3.11 (0.09)	$t = 1.46$, $p = 0.14$
PTSD symptoms (PCL-5), *M* (*SD*)	58.93 (11.97)	58.57 (12.23)	59.90 (11.22)	$t = 3.13$, $p = 0.002$
Physical functioning (SF-12), *M* (*SD*)	−0.86 (1.22)	−0.90 (1.23)	−0.76 (1.21)	$t = 3.26$, $p = 0.001$
Role-physical (SF-12), *M* (*SD*)	−1.30 (1.13)	−1.32 (1.13)	−1.26 (1.13)	$t = 1.40$, $p = 0.16$
Role-emotional (SF-12), *M* (*SD*)	−2.40 (1.07)	−2.39 (1.07)	−2.44 (1.06)	$t = -1.36$, $p = 0.17$

[1]*Includes items assessing substance use on the BAM Brief Addiction Monitor (BAM; Cacciola et al., 2013). TFP, Trauma-focused psychotherapy; PCL-5, Posttraumatic stress disorder checklist-5 (PCL-5; Weathers et al., 2013); SF-12, Short form health survey (SF-12; Ware et al., 1996).*

TABLE 2 | Results from generalized estimating equation analysis predicting residential treatment non-completion.

Parameter	*Estimate*	Standard error	95% confidence limits		*Z*	Pr Z > |Z|
Intercept	−0.41	0.15	−0.70	−0.11	−2.72	0.007
Age	−0.01	0.00	−0.02	−0.01	−4.46	<0.001
Married	0.14	0.09	−0.03	0.31	1.59	0.11
Non-combat trauma	−0.16	0.17	−0.50	0.28	−0.92	0.36
PTSD symptoms (PCL-5)	0.09	0.03	0.03	0.15	2.86	0.004
Physical functioning (SF-12)	0.06	0.03	0.01	0.11	2.30	0.022

This analysis was run modeling the probabilities of dropout/non-completers (0 dropout, 1 complete). PCL, standardized scores from posttraumatic stress disorder checklist-5 (PCL-5; Weathers et al., 2013); SF-12, short form health survey (SF-12; Ware et al., 1996).

in residential PTSD treatment. We found that over one in four veterans prematurely terminated residential treatment. Although this number is lower than in outpatient settings (e.g., Garcia et al., 2011; Kehle-Forbes et al., 2016; Doran and DeViva, 2018), it is alarming that a significant minority of veterans are prematurely terminating treatment despite reduced logistical barriers such as need to travel and work obligations. We discovered that younger age, more severe PTSD symptoms, and better physical functioning were related to premature termination of residential PTSD treatment.

Our results are consistent with previous studies in outpatient settings indicating that younger age is associated with greater likelihood of dropout (e.g., Garcia et al., 2011; Kehle-Forbes et al., 2016; Goodson et al., 2017; Niles et al., 2018). Although previous literature is mixed as to whether PTSD symptoms are associated with dropout (e.g., Garcia et al., 2011; Grubbs et al., 2015; Kehle-Forbes et al., 2016; Niles et al., 2018), we found support for the premise that individuals with more symptoms at baseline were less likely to complete residential treatment. Identifying younger and more symptomatic veterans at admission could be important in reducing dropout. Creating interventions to enhance engagement for these individuals may be key to promoting successful treatment.

The findings from this study have important clinical implications as they indicate that those who are more in need of treatment (e.g., those with higher symptoms) are more likely to drop out from residential programs. Although initial impairment appears to be a general risk factor for premature termination in our study as well as in outpatient samples with various diagnoses (e.g., Zimmermann et al., 2017), there are potentially ways to target this group. Additionally, adherence to TFP protocols, veterans' agency in treatment choice, and attitudes regarding treatment effectiveness (Zimmermann et al., 2017; Doran and DeViva, 2018; Zoellner et al., 2018) could be ways to address internal barriers to completion. Including motivational enhancement techniques in this particularly at-risk group is a potential avenue to address premature termination (Murphy et al., 2009). An additional option is to target provider characteristics, such as enhancing training in TFPs, which has been shown to be related to reduced treatment dropout (e.g., Goodson et al., 2017). A third option is to increase utilization of virtual reality as it appears to have lower dropout rates (Benbow and Anderson, 2018), and to be efficacious in the treatment of PTSD (Gonçalves et al., 2012). Finally, increasing the availability and delivery of TFPs and in ways that have been shown to increase the completion rate of treatment such as condensed daily sessions of treatment (e.g., Bryan et al., 2018; Foa et al., 2018) or perhaps by combining a condensed protocol with virtual reality (e.g., Beidel et al., 2017). This would allow for patients to complete TFP as part of their daily residential routine with the same outcomes as weekly treatment. These options offer promising ways to enhance the care that veterans receive in residential treatments in order to increase completion of TFPs and reduce the impact of PTSD on long-term outcomes.

It was surprising that better physical functioning was related to greater treatment dropout. It could be that those with reduced functioning tended to rely more on the services provided in a residential setting thus attenuating tendencies to prematurely terminate. Alternatively, those with greater physical functioning could more readily apply some of the techniques that might be helpful in reducing symptoms such as physical activity (Rosenbaum et al., 2015), behavioral activation (e.g., Jakupcak et al., 2010), and *in vivo* exposure techniques (e.g., Gros et al., 2012).

We also found that the individuals who dropped out of the program were less likely to receive at least eight sessions of TFP, which is expected since dropout typically occurs in earlier sessions (Garcia et al., 2011; Davis et al., 2013; Mott et al., 2014; Kehle-Forbes et al., 2016). Among non-completers, there were significant correlates of receipt of TFP, but none of these variables predicted receipt of TFP in multivariate analyses. However, given bivariate relations, it could be important to consider pre-treatment substance use as a potential additional risk factor for not receiving at least eight sessions of TFP, particularly given that there appears to be a bidirectional relationship between PTSD symptoms and substance use (Back et al., 2014) and that substance use is related to a shorter length of stay in inpatient settings (Szafranski et al., 2014).

It is important to highlight that it is unlikely that veterans dropped out of treatment due to reduced symptoms (e.g., Szafranski et al., 2017). Only 34.1% of those who dropped out received eight or more sessions of a TFP, which is thought to be the point at which end state criteria are met; in comparison, more than half of the completers (57.9%) received eight or more sessions. The majority of individuals who dropped out did not receive a substantial course of TFP; this is consistent with data indicating that many veterans with PTSD are not receiving clinically adequate care (i.e., at least eight appointments in 14 weeks; Smith et al., 2017). However, our results indicate that when veterans complete residential programming, the majority of veterans received eight or more sessions of TFP. Therefore, addressing premature termination could help to enhance the proportion of individuals receiving gold standard treatment.

The quality of treatment program or therapies delivered was not assessed in the current study and there appears to be varying degrees of adoption of TFP among various residential programs (Cook et al., 2013). It was striking that almost half (43.6%) of those who dropped out did not receive any TFP. Even among treatment completers, more than 1/3 did not receive any sessions of the gold standard treatments. Thus, there appears to be room for enhanced adoption and delivery of TFPs among residential programs.

This study has a number of limitations that require mentioning. Clinician-reported completion of program and TFP limited understanding of veterans' perspective on treatment completion. Previous receipt of treatment for PTSD in outpatient or residential settings, length of time since trauma or PTSD diagnosis, and information related to deployment or childhood trauma were not available in the current study, but are important, as these factors could impact treatment dropout, compliance, and participation in TFP. Dichotomized outcomes did not account for dose of clinical programming or dose of TFPs. Additionally, VA residential treatment programs have significant heterogeneity

in program length and composition; therefore it is difficult to compare across treatment programs. Although we controlled for data nested within sites, we did not control for other differences across the sites. Moreover, symptoms were not assessed at the time of program termination and veteran self-reported reasons for not completing the program were not assessed, thus limiting the understanding of treatment dropout.

This study provides a preliminary investigation into components of dropout as an important form of treatment failure in the residential PTSD treatment programs. More symptomatic veterans appear to be at increased risk of premature termination, consistent what has been observed in outpatient populations. Future studies should qualitatively investigate veterans' reasons for treatment dropout, examine the role of medication usage and compliance, determine symptom changes across the course of treatment and how they relate to program completion, and examine moderators of treatment completion (e.g., Keefe et al., 2018) and receipt of TFPs in order to enhance treatment completion and outcome.

AUTHOR CONTRIBUTIONS

NS was involved in idea generation, data analysis, manuscript preparation, and submission preparation. LS and DR reviewed the literature and contributed to manuscript preparation, editing, revising, and table construction. RH contributed to data preparation and various components of manuscript preparation. IH-R was involved in idea generation, prepared and analyzed the data, and contributed to manuscript preparation.

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How Does Therapy Harm? A Model of Adverse Process Using Task Analysis in the Meta-Synthesis of Service Users' Experience

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Background: Despite repeated discussion of treatment safety, there remains little quantitative research directly addressing the potential of therapy to harm. In contrast, there are numerous sources of qualitative evidence on clients' negative experience of psychotherapy, which they report as harmful.

Objective: To derive a model of process factors potentially leading to negative or harmful effects of therapy, from the clients' perspective, based on a systematic narrative synthesis of evidence on negative experiences and effects of psychotherapy from (a) qualitative research findings and (b) participants' testimony.

Method: We adapted Greenberg (2007) task analysis as a discovery-oriented method for the systematic synthesis of qualitative research and service user testimony. A rational model of adverse processes in psychotherapy was empirically refined in two separate analyses, which were then compared and incorporated into a rational-empirical model. This was then validated against an independent qualitative study of negative effects.

Results: Over 90% of the themes in the rational-empirical model were supported in the validation study. Contextual issues, such as lack of cultural validity and therapy options together with unmet client expectations fed into negative therapeutic processes (e.g., unresolved alliance ruptures). These involved a range of unhelpful therapist behaviors (e.g., rigidity, over-control, lack of knowledge) associated with clients feeling disempowered, silenced, or devalued. These were coupled with issues of power and blame.

Conclusions: Task analysis can be adapted to extract meaning from large quantities of qualitative data, in different formats. The service user perspective reveals there are potentially harmful factors at each stage of the therapy journey which require remedial action. Implications of these findings for practice improvement are discussed.

Keywords: psychotherapy harm, patient safety, negative effects, adverse effects, qualitative systematic review, task analysis

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INTRODUCTION

Psychotherapy outcomes are not always positive. Approximately 40–60% of patients do not reach a recovery criterion (Fisher and Durham, 1999; Gyani et al., 2013; HSCIS, 2018) and between 5 and 8.2% have a negative outcome, with worse mental health at the end of therapy than at intake (Barkham et al., 2001; Hansen et al., 2002). Estimates vary because of measurement and population differences. However, there is an important difference between an unsuccessful therapy and a harmful one. Clinical deterioration can be caused by many factors external to the therapy, and failure to benefit from therapy does not imply harm. Negative effects of therapy are common, may be short-lived, and emotionally distressing experience may be an intrinsic part of good therapy (Schermuly-Haupt et al., 2018). Rozental et al. (2019) found that 50.9% of 564 clients in low intensity CBT reported some degree of adverse experience during therapy on the Negative Effects Questionnaire (NEQ). In contrast, in a survey of 14,587 British patients receiving National Health Service psychotherapy, 5% reported "lasting bad effects" of therapy (Crawford et al., 2016). Although this is a much smaller proportion, it represents a large number of patients who report that therapy has been, to some extent, harmful.

Although the broad topic of negative outcomes has been extensively discussed, empirical research on patient safety, directly examining the causes and prevention of harm, is not well established. Because harm (defined here as enduring negative effects directly caused by therapy) is relatively rare, and not amenable to experimental manipulation, such research is difficult. Randomized controlled trials in psychotherapy can monitor adverse events during treatment and could usefully report deterioration rates alongside overall weighted mean differences (Parry et al., 2016) but neither of these methods can directly investigate causes of harm.

Another strategy is to draw on qualitative evidence from patients' reported experience of adverse process and outcome in therapy. In support of this, a report from selected psychotherapy researchers in this field (Rozental et al., 2018) suggested that whilst awareness of negative effects has increased, there remain many unresolved issues. One consensus recommendation to address this was to pursue qualitative methods. Although individual qualitative studies are often small and idiosyncratic, there are sufficient published to enable narrative synthesis of their results. In addition, there are many sources of patient testimony in the "gray" literature and online.

Methods for meta-analysis and thematic synthesis of qualitative evidence are available which provide comprehensive description of a phenomenon and an assessment of the influence of the method of investigation on findings (Thomas and Harden, 2008; Timulak, 2009). Yet they may not in themselves yield a testable process model of the mechanisms by which patient experience is linked to lasting negative effects. To address this directly, we adapted the psychotherapy research method of task analysis (Rice and Greenberg, 1984) to derive and refine such a model.

Task analysis in psychotherapy research was developed by Rice and Greenberg (1984) as an intensive observational method in psychotherapy process research, sensitive to context and based on identifying and describing key change events. An *event* was defined in terms of a patient-therapist interactional sequence with a beginning, a working through process and an end point. In these events, the psychotherapy patient was seen as an active agent engaged in the task of trying to resolve their problem. Identification of key change events requires theoretical understanding and clinical experience and is therefore undertaken by clinician-scientists rather than naïve observers. There are two phases to the method; the discovery phase and the validation phase.

In the discovery phase, a rational model of the process under study is constructed after making the cognitive map of the investigators as explicit as possible and describing the task environment; the wider intervention context. The rational model pulls together the investigators' understanding of how the process unfolds and is a hypothesized possible task performance. This is followed by the empirical task analysis, which is based on a rigorous observation of actual psychotherapy process followed by a form of qualitative content analysis describing a sequence of phenomena that unfold over time. When the first empirical model has been delineated, it is compared to the rational model and used to corroborate, modify or even falsify the rational model. The modified model is then used in a reiterative process of empirical-rational comparison with a new case, until no further discoveries are made (model saturation). The final rational-empirical model completes the discovery phase. The validation phase investigates how well the rational-empirical model describes task resolution and ideally, as a final but less often completed step, tests the extent to which the process predicts therapy outcome.

In this study, we depart from the fundamental purpose of task analysis in analyzing text rather than verbatim therapy process, but we retain the essential logic of the discovery phase of the analytic method. The process under analysis is the course of bad or harmful therapy, with events in the *patient's* experience as the focus of study, although therapist factors are also considered because they are crucial to the task environment. The investigators' cognitive map and the context of poor therapy contribute toward development of the rational model, followed by empirical observation of process reported in (a) qualitative research and in (b) patient testimony. Then we make rational-empirical comparisons to derive two separate models using reiterative sampling of best examples, followed by comparison between them and a final combined rational-empirical model. We finally undertake a partial validation by a structured comparison of the new model against data from an independently-conducted qualitative study.

The aims of this study are to derive a model of process factors potentially leading to negative or harmful effects of therapy, from the patient's perspective, based on a systematic narrative synthesis of evidence on negative experiences and effects of psychotherapy from (a) qualitative research findings and (b) patients' testimony, using task analytic methods.

METHODS

Overview of Method

Using the principles of task analytic method described above, we adopted the following research strategy:

(a) A rational model of adverse processes in therapy leading to negative outcomes was developed by a group of psychotherapists, psychotherapy researchers and service users.
(b) This initial model was then used to inform strategy and keywords for two literature searches: (i) qualitative research reports and (ii) service user reported experiences.
(c) Data extraction from qualitative research reports of patient experience meeting inclusion criteria was based on themes and categories derived by authors of the original studies, where available. Where no such results were presented, free text of the original studies' interpretation of the respondents' experiences was used.
(d) Data extraction listed therapy processes, adverse effects, and any reported direct relationships between adverse processes and adverse effects.
(e) In addition, data on the broader context associated with adverse processes and therapist factors were extracted, using the themes reported in the original studies' analysis of therapists' experiences.
(f) Service user testimony was obtained from blogs, discussion boards, book chapters, and articles. Data extraction was from patients' verbatim reports of adverse processes and adverse effects of psychotherapy, and any reported direct causal relationships between adverse processes and adverse effects.
(g) All data categories were coded by initially comparing and matching them to processes in the rational model. If no match was apparent, the original study authors' theme or testimony unit was retained and categorized as "Adverse Process not in Rational Model" for later analysis.
(h) Two separate rational-empirical comparisons were made, one using qualitative research evidence and the other using service user testimony. In each, the rational model was successively amended and refined to incorporate the empirical coding and categories rejected by the empirical comparison were removed.
(i) The two rational-empirical models were compared and finally combined into a single rational-empirical model of causal processes for harm.
(j) The final model from the discovery phase was tested against independent findings from a more recent qualitative study.

An overview of the process is shown in **Figure 1**.

Development of Rational Model

The "expert" consensus was developed by the first and second authors working with five others; the group consisted of service users, clinical psychologists, counselors, psychotherapists and researchers (some participants having more than one role). The psychotherapy process was broken down into key stages by JC and GP, based on their understanding of psychotherapy process research (e.g., Howard et al., 1993; Schaap et al., 1993). The focus of the model (the "task environment") was specified as "psychotherapy and counseling." This allowed for the specific inclusion of bona fide psychotherapies, and justified the exclusion of descriptions of psychotherapy, such as equine therapy, that were not considered so.

The group collaboratively constructed a rational model of adverse processes in psychotherapy they considered would lead to adverse effects. They first reflected individually on their experience of psychotherapy and of research findings, in order to develop a list of therapy related events that have led, or could lead, to a therapy causing adverse effects in the client. Detailed discussion of these stages and processes resulted in agreement on eight essential stages and contextual areas (Domains) and 46 adverse processes that were then constructed into a provisional phase model of adverse processes. This was then circulated to the group members for comment, clarification, amendment and agreement. A researcher external to the group (GH) subsequently reviewed this working model to ensure clarity and the expert group then confirmed this final model. After consensus was reached, the rational model of adverse processes was confirmed.

The Rational model comprised eight Domains (in bold) that were associated with an adverse effect (see **Figure 2**). The first Domain, **Contextual factors,** contained six themes relating to the setting of therapy, (*Referral and access to service*, *Organizational factors, Socio-economic factors, Political factors, Lack of information*, and *Impact of medication*). The model then considered a second Domain, **Pre-therapy factors** (*Poor pre-therapy contracting, Experiences of previous therapy, Clients' sense of entitlement, Service is focused on symptoms rather than client as a person, Client too compliant*, and *Wrong time in client's life*). In addition, characteristics that clients and therapists brought to therapy were considered: **Therapist factors** *(Confidence, Financial interest, Attitudes,* and *Person of the therapist)* and **Client factors** (*Demographics, Lack of understanding, Fear, Desperation,* and *Sense of last chance*). These Domains impacted on **Relationship processes** *(Negative relationship patterns, Negative countertransference, Poor fit between client and therapist, Power, Pseudo alliance,* and *Client preferences not taken into account),* **Therapist behaviors** *(Therapist errors, Therapist persecutory style, Malpractice, Inappropriately applying techniques, Not standing back, Poor meta-communication, Poor self-monitoring, Passive therapist*, and *Therapist acting out*) and **Therapy processes (***Types of therapy, High rates of transference interpretations, Contradictions within therapy, Therapist not responsive to individual client needs, Helpful processes becoming adverse, No contracting***)**. These processes and behaviors finally impacted on therapy **Endings (***Unprepared, Terminal alliance rupture, Short term therapies opening a "can of worms," Client left high and dry,* and *No maintenance dose***)**. All of these Domains are linked to adverse effects.

Search and Sampling Strategies

Search strategy for qualitative research used the following sources:

- MEDLINE via OvidSP (1946–2011)
- Embase via Ovid SP (1974–2011)

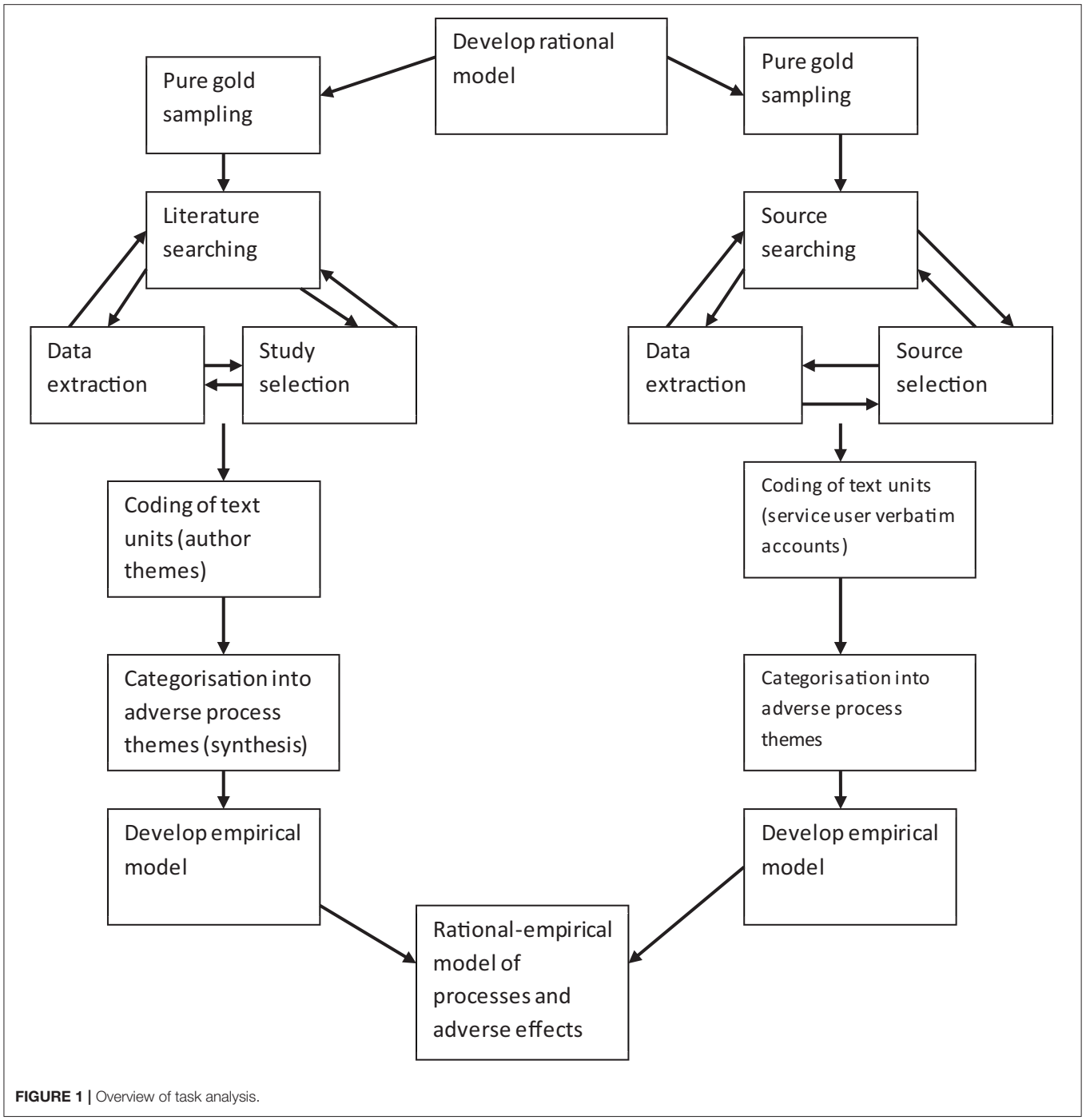

FIGURE 1 | Overview of task analysis.

- CINAHL via EBSCO (1981–2011)
- PsycINFO via OvidSP (1967–2011)

A combination of free-text and thesaurus searching was used. Full details of search terms used are available from the authors. Published methodological search filters to limit study type (qualitative) were used where available. Studies were limited to adult participants and those published in the English language. No other search filters were used. Reference sections of included studies were scrutinized for additional potential includes, as were reference lists from relevant reviews and contact with key authors.

In contrast to more general systematic reviews, the intention of the literature search was to look for the best available sources of qualitative research that would facilitate the task analysis. In this context this was determined to be the most clearly observed and described accounts of therapy processes and their consequences, as experienced by patients in psychotherapy. The key data that we sought from qualitative studies were original study author-derived themes, categories or free-text that

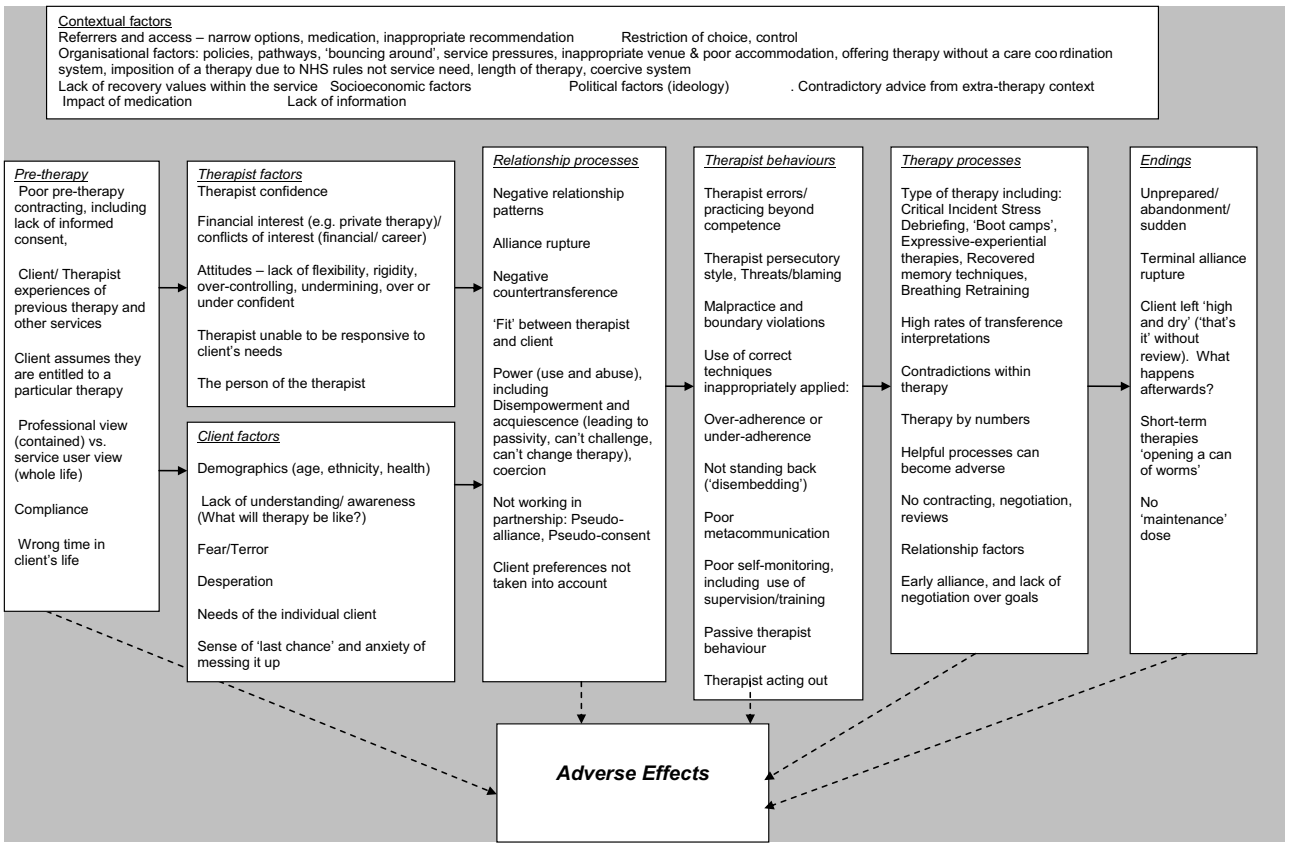

FIGURE 2 | Rational model of adverse processes in psychotherapy.

described a process that participants had experienced as adverse or harmful. These were drawn from the original study authors' qualitative analysis of the research participants' experiences of psychotherapy. Verbatim reports from research participants were extracted only for verification purposes.

The "pure-gold" purposive sampling strategy described by Greenberg (2007) required the researchers to use the following inclusion criteria to identify research which:

- Explores participants' experiences of therapy/counseling
- Reports adverse process and adverse effects
- Yields themes, categories or free-text
- Are the best examples of detailed, thorough and rich data of adverse process and adverse effect in their purest form (i.e., included participants' cognitive, affective, and behavioral experiences in temporal sequence as part of a clearly described therapy event).

The same sampling strategy and definition of adverse processes and effects was used for service user testimony, drawing on the following sources:

- Mental health organizations and websites
- Therapist associations, societies and websites
- Survivor/user groups and websites
- Key book publications
- Blogs and comments on blogs
- Anti-therapy groups and websites
- Newspaper websites
- Law firms
- Journal articles

Google search engine was used to locate Internet sources. Search methods used key search terms within websites, using the "find" function on individual web pages, manually browsing websites, manually searching index and reference lists, key search terms in various combinations, Amazon books online "similar items" function.

Inclusion criteria for service user testimony were

- First person account of experience of psychotherapy
- Detailed description of adverse effect, adverse process, and their relationship

Studies were selected which reported adverse processes and adverse effects in greatest detail and depth. In line with the reiterative nature of task analysis, further studies were selected which provided additional clarification of the nature of the adverse processes, adverse effects and their relationship. Reports of helpful effects of psychotherapy were also sampled, to

discriminate the precise nature of the phenomena of interest (Greenberg, 2007), and are described more fully below.

A sample of 32 research studies with data on adverse process and adverse effects was obtained. A sample of 26 studies on the helpful effects of psychotherapy was obtained to aid discrimination (some of these were the same as they covered both helpful and hindering factors).

A sample of 27 sources of service user testimony reporting adverse processes was obtained. A further 16 accounts of helpful therapy were used to inform the discrimination of adverse effects.

Details of referenced sources on which the data extraction was based are given in (**Supplementary Data Sheet S1**).

Data Extraction and Quality Appraisal

For qualitative research papers, data on the publication, research method, type of psychotherapy, the phase of therapy, specific adverse process and adverse effects of studies were extracted by one of two researchers, who then compared their results for the sample overall to establish consistency. The quality of the studies was examined using a scale derived from the UK Critical Appraisal Skills Programme (CASP, 2001), and poor quality studies excluded from the sample. Poor quality studies were judged to be those that on this scale did not demonstrate rigorous use of qualitative methods of data collection and data analysis in producing their findings and/or produced unclear statements of their findings (negative ratings on CASP items 1, 2, 8, and 9).

For service user testimony, the data extracted centered on first person accounts of psychotherapy, as well as contextual features of the events and the account. Quality of the reporting of the testimony was completed using a checklist informed by one developed by the Joanna Briggs Institute (2008).

Derivation of Empirical Categories—Qualitative Research Papers

The first stage in extracting empirical categories was to identify an adverse process marker. This needed to have all of the following features; (a) Be a description of a therapy process, technique, therapist behavior or contextual factor; (b) Be derived by the researchers/authors of qualitative research studies; (c) Be based on an analysis of first-hand accounts of psychotherapy service users' experiences of psychotherapy; (d) Be negatively evaluated (implicitly or explicitly).

Then adverse effects were identified, which needed to be as a consequence of the task marker, experienced directly by the research participant and negatively evaluated (implicitly or explicitly). Codes were applied to the extracted data with reference to the processes identified in the rational model. Where the study authors' themes/service user testimonies and the rational model processes were considered to match (or be synonymous) the rational model term was applied. If the process did not correspond to any rational model code, the study authors' themes were retained for evaluation and synthesis later. For service user testimonies codes were applied to the textual data units. After adverse effects, adverse processes and relationships between them had been identified, the process was repeated for "helpful" factors to aid discrimination.

Derivation of Empirical Themes—Service User Testimony

The extracted data from testimony were explored and coded, either using the rational model, or where the data did not appear in the rational model, according to the researchers' understanding of the service users' experience, consulting with a service user member of the project steering group. Descriptions/categories and themes coded as adverse effects were recorded and brought together using thematic analysis using the methods described by Braun and Clarke (2006). The resulting categories were constructed into an empirical model of service user experiences of adverse processes of psychotherapy. This resulted in the specification of key themes across several areas, and an overarching theme. A matrix of regularities in relationships between specific adverse processes, (or themes) and adverse effects, where they existed, was constructed.

The contribution of each research paper and service user testimony is provided in **Supplementary Tables S1,S2**, from which two empirical models were developed (available from the authors).

Rational-Empirical Comparisons and Development of Combined Rational-Empirical Model

The synthesis of the research findings involved construction of a rational-empirical model of adverse processes which incorporated evidence from both empirical models. Two researchers independently reviewed all of the coding for each adverse process reported at each phase of therapy and developed initial ideas for ways of describing the key themes that uniquely distinguish adverse processes in psychotherapy. In order to ensure that the themes were exhaustive, each was applied to every segment of coded data extracted from the selected studies, including the additional category "adverse processes not in the rational model." These were also applied to the helpful processes to explore whether the adverse process theme was "confirmed," or whether some contextual consideration applied (for example the impact of therapist self-disclosure varied according to context).

Empirical themes from both research and testimony were successively compared with the descriptions suggested in the rational model, which was refined, modified and extended, adapting the rational model to fit the empirical data. The themes were placed into the model, and further overarching themes derived to account for regularities in adverse processes across stages of therapy.

Validation Phase

The validation phase usually involves looking at whether the model discriminates between therapy events, such as unresolved and resolved moments in therapy. This comparative method is problematic when considering a whole therapy experience; we therefore adapted this step to include a comparison with a thematic analysis of risk factors for negative experiences of therapy that was developed by the same research group in parallel but with different members undertaking it, blind to the task analysis. Therefore, the results used for validation purposes are

entirely independent of the task analysis study. The risk factors in the validation study were developed using the thematic analysis of therapist and patient interviews and questionnaires (see Hardy et al., 2017 for details). The validation process involved three of the authors (JC, GP, and GH) separately comparing the themes of the rational-empirical model to the themes from the qualitative study, noting similarities and differences. Agreement was then reached through discussion, noting which task analytic themes were present in or absent from the thematic analysis.

RESULTS

The final synthesized rational-empirical model is described below. As before, the Domains (overarching themes) in the Synthesized Model are given in **bold**, and the subordinate themes in *italics*.

The final synthesized rational-empirical model contained 51 themes subsumed under the eight Domains that were identified in the rational model of adverse processes, plus two additional Domains, **What to do** and **Adverse effects**. Nineteen of the subordinate themes were part of the original rational model (these are indicated in **Figure 3**) and were confirmed in either service user testimonies (*Venue, Narrow options, Poor information, Deference, Money*, *Blaming, Over adherence*), qualitative research (*Demographic identity not attended to,* and *Suddenly left high and dry*) or both (*Cultural validity of therapy, Professional lack of knowledge, Negative relationship patterns, Misuse of power, Goals not being met, The wrong therapy, Helpful experienced as unhelpful, Malpractice, Personality,* and *Money*). The remaining themes came from either or both of the empirical models but not the Rational Model (see **Figure 3**).

The final model includes the following themes that have been linked to adverse effects.

Contextual Factors

These themes include the *Cultural validity of therapy*, which refers to the ways in which therapy and therapists are represented and understood, as suggested by the quote:

> We've all been told that this baloney somehow is on the same par with medical services. They've been trained and validated by prestigious institutions. Much of what we watch and read tell us these are serious, qualified, responsible people who will improve our lives if we follow their program (Service User Testimony 1).

The theme *Narrow options/Restriction of Choice* refers to organizational and social factors restricting access to therapy, for example:

> Participants in both studies highlighted a range of deficits in conventional services that left them expressing feelings of desperation and powerlessness in a system that appeared to undermine access to effective care (Bee et al., 2010, p. 1310),

> Some survivors also seemed to believe that living in certain areas affected their access to services (Chouliara et al., 2011, p.146).

Professionals' lack of knowledge/fear was applied to data where therapists' attitudes and emotions were identified as impediment to therapy.

The tendency for health professionals to address symptoms rather than causes led to what many respondents believed was an over-emphasis on a medical model of care and a sole reliance on pharmacological treatments (Bee et al., 2010, p. 1310).

Pre-therapy Factors

The theme *Client experience and expectations* was developed from clients' experiences of previous therapy (good and bad), and covers client expectations on the nature and structure of therapy and their own role in the process.

> The description of a previous therapeutic alliance as "strong" or 'not strong" were both related to the experience of rupture events in therapy as was a similar episode having occurred before (Coutinho et al., 2010, p. 532).

> Negative feelings seemed to occur because of the clients' feelings that their expectations for therapist behavior were breached (Rhodes et al., 1994, p. 480).

> "I entered therapy having little idea…what I was getting into" (Patient testimony 6).

Relationship Factors

Several relationship factors were identified. An important theme that was present in both sets of literature were the derived and directly experienced *Negative patterns in therapy relationships* that were described in several ways:

> Experience of an impersonal therapist (Poulsen et al., 2010, p. 487),

> "Perceived therapist detachment, and therapist perceived as a threatening and shame-inducing audience" (Grafanaki and McLeod, 1999, p. 297),

> Distant and Rigid Therapeutic Relationships (Grunebaum, 1986, p. 170) It really did replicate the experience of having an emotionally abusive parent (Service user testimony 3).

The *Misuse of power* theme refers to the ways in which people felt disempowered in the relationship, as indicated in:

> At the same time, he felt pushed by the therapist to pursue a treatment goal that he did not share and by which he felt restricted (Qureshi, 2007, p. 473).

> So long as there was a payment and revelations were not mutual, the therapist always had huge power over me, the troubled client (Service User Testimony 3, p. 25).

Clients reported *Not being heard or understood* and *Conditional conditions* refers to the impact of what might be considered the standard, typical or core conditions of therapy may

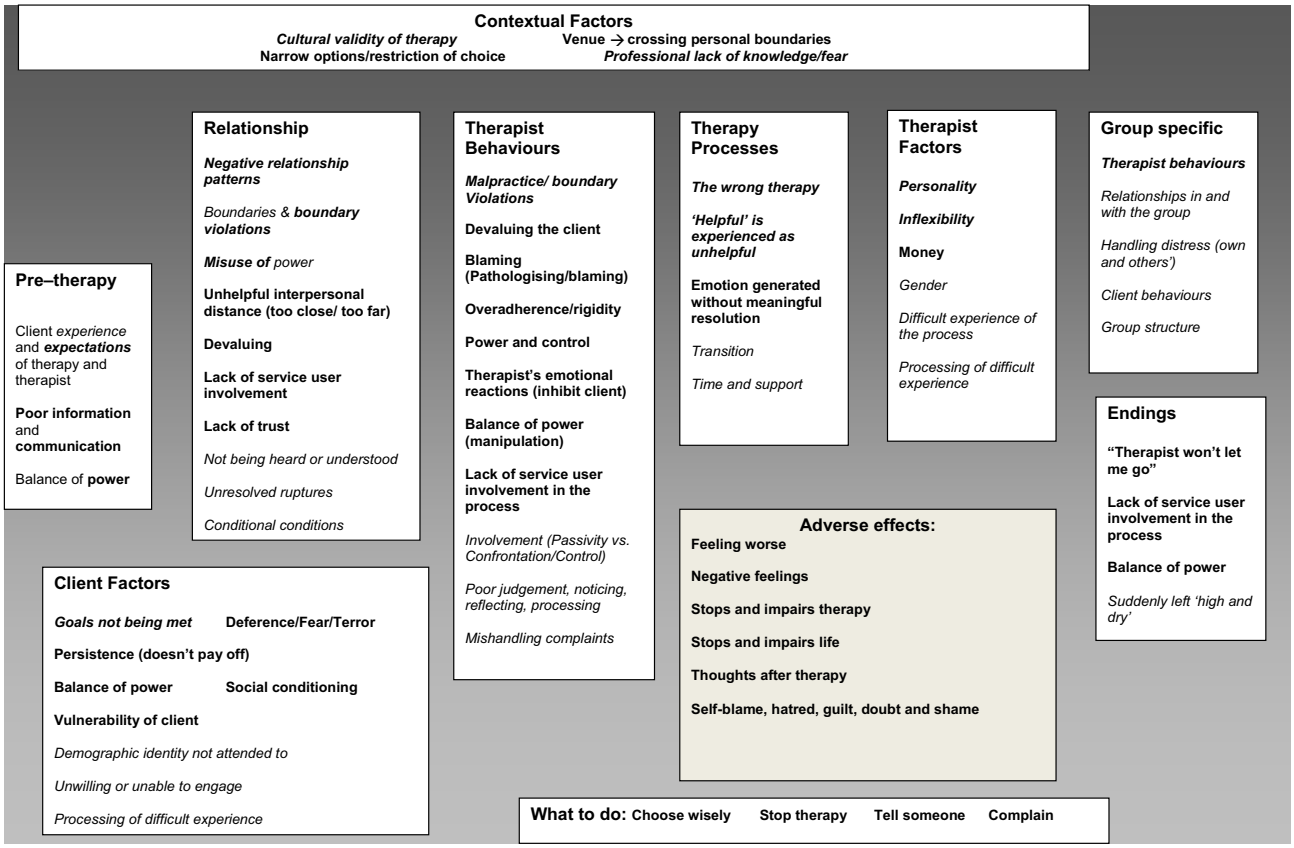

FIGURE 3 | Final synthesized rational-empirical model of adverse effects Bold italic = service user testimony and qualitative research; Bold = Service user testimony only; Italic only = qualitative research only.

be experienced adversely in some contexts, as suggested by the following:

> Negotiating Distance: A sense of professional caring is needed, or the therapist is experienced as too distant, defensive, or unattuned to clients' emotions. However, caring is too intense if the therapist is experienced as jealous, controlling, or pitying (Levitt et al., 2006, p. 320).

Ruptures that were maintained or not attended to also were seen as leading to adverse effects.

Client Factors

The theme *Goals not being met* was developed from themes evident in both sets of literature:

> All of the patients experienced a conflict between a wish for more simple, functional help in contrast to the intensive therapy they had been given (Wilson and Sperlinger, 2004, p. 227).

> So it's like a lottery, only you can either gain big, lose big or land anywhere in between (Service User Testimony 5).

The theme *Vulnerability of clients* was present only in the patient testimony and refers to the reported experience of seeking therapy at particularly vulnerable times, exemplified by:

> Particularly after my divorce I felt unattractive and unwanted. I wished to be seen as a viable woman who was worthy of love. I desperately needed to know if Dr. A could see me in such a light. Not to act on it but just to know that he could see those qualities in me (Service user testimony 6).

Although lack of attention to *Demographic identity* of the client could be related to therapist factors or behavior it is in this overarching theme to emphasize the importance of this theme to the client, where failure to address issues such as race, spirituality, or culture led to adverse events.

Therapy Processes

Certain processes relating to the therapy that clients went through were associated with adverse experiences. Being in the *Wrong therapy* was developed from clients' descriptions that they did not agree with the techniques or model of therapy. More subtly, typical therapy processes can have both helpful and unhelpful effects, for instance Grafanaki and McLeod (1999) analysis of qualitative interviews from clients in experiential

psychotherapy identified a theme of "Negotiating a New Story Line" as both helpful and hindering to therapy:

> In helpful events, this new story line was perceived as empowering and emancipating. By contrast, in some hindering events, the new story line was regarded as threatening, painful, or untimely (p. 298).

Therapist Factors

Amongst the several therapist factors the client's perception of the therapist's *Personal characteristics* and or personality adversely affects the therapy process for example:

> Therapists described by their patients and having great difficulty dealing with their patients in ordinary human ways and often in a cold or *Inflexible* manner (Grunebaum, 1986).

> When I went to therapy, I was looking in large part for a role model, someone who set a good example. What I found was quite the opposite. I so often thought, "I don't want to be like this person; they don't exhibit the values I'd like to live by." But after the first one, I felt helpless and kept trying to look for help. I didn't know where else to turn (Service User Testimony 1).

A further therapist factor, *Experience of the process/processing of difficult experience* describes clients' experiences of when their therapists appeared not be able to help them process their experience, as in:

> None of the patients in the (Emotionally Seductive) group thought that their therapists had helped them sufficiently to work on their feelings that had been aroused (Grunebaum, 1986).

Unhelpful Therapist Behaviors

Beyond the suggested specific characteristics of therapists, themes around how therapists behaved in ways that led to adverse events were developed. These behaviors included clearly unethical behaviors, captured in the *Malpractice/boundary violations* theme:

> As well as writing secretly, we began texting. Some of his texts became very sexually explicit (Service User Testimony 13, p. 125).

> It was hindering when the counselor was perceived as pushing his/her agenda onto the client. For example, the client may have felt pressured into participating in certain exercises, engaging in non-sexual touch, remembering past experiences, disclosing the abuse to others, talking about certain topics, or engaging in some behavior outside of the therapy setting for which she did not feel ready. She viewed the counselor as being controlling, rigid, and violating or minimizing her boundaries, and she may even have felt re-abused (Koehn, 2007, p. 47).

They also related to less overt, but still problematic and aversive behaviors. For example, therapists were sometimes seen as *Devaluing* or *Blaming* the client. Therapists were also reported to be too confrontational or characterized as too passive, vague and silent. These behaviors were related to the theme *Involvement*:

> It was noted that the therapist did good work but exercised too much control over the direction it took (Service User Testimony 8).

Endings

The ending of therapy, including where clients choose to end therapy unilaterally or when they felt *Suddenly left high and dry*, and the ways in which it was handled and processed contributed to the overall experience of therapy (Knox et al., 2011). This was characterized by:

> No expression of termination related emotion, No review of therapy or client growth, Unplanned termination and No discussion of post-termination plan (Knox et al., 2011).

What to Do

Four specific themes were developed from the service user testimony in which people reporting adverse effects had provided accounts of actions they had taken to address or resolve these consequences, and were therefore encouraging other to do the same. One suggestion is to *Choose wisely*:

> I would say ask for recommendations if you can, and if the person's not right for you, say so, and ask if there's someone else you can see (Service User Testimony 9).

Other suggestions are to *Stop Therapy*, or *Tell someone*:

> "I did not do all of this alone. I am lucky to have had a good support network. My husband has been a safe haven of love and support. I have had mental health care providers who understand how to help victims of trauma and sexual abuse. Through TELL and Advocateweb, I have found other victims and professionals willing to share their experiences, thus breaking my feelings of isolation and of being different" (Service User Testimony 10).

This theme also includes the client telling the therapist about their experiences of therapy.

The final suggestion was to *Complain*:

> Writing a complaint helped me put the blame where it belongs. My therapist was entirely responsible for what had happened between us. I had done nothing wrong by holding him accountable for his actions (Service User Testimony 11).

Adverse Effects

This Domain was derived from the qualitative literature. All themes (except one, *No return on investment*) were observed in both the qualitative literature and patient testimonies and included *Feeling worse, Negative feelings, Stops, and impairs life* (patients), *Stops* and *impairs therapy* (qualitative literature), and *Thoughts after therapy*. These themes were evidenced by the strong negative feelings expressed by patients:

> I was confused about the nature of our relationship and this confusion resulted in a profound trauma that I am still trying to heal (Service User Testimony 12).

These feelings interfered with therapy:

> Impeding involvement—feelings of vulnerability led to desire to disengage (Audeta and Everall, 2010)

and were often long lasting:

> Therapy has always tended to reduce my experience of life to monochrome (Service User Testimony 3).

Patients also described feelings of *Self-Blame*, *Hatred*, *Doubt*, *Guilt*, *and Shame*.

Although most of the Domains identified in the rational model were confirmed in both the qualitative and service user literature, the themes described above often came from the empirical models. The Domain **Therapist** behaviors contained the highest number of themes present in both the rational and one or both of the empirical models (5/10); all other Domains contained at the most two of the rational model themes.

Validation

Fifty-eight themes from the task analytic model were examined in terms of whether they matched themes from the validation study (**Supplementary Table S3**). Of the 58 themes coded, 53 matched themes in the validation study (24 were fully matched independently, 29 were partially matched and agreed by consensus). Only 5 remained unmatched. Overall, the task analysis yielded more finely grained themes than the validation study, but overall agreement was acceptable, with 91% of themes matched.

Three themes present in the task analysis were not found in the validation study: the negative therapeutic relationship pattern where an earlier relationship is re-enacted in therapy (transference and counter-transference), the theme on what clients can do to prevent or escape from negative experiences, and a range of difficulties over ending therapy. From the client's point of view, ending could be premature, abrupt, and emotionally unmanageable or conversely, therapy could be difficult to escape from, or to end against the therapist's advice.

Helpful Processes

Consistent with the method of task analysis, each adverse process theme was contrasted and compared with data, themes or descriptions of helpful processes, using the within-study data for those studies that had examined both adverse and helpful processes. For example, the identification of the "Experience of an impersonal therapist" as an adverse process Poulsen et al. (2010) contributed to the *Negative Relationship Patterns* theme, with the further observation that "the therapist's acceptance of them as people as well as their needs and feelings had been helpful" (op. cit) providing some clarification on the importance of a validating interpersonal process. This was particularly important for processes that become more or less adverse according to context, such as the **Therapy Process "***Helpful is Experienced as Unhelpful"* where the impact of choice on the experience of trauma-focused work affected the participants' experience of the therapy process:

> Trauma focused work was largely seen as challenging by some survivors and professionals alike. The challenges by survivors centered mainly on choosing appropriate timing and depth of such work, which may differ for each survivor. Being prepared for the process and being given the option to opt out when it feels too much were important caveats emphasized by survivors (Chouliara et al., 2011, pp. 140–141.)

The refinement of the adverse process themes from the service user testimony involved a similar process of comparison. For example, within the *Negative Relationship Patterns* theme, patients reported relationship patterns which were helpful; these helpful processes were absent in the adverse accounts:

> Someone who I feel has the time for me and knows where I'm coming from someone who I feel I can relate to and understands me, being able to face up to painful aspects of myself and memories with support forming a relationship, albeit with a therapist, where I feel safe (Patient testimony 15).

DISCUSSION

Methodology

The use of a task analysis paradigm to synthesize two types of qualitative evidence about adverse effects of psychological therapies is innovative. We believe this study demonstrates that it is a feasible and productive method. However, it can be argued that other qualitative systematic review techniques would serve this purpose just as well, for example, realist synthesis (Pawson, 2002). Dixon-Woods et al. (2006) have demonstrated that every stage of such a review process, from asking the review question through to searching for and sampling the evidence, appraising the evidence and producing a synthesis, challenges the frame of conventional systematic review methodology. They conclude that "attempts to impose dominant views about the appropriate means of conducting reviews of qualitative research should be resisted so that innovation can be fostered" (p. 27). It is in this spirit that we used task analysis, as we considered it particularly well-suited to the systematic integration of both qualitative research findings and patients' testimony. In common with realist synthesis, it uses iterative and heterogeneous processes to produce a review of evidence, and, as an interpretive review, uses theoretically derived sampling in a complex field. However, in task analysis these processes are fully explicit and the method is transparent and reproducible rather than opaque and idiosyncratic.

This study has methodological limitations. The literature search preceded the lengthy process of empirical refinement, which preceded the study used as validation, and so is not contemporary. However, there is no reason to believe that people's experiences of therapy have fundamentally altered during this time period; indeed more recent reports confirm that very similar issues continue to be raised (Werbart et al., 2015; Radcliffe et al., 2018). Our verification results were encouraging, although we did not proceed to the final stage of verification, which would require testing whether the model can distinguish

between beneficial and adverse therapies in a new, prospective study.

Findings

The findings of this study bring into sharp focus the experience of service users throughout their therapy journey, demonstrating the multi-causal nature of adverse effects, including service level parameters, patient/client expectations, therapist competence, attitudes, values and behaviors and client vulnerability to disempowerment. Each of these factors has the capacity to influence the others.

The findings suggest that contextual issues, such as lack of cultural validity and limited therapy options, together with unmet client expectations, fed into negative therapeutic processes. Examples of negative process include unresolved alliance ruptures and client disengagement. These involved a range of unhelpful therapist behaviors, such as rigidity, over-control, boundary violations and lack of knowledge, which in turn were associated with clients feeling disempowered, silenced, or devalued. From the service user's point of view, these were coupled with issues of misuse of power and being blamed.

To a surprising extent, many of the themes in the rational model failed to find empirical evidence in their support from the qualitative research sample or the service user testimony. Whilst this may be attributable to the selected sample, it does emphasize the difference in views between professionals, researchers, and clients about adverse process and effects. We found a similar disparity in the views of therapists and clients in a UK survey of their experiences of failed therapies. Patients generally reported their negative experiences as more harmful, whereas therapists with failed therapies rated them as less harmful for their patients (Hardy et al., 2017), although those surveyed were not describing the same therapies. A discrepancy between the views of professionals and their patients or clients is not unique to psychotherapists, and has long been noted in other disciplines (Robinson, 1978).

The service user perspective reveals there are potentially harmful factors at each stage of the therapy journey, rather than simply negative reactions to therapy itself, which require remedial action. There are several implications of this for practice. First is the importance of methods for ensuring the client's voice is enabled to be heard, so that the therapist-client relationship is not enacted within a closed system. This involves the wider system within which therapy is offered, so that client expectations, cultural validity and therapy choices are actively managed prior to therapy starting. The principle of informed consent requires that risks as well as potential benefits of therapy are clearly explained before therapy starts, and there should be explicit guidelines for both therapist and client on how they can address the problems outlined here.

There is a balance to be struck between protecting the framework of the therapy relationship so that it remains safe, confidential and well-boundaried, whilst allowing and empowering the client to find support, if it deteriorates into a negative, potentially harmful state. Suitable methods might be routine consultation with clients (independent of the therapist) on how therapy is progressing, providing clients with pre-therapy information explaining what to expect in therapy and how to know if therapy is causing harm. This could also give details of who to contact if therapy is going badly, and emphasizing that a change of therapist may be necessary in these circumstances. Any of these policy initiatives would need evaluation.

Another important area of practice improvement concerns the training, accreditation and supervision of competence in therapists, all of which could be improved. Currently there is little education in therapy trainings on the potential for harm, the prevalence of negative effects, the importance of informed consent which explains risks as well as benefits, and developing skills in noticing the signs of a negative process and knowing how to address them. Accreditation is usually offered on the basis of completing a course of study and supervised practice rather than on monitored outcomes including negative outcomes. Although many psychotherapy courses routinely use audio or video recordings of sessions in supervision and appraisal, in others supervision is only based on the therapist's account of their client's presentation, the session process and the therapist's feelings and difficulties. When a therapist is out of touch with the client's feelings or behaving unethically, they are unlikely to reveal this in supervision (Ladany et al., 1996). For this reason, direct or indirect observation of practice is always necessary.

Our findings also have implications for research. We must distinguish between those methods which study "objective" negative effects, such as clinical deterioration on outcome measures, and those which focus on the patient's own experience and view of whether the therapy was damaging for them. They are different phenomena. Researchers need to be careful to distinguish between lasting negative effects of therapy (harm) and more transient negative experiences (sometime called "side effects") which may or may not result in harm. In addition, there is a danger in labeling negative therapy process as a "side effect," implying an unwanted but inevitable part of a technically correct treatment procedure. This medical terminology does not capture the co-constructed nature of the therapeutic relationship and the negative interactional patterns that both therapists and clients are drawn into.

We do not yet have a complete understanding of what causes harm and how to prevent it. The divergence between patients' and therapists' understanding of negative effects should be acknowledged and is a neglected topic of research in this field. For example, in line with Rozental et al. (2018) recommendation of more qualitative research, understanding the similarities and differences between therapists' and patient's perception of the same therapy, in a sample of failed therapies, would be illuminating.

Finally, findings in this field are now robust enough to support intervention studies. Using implementation science methods, a fruitful line of services research would evaluate the impact of introducing organizational systems of harm reduction.

AUTHOR CONTRIBUTIONS

JC: conducted the data searches, data extraction and the full task analysis, contributed to the validation phase and co-drafted the paper; GP: designed the study, contributed to rational model development, contributed to the validation phase and co-drafted the paper; GH: conducted the validation study, contributed to the validation phase, and co-drafted the paper; JD: coded and derived themes in the analysis of the qualitative literature and patient testimony; A-MM: coded and derived themes in the analysis of the qualitative literature and patient testimony; EC: contributed to rational model development, assisted with data searching and designed the data extraction forms (particularly for the patient testimony).

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SUPPLEMENTARY MATERIAL

The Supplementary Material for this article can be found online at: https://www.frontiersin.org/articles/10.3389/fpsyg.2019.00347/full#supplementary-material

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ORIGINAL RESEARCH
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No Change? A Grounded Theory Analysis of Depressed Patients' Perspectives on Non-improvement in Psychotherapy

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Aim: Understanding the effects of psychotherapy is a crucial concern for both research and clinical practice, especially when outcome tends to be negative. Yet, while outcome is predominantly evaluated by means of quantitative pre-post outcome questionnaires, it remains unclear what this actually means for patients in their daily lives. To explore this meaning, it is imperative to combine treatment evaluation with quantitative and qualitative outcome measures. This study investigates the phenomenon of non-improvement in psychotherapy, by complementing quantitative pre-post outcome scores that indicate no reliable change in depression symptoms with a qualitative inquiry of patients' perspectives.

Methods: The study took place in the context of a Randomised Controlled Trial evaluating time-limited psychodynamic and cognitive behavioral therapy for major depression. A mixed methods study was conducted including patients' pre-post outcome scores on the BDI-II-NL and post treatment Client Change Interviews. Nineteen patients whose data showed no reliable change in depression symptoms were selected. A grounded theory analysis was conducted on the transcripts of patients' interviews.

Findings: From the patients' perspective, non-improvement can be understood as being stuck between knowing versus doing, resulting in a stalemate. Positive changes (mental stability, personal strength, and insight) were stimulated by therapy offering moments of self-reflection and guidance, the benevolent therapist approach and the context as important motivations. Remaining issues (ambition to change but inability to do so) were attributed to the therapy hitting its limits, patients' resistance and impossibility and the context as a source of distress. "No change" in outcome scores therefore seems to involve a "partial change" when considering the patients' perspectives.

Conclusion: The study shows the value of integrating qualitative first-person analyses into standard quantitative outcome evaluation and particularly for understanding the phenomenon of non-improvement. It argues for more multi-method and multi-perspective research to gain a better understanding of (negative) outcome and treatment effects. Implications for both research and practice are discussed.

Keywords: non-improvement, psychotherapy, outcome research, grounded theory, depression-psychology, mixed-method analyses, qualitative and quantitative methods, patient perspective

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Negative outcome or nonresponse to treatment is undeniably part of clinical practice. It is estimated that 5 to 10% of patients deteriorates in therapy (Cooper, 2008; Lambert, 2013), and a proportion of 35 to 40% of the participants in clinical trials do not improve (Lambert, 2007). A better understanding of negative outcome and treatment effects is crucial for both research and clinical practice, yet outcome research has focused predominantly on capturing positive change and "what works," while less is known about non-improvement or what it actually means when treatments fail (Barlow, 2010).

There is no uniform understanding of negative outcome, nor is there agreement on the definition of treatment failure (Lambert, 2011; Lampropoulos, 2011). "Negative outcome" and "negative therapeutic effects" are often used as synonyms, although they do not have a one-on-one relationship, as negative outcome is not necessarily caused by therapy (Mays and Franks, 1985; Mohr, 1995). Depending on the perspective (e.g., patient, therapist, researcher), the type of outcome (e.g., symptoms, quality of life), measurement method (e.g., quantitative or qualitative) and time point (e.g., post treatment or follow-up) being used for treatment evaluation, the conception of outcome and treatment effects varies (Lampropoulos, 2011).

In outcome research, outcome and treatment effects are typically evaluated using statistical tests of significance that provide an indication of the reliability of the measured change. Statistical significance shows that an outcome difference is larger than could have been expected by mere chance. Clinical significance shows whether such a statistical effect is also clinically meaningful (i.e., change toward a normal level of functioning) (Jacobson et al., 1999; Ogles et al., 2001; Lambert et al., 2008; Lambert and Ogles, 2009). Based on the Jacobson and Truax widely used method for clinical significance, outcome can be classified into four categories: (1) recovery (i.e., clinically significant change), (2) improvement (i.e., reliable change), (3) no reliable change and (4) deterioration (i.e., reliable change in the negative direction). Generally, the first category "recovery" is taken as the gold standard outcome and treatment goal: a reliable decrease in symptoms[1] and return to a non-clinical level of functioning. When neither criterion is met, it is concluded that patients remained "unchanged" in comparison to their level of functioning prior to treatment (Jacobson and Truax, 1991).

Despite the added value of clinical significance testing of measured changes, this type of statistical outcome classification cannot overcome the limitations that are voices for standard outcome research (Hill et al., 2013). Quantitative pre-post outcome evaluation is criticised for relying predominantly on one-dimensional rating scales, most often symptom-based (Braakmann, 2015), and consequently, for offering only an incomplete approximation of the multi-dimensional nature of human functioning (Kazdin, 2001; Hill et al., 2013). The possible discrepancy between what is measured with outcome questionnaires and what is meaningful in patients' daily life has been problematised: a patient's outcome score might fall within the non-clinical range while it does not reflect the person's functioning (Kazdin, 2011). Real-life contextualisation is necessary in order to make sense of what changes in scores (or the lack thereof) actually mean for an individual (Blanton and Jaccard, 2006; Kazdin, 2006). The latter is typically missing in large sample standardised outcome studies, and consequently, the dissemination of research findings into clinical practice generally fails (Kazdin, 2008).

The past decades have seen an accumulation of qualitative studies attempting to contribute to overcoming this research-practice barrier, gradually offering a more central role to the voice of patients (Levitt et al., 2016). Qualitative research focusing on patients' experiences of outcome has provided a diverse picture of treatment-related changes (McLeod, 2011). Apart from symptomatic changes, alterations on the level of patients' self, life, interpersonal relations, and self-understanding have been observed (e.g., Binder et al., 2009). The largest strand of qualitative psychotherapy research has focused on patients' experiences of therapy, aiming to identify helping and hindering aspects (McLeod, 2013). Hindering elements in therapy that have been mentioned by patients are contra-productive therapist features (e.g., being unsure, absent or non-responsive, lack of direction and advise in therapy), patients' own difficulties to express or get in touch with their feelings and lack of commitment and motivation, and a lack of trust between patient and therapist (Paulson et al., 2001; von Below and Werbart, 2012) and so forth. On the other hand, a joint exploration of difficulties and experiencing warmth, understanding and empathy in the relationship with the therapist were found to be helpful for patients (Timulak and Lietaer, 2001; Lilliengren and Werbart, 2005; Bohart and Wade, 2013).

Interestingly, findings from qualitative outcome studies shine a somewhat more pessimistic light on psychotherapy outcome than is typically observed in quantitative studies. In general, patients tend to be more critical about therapy during interviews, for instance, expressing disappointment about unaltered core problems or ambivalence about the gains of therapy (McLeod, 2013). Moreover, research findings suggest that, patients' treatment satisfaction does not correspond to changes in outcome scores. Werbart et al. (2015), for instance, observed that only three out of twenty patients with a nonimproved or deteriorated outcome also clearly indicated to be dissatisfied about treatment.

Nonetheless, the association between quantitative and qualitative evaluations of therapy and outcome remains unclear (Timulak and Creaner, 2010). Mixed-methods studies have amassed in the past couple of years, though whether and how patients' experiences correspond to quantitative outcome evaluation is underexplored (McLeod, 2013). The few studies that have been executed differ in the extent to which qualitative and quantitative findings show an accord (see Svanborg et al., 2008 vs. Klein and Elliott, 2006). The study of McElvaney and Timulak (2013) found only little differences between patients classified as "recovered/ improved" and "unchanged/ deteriorated" regarding their experience of therapy. As the strict demarcation

[1]Note of nuance: as outcome is predominantly evaluated by means of symptom-based scales (Braakmann, 2015), throughout this paper we will refer to a decrease in symptoms, even so we acknowledge outcome measurement is not limited to symptom-based scales but can also contain measures of general wellbeing, satisfaction and interpersonal functioning.

of "poor" and "good" outcome does not appear in qualitative inquiry, questions can be raised about how representative such a statistical distinction is for the clinical meaning of outcome for individual patients (see Lambert and Ogles, 2009).

So far, the meaning of negative or poor outcome—distinguished by means of standard outcome measures—in relation to patients' subjective experiences, remains underexplored. As non-improvement and worsening are likely distinct phenomena with potential different clinical implications (Mohr, 1995; Lambert, 2011), more focused investigations are required in order to grasp the phenomenon of non-improvement (in contrast to the approach of McElvaney and Timulak, 2013, who studied unchanged and deteriorated cases together). In past endeavours, most of the studies have focused on deterioration or other "extreme cases," yet little attention has been allotted to understanding treatment nonresponse or patient non-improvement specifically (Lambert, 2011). Given the observation that lack of improvement occurs in a significant number of cases, and considerably more frequently than deterioration, this lack of attention is striking (Lambert, 2007, 2013). Importantly, gaining a better understanding of cases who seemingly have not moved forward or backward, will contribute to a more thorough and nuanced understanding of treatment-response and outcome in general. More specifically, this nuanced understanding is pivotal to elaborate the clinical meaning of outcome for patients themselves.

The integration of multiple methods and specifically the comparison of quantitative and qualitative methods is an indispensable development for the field of psychotherapy research (McLeod, 2013; Bowie et al., 2016). The current study therefore provides a mixed-method analysis of patients suffering from major depression. Major depression is one of the most prevalent mental disorders worldwide (WHO, 2017), and previous research has shown symptomatic evaluation of change alone cannot live up to the task of representing depressed patients' experience of outcome (Zimmerman et al., 2006, 2012). Based on this representative case, the present study aims to complement quantitative pre-post outcome scores indicating no reliable change in depression symptoms with a qualitative inquiry of depressed patients' perspective. In doing so, we move beyond the level of description (i.e., a lack of change in symptom scores) and toward a level of in-depth understanding (i.e., patients' subjective experience). Finally, instead of adopting a single focus on experiences of outcome or experiences of therapy, the present study aims to understand their interrelation as well as the broader context of potential influences, as these are typically not limited to therapeutic features alone (Drisko, 2004; De Smet and Meganck, 2018).

The current study investigates how non-improvement in pre-to-post symptom severity can be understood in relation the experience of depressed patients themselves. We examine: (1) which potential changes patients have experienced and which factors can help to explain these changes from their perspective; (2) which potential issues remained and which factors can help explain these remaining issues according to patients; (3) how patients' perspective on non-improvement relates to the quantitative outcome evaluation of non-improvement (or no reliable change) in symptom severity. For the purpose of the study, the term "non-improvement" is used to indicate a specific definition of negative or poor outcome in accordance to the widely used statistical concept of a lack of reliable change in outcome scores (cf. Jacobson and Truax, 1991). We use this categorisation as a starting point to be able to *broaden* this influential framework of understanding, by nuancing it based on patients' perspectives.

METHODOLOGY

An explanatory sequential mixed-methods study was conducted, comprising a quantitative pre-post outcome evaluation as well as a qualitative analysis of nonimproved patients' perspective. The study is "explanatory" as the focus is on understanding non-improvement in-depth, and "sequential" because, even though quantitative and qualitative data were gathered simultaneously, both strands were analysed independently and integrated at the phase of interpretation. The design can be summarised as "quan →QUAL": The qualitative analyses build on the quantitative outcome evaluation yet becoming the most important focus of the explanatory study; "the quantitative study (quan) is in service of the more dominant qualitative (QUAL) one" (Hesse-Biber, 2010, p.71). In the current study, a first phase comprised a quantitative outcome evaluation, based on which the target sample was selected. In a second phase, the corresponding interviews were qualitatively analysed. Integration and comparison of the two strands allowed for a better understanding of both the quantitative and qualitative outcome findings. Given the aim for in-depth exploration of patients' experienced changes, as well as understanding of the processes and factors that may explain those experienced changes, a grounded theory approach was selected as method of choice for the qualitative analyses (Strauss and Corbin, 1990). Grounded theory can be used to provide description and interpretation, with the aim to generate conceptual models that can consecutively be translated into further hypotheses (Fassinger, 2005; Charmaz, 2014). For our purposes, thus, this method seemed well-suited to build a thorough understanding of negative outcome and non-improvement from patients' perspective.

Setting

This study is based on data from the Ghent Psychotherapy Study (GPS), an RCT on the treatment of major depression; the trial has been registered on Open Science Framework (ISRCTN 17130982). For a specific description of the GPS context and methodology, we refer to the pre-registered study protocol (Meganck et al., 2017). Patients in this study were recruited via social media and general practitioners in the area of Ghent, Belgium. Patients included in the study qualified for a diagnosis of Major Depressive Disorder, measured by the Rating Scale for Depression (Hamilton, 1967) and Structured Clinical Interview for DSM-IV-TR (First et al., 2002), both well-established and frequently used interview-based instruments in depression studies (Nezu et al., 2000). The assessment interviews were conducted by six postgraduate research assistants trained

in the respective procedures. Further eligibility criteria were sufficient knowledge of the Dutch language and age between 18 and 65; patients with a primary diagnosis of substance abuse, acute psychosis and suicidal ideations were excluded. Patients were randomly assigned to time-limited Cognitive Behavioral Therapy (CBT) or Psychodynamic Therapy (PDT). Patients progress was evaluated using questionnaires accompanying every session, interviews were conducted prior to treatment, around the eighth session and after treatment termination. The follow-up period of the study spans 2 years (ongoing) and consists of 4 interviews and quantitative assessment. This study was approved by the Ethical Committee of the University Hospital of Ghent University (Belgium; EC/2015/0085). All participants gave written informed consent in accordance with the Declaration of Helsinki.

Treatment

Treatment consisted of CBT and PDT for major depression, two types of therapy that can be distinguished based on their directive (i.e., CBT) and exploration (i.e., PDT) style of interventions. Therapy was provided by one of four therapists in each approach. Both treatments were manualised and time-limited, consisting of 16–20 sessions. Treatment was delivered with an average frequency of one session per week; sessions lasted approximately 45 min. The CBT manual was based on the Cognitive-Behavioral Protocol for Depression by Bockting and Huibers (2011). The PDT manual was based on the Supportive-Expressive Time Limited manual for Major Depressive Disorder by Luborsky (1984) and Leichsenring and Schauenburg (2014). Therapists had an average age of 33 ($SD = 9.6$) and had 3 to 8 years of relevant clinical experience and training in CBT or PDT. In the study, all therapists received 2 days of training, one patient to practice the treatment manual and the research procedure under supervision, and bi-weekly supervision sessions throughout the study.

Instruments

Beck Depression Inventory

The Beck Depression Inventory (BDI-II-NL; Beck et al., 1996; van der Does, 2002)[2] is a measure of self-reported depression severity. The questionnaire consists of 21 items that are scored on a scale of 0 to 3 and is divided into a cognitive, somatic and affective subscale. A total score between 0 and 13 indicates minimal depression, 14–19 mild depression, 20–28 moderate depression, 29–63 severe depression. The questionnaire shows good validity and reliability (van der Does, 2002).

Semi-structured Interview

An adjusted version of the semi-structured Client Change Interview (CCI; Elliott et al., 2001) was administered. The interview guide was constructed to evoke participants' experiences of therapy, the changes they believe occurred during therapy, and what they believe influenced these changes, for instance, helping and hindering aspects of therapy. Every interview started with the open questions: "How are you doing in general?" and "How are you feeling compared to when you started therapy?" Subsequently, patients were asked more specifically about experienced changes: "Which changes have you noticed since the start of therapy (e.g., in relation to others, at school/work, in your emotional wellbeing)?" and the role of therapy or other factors: "How did therapy contribute to these changes?" and "What other factors (outside of therapy) do you think have contributed to these changes?" Patients were also explicitly asked about negative changes or lack of change: "Is there something that did not change or that you would like to change in the future?"; "Did something change in a negative sense during therapy?" All interviews were conducted at the psychology department (Ghent University, Belgium) in the week following therapy termination. Interviews lasted 60 min on average. Interviews were audiotaped, and transcripts were analysed using Nvivo 11 (QSR International).

[2]Given the focus of the current study on patients being treated for major depression, the BDI-II-NL was selected as the outcome measure in this study. A complete overview of all measures used in the GSP can be found in the study protocol (Meganck et al., 2017).

Quantitative Outcome Classification on the BDI-II-NL

Participants were classified in terms of reliable change and clinically significant change based on the Jacobson and Truax (1991) method for outcome classification. Patients self-reported symptom severity was measured prior to therapy and 1 week after treatment ended. The outcome scores of the patient population were compared to Dutch norms (van der Does, 2002). In order to reach reliable change for the BDI-II-NL total score, a person must show a decrease in scores equal to or larger than 9.6. The cut-off between the clinical and nonclinical population for the Dutch BDI is set at 11.3 (based on the internal consistency of 0.92; van der Does, 2002). This leads to four possible outcomes: Clinically significant change (CS; a decrease in scores equal to or larger than 9.6 and post-treatment score below 11.3), reliable change (RC; a decrease in scores equal to or larger than 9.6), no RC (a decrease or increase in scores <9.6) and deterioration (an increase in scores equal to or larger than 9.6). In the total sample of the RCT ($n = 94$), 31.9% ($n = 30$) of the patients changed clinically significant, 20.2% ($n = 19$) changed reliably, 23.4% ($n = 22$) remained unchanged and 3.2% ($n = 3$) deteriorated in scores on the BDI-II-NL; 21.3% ($n = 20$) had missing outcome data (see **Figure 1**).

Participants

For the current study, patients showing no reliable change in pre-to-post outcome scores on the BDI-II-NL (van der Does, 2002) were included. We did not incorporate deteriorated patients based on the assumption that non-improvement and worsening are distinct phenomena with potential different clinical implications (cf. supra; Mohr, 1995; Lambert, 2011). For the same reason, we excluded patients who ended treatment prematurely (i.e., drop-out from treatment), which was defined as the patient-initiated premature termination of therapy within four sessions of treatment (in line with other commonly used definitions of drop-out; Wierzbicki and Pekarik, 1993; cf. Barrett et al., 2008) This resulted in the selection of 19 participants. The flowchart in **Figure 1** gives an overview of the selection process for this study. The sample consisted of 12 women and

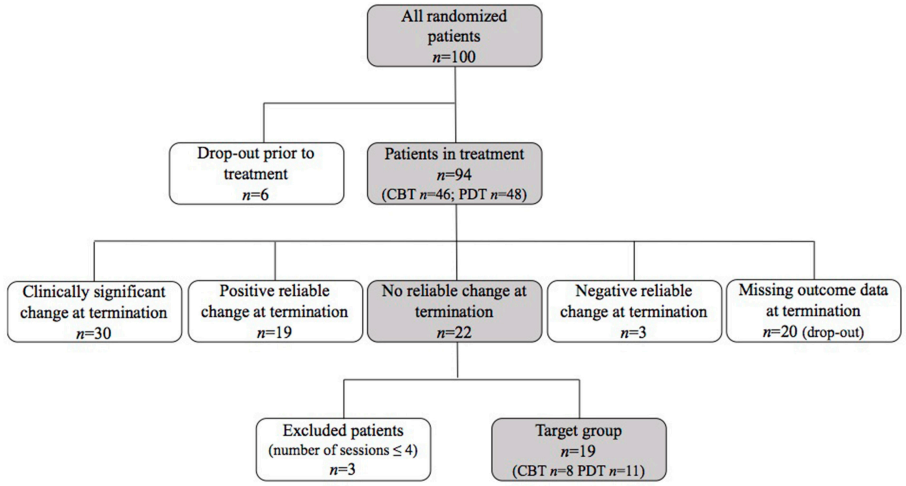

FIGURE 1 | Flow chart of sample selection.

7 men ranging in age from 21 to 59 ($M = 34$; $SD = 10.7$). All patients were born in Belgium except for 1 patient who was born in the Netherlands; 1 patient had a parent of foreign origin. **Table 1** gives an overview of the demographic information per patient. During the study, 8 patients received CBT; 11 patients received PDT. Patients' average treatment duration was 17 sessions (range 6–20 sessions). All patients were diagnosed with major depression prior to treatment (comorbid Axis I diagnoses as assessed using the SCID for DSM-IV-TR are presented in **Table 1**).

Grounded Theory Analysis

Grounded Theory (Glaser and Strauss, 1967) can be described as an explorative and interpretative qualitative research method, aimed at the construction of new theories or rationales grounded in data (in our case patient interviews) (Fassinger, 2005; Charmaz, 2014). Using this method, a tentative conceptual model of non-improvement that comprises patients' experienced changes and explanatory factors was created Characteristic of grounded theory, several stages of analysis were completed in a cyclic manner before arriving at the final conceptual model (Mortelmans, 2013). This form of inquiry enabled the exploration of the phenomenon of non-improvement in the participants' terminology and to identify themes in the data in a bottom-up manner. As the interviews were conducted in the context of a larger study, the interview questions were not altered throughout the data gathering process as is often the case in grounded theory analysis.

Prior to the actual coding of the interview transcripts, the first author wrote a vignette about every participant that included demographic information, treatment duration, pre-post outcome scores and a summary of the most important themes addressed in the interview. The vignettes were used to get an initial idea of the individual cases in the sample prior to the analysis. During later stages, the first author repeatedly reread the vignettes to validate the constructed model and conclusions with the individual cases. The interview transcripts were subsequently analysed by the first author in dialogue with the third author; the second author functioned as an auditor throughout the process (Hill et al., 1997).

Open Coding

Open coding is defined as "the analytic process through which concepts are identified and their properties and dimensions are discovered" (Strauss and Corbin, 1990, p. 101). In this phase, the interviews were first read and reread to identify relevant parts of the interviews relating to the research questions (cf. selecting meaning units; Giorgi and Giorgi, 2003). Labels were attached to certain parts of the text, differentiating experienced changes/remaining issues from therapy factors and other mentioned influences. Non-relevant parts, i.e., not dealing with the topic of well-being, experienced changes or therapy, for instance, were omitted. In order to prevent relevant information from being omitted during the coding process, this work was first conducted on printed versions of the interview transcripts and repeated in the Nvivo software package. This phase resulted in a first list of codes that were formulated with the intent to remain close to the narrative of patients. A first rough classification was made between the various codes (i.e., experienced changes, remaining issues, therapy effects, social context). They were discussed between the first and third author and altered until consensus was reached.

Axial Coding

Axial coding can be summarised as "the process of relating categories to their subcategories termed 'axial' because coding occurs around the axis of a category, linking categories at the level of properties and dimensions" (Strauss and Corbin, 1990, p. 123). In this phase, the various codes were further divided into subcategories in order to refine the first initial classification of codes. In dialogue between the first and third

TABLE 1 | Demographical information of patients in the sample.

Pt	M/F	Age range	Marital status	Education level	Employment status	Therapy (*n* sessions)	Prior care	Comorbid diagnoses
A	F	35–40	Divorced	Higher	Employed	PDT (20)	Therapy	Panic disorder
B	F	25–30	Single	Higher	Internship	PDT (20)	No	GAD
C	F	35–40	Cohabiting	Higher	Employed	PDT (20)	Both	OCD; GAD
D	M	35–40	Single	Secondary	Interrupted	PDT (20)	No	None
E	F	55–60	Married	Secondary	Employed	PDT (20)	No	OCD; Pain D.; ED.
F	M	50–55	Married	Higher	Unemployed	PDT (20)	Therapy	None
G	F	50–55	Divorced	Higher	Housewife	PDT (7)	Meds	Somatisation D., BDD
H	F	30–35	Single	Secondary	Unemployed	PDT (20)	Both	Agoraphobia; BDD
I	M	20–25	Single	Secondary	Student	PDT (20)	No	Panic disorder; GAD
J	F	25–30	Single	Secondary	Interrupted	PDT (20)	Both	Social Phobia; GAD; ED
K	M	25–30	Single	Higher	Unemployed	CBT (20)	Therapy	None
L	M	30–35	Single	Secondary	Unemployed	CBT (12)	Both	Specific phobia; OCD
M	F	20–25	Cohabiting	Secondary	Employed	CBT (6)	Both	None
N	F	25–30	Single	Higher	Employed	CBT (20)	Therapy	PTSD
O	F	20–25	Cohabiting	Higher	Student	CBT (17)	Both	GAD
P	F	50–55	Divorced	Secondary	Employed	CBT (20)	Both	None
Q	M	35–40	Cohabiting	Higher	Employed	CBT (8)	No	None
R	M	40–45	Single	Higher	Employed	CBT (20)	Both	Panic Disorder
S	F	25–30	Cohabiting	Higher	Employed	CBT (20)	Therapy	Panic D., Agoraphobia; Social phobia; OCD; GAD; PTSD; Hypochondrias

Information as indicated prior to therapy. To safeguard participants' anonymity, no exact ages are mentioned in the table. M/F: male/female. "Cohabiting": living together with romantic partner. "Higher education": college or university degree. "Interrupted employment" (i.e., temporarily): e.g., due to sick leave. "Prior care": previous psychotherapy or medication (i.e., antidepressants or other psychopharmaceutic treatment). "Both": medication and psychotherapy. GAD, generalised anxiety disorder; OCD, obsessive compulsive disorder; ED, eating disorder; BDD, body dysmorphic disorder; PTSD, post-traumatic stress disorder.

author, the resulting codes were thematically connected and where needed rephrased. At the end of this phase, the first author looked for visual images and metaphors that could help to grasp the central categories and mechanisms emerging from the narratives of the patients (e.g., "stuck in a maze"; "impasse"). These were further developed and refined in the next phase.

Selective Coding

Selective coding comprises "the process of integration and refining the theory" (Strauss and Corbin, 1990, p. 143). In this phase the theory was cultivated by creating a core category and building other categories around it. In discussion with the third author, this theory was refined. The second author audited the selection of the core and subcategories by asking critical questions regarding the rationale behind the extracted central mechanism. At the end of this phase a set of subcategories was created based on the entire nonimproved sample. Subsequently, we looked into the frequencies of the different categories represented in the CBT and PDT group in order to unravel therapy-related differences. These were included in a detailed table. After finalising the theory, adequate and valuable phrases were chosen to describe the categories and informative quotes were selected to illustrate the various categories and their interrelations and influences. Patients were given a letter of the alphabet to anonymise text fragments (i.e., from A to S).

Credibility

Credibility checks were held at several stages of the analysis. At the end of every interview, patients were asked whether they wanted to add further information that had not been addressed in the interview. During the analysis, we tried to remain transparent about the entire process (Stiles, 1993) and we acknowledge the influence of the perspective and background of the researchers. The researchers' personal interest in patients' idiosyncratic perspective for instance instructed the focus of the study and analysis. Potential consequences of implicit guiding assumptions were controlled as much as possible by making this idiosyncratic focus central to our study (Creswell and Miller, 2000). We furthermore departed from the assumption that "non-improvement" can also include changes, therefore this was explicitly integrated in our research questions. We worked in a systematic manner to form conclusions and interpretations (Stiles, 1993) and attempted to stay open for any information coming from the narratives throughout the entire process. The analysis aimed at outlining macro-processes in psychotherapy, i.e., examining a wide angle rather than micro-processes (e.g., specific therapeutic effects) and investigated the subjective experience of several different participants (i.e., between-case variation) (Denzin and Lincoln, 2005). In line with our research aim to investigate therapy and outcome in a broader context, the analysis and interpretation of patients' narratives were conducted using a contextual perspective that departs from the assumption that the broader social context influences how patients give

meaning to their experiences (Boyatzis, 1998). Triangulation among researchers, several interviews, and quantitative and qualitative indications of outcome were applied to gain different perspectives on the issue. The ultimate themes were formed by asking critical questions regarding codes and categories (Mortelmans, 2011).

RESULTS

In this section, we will present the quantitative pre-post outcome data and qualitative analysis of patients' experiences respectively. Interpretations of the quantitative and qualitative findings will be described separately; broader integrative conclusions and implications will be presented in the discussion.

Descriptive Pre-post Outcome Scores on the Beck Depression Inventory

Table 2 summarises the average score on the BDI-II-NL (Beck et al., 1996; van der Does, 2002) before and after treatment, the standard deviations (SD) and range in scores (i.e., minimum and maximum score) for the entire nonimproved sample, the PDT and CBT group.

Both at the start and end of therapy, the non-improved patient group is characterised by a wide range in scores. At the start of treatment, patients scores varied between moderate depression ($n = 10$) and severe depression ($n = 9$) (cf. van der Does, 2002). At treatment termination, 1 patient scored mildly depressed, 9 scored moderately depressed and 9 others scored severely depressed. The average score both before (30) and after (30) therapy indicate severe depression for the total sample, although at the borderline of moderate depression. All patients remained in the clinical range and did not change reliably in scores compared to the start of treatment.

Conceptual Model of Non-improvement From Depressed Patients' Perspective

The grounded theory analysis of nonimproved depressed patients' narratives resulted in the core category *Stuck between "knowing vs. doing."* Around this core category, a model was constructed consisting of 10 subcategories that help to explain this core concept. The subcategories are divided into the changes and remaining issues patients mentioned and the positive and negative influences patients ascribed these changes/remaining issues to. These influences are referred to as "explanatory factors" and specified as "facilitating factors" and "impeding factors." **Figure 2** depicts the conceptual model: The left part of the model comprises positive changes and facilitating factors, the right part of the model shows remaining issues and impeding factors. **Table 3** summarises all core and subcategories in more detail for the entire nonimproved sample, the PDT, and CBT group. The frequencies of patients contributing to each category were added.

TABLE 2 | Pre-post outcome scores on the BDI-II-NL.

Total score (BDI-II-NL)	All $n = 19$		PDT $n = 11$		CBT $n = 8$	
	M	SD (range)	M	SD (range)	M	SD (range)
Start therapy	30	5.3 (22–42)	31	10.2 (24–36)	29	6.2 (22–42)
End therapy	30	7.8 (18–46)	29	7.4 (20–44)	30	8.3 (18–46)

Meaning of scores on the BDI-II-NL (van der Does, 2002): 0–13: minimal depression, 14–19: mild depression, 20–28: moderate depression, 29–63 severe depression. Cut-off clinical range: 11.3.

Core Category: Stuck Between "Knowing vs. Doing"

The central mechanism for understanding non-improvement from the patients' perspective is "knowing versus doing": A feeling of having acquired certain changes yet being unable to go a step further, or to know what the problem is but feeling an incapacity to do deal with it. In general, patients wanted to move forward but felt unable to. Some patients stated this literally: "Rationally I know what my problems are or what I should do, but there is just nothing changing." At the same time, the core category captures the effects of therapy that on the one hand facilitated patients' self-understanding and mental stability, but on the other have not been able to overcome certain barriers. A plus (for positive changes and positive influences) and minus (for remaining issues and negative influences) seem to cancel out each other, resulting in a stalemate.

> "I have learned a lot, I have gained many insights. (…) I am not as despondent anymore, but if I say that 'not that much has changed' I mean, I still have difficult periods and a few fundamental problems, which I do understand better now, are not really solved yet, or maybe they are not easy to solve. So, I know much more, I have improved on the level of knowing, but not so much on the more practical level." (Patient C., CBT)

Positive Changes

The overarching experience of being stuck does not imply that patients have not experienced changes at all. Two themes resulted from the analysis showing that throughout the process of therapy, patients have grown *mental stability and strength* ($n = 14$) and have gained more *insight* ($n = 15$). Moreover, these changes seem interconnected, as increased understanding was said to have influenced patients' personal strength. In the model in **Figure 2**, this is indicated by a dotted line (showing interconnection) and an arrow from "Insight" to "Mental stability and personal strength."

> "In general, I feel much stronger, mentally. I have gained many insights in therapy. (…) It gave me peace of mind and recognition that okay, my thoughts, experience and things I long for are not that strange." (Patient J., PDT)

Mental stability and personal strength

Increased mental stability ($n = 11$) consisted of two subthemes: A more positive state of mind ($n = 9$) and the ability to accept and let things go ($n = 6$). Patients had learned to deal with certain situations, they felt less emotionally overwhelmed and believed they could handle challenges better. Patients' personal strength ($n = 11$) consisted of an increased self-confidence

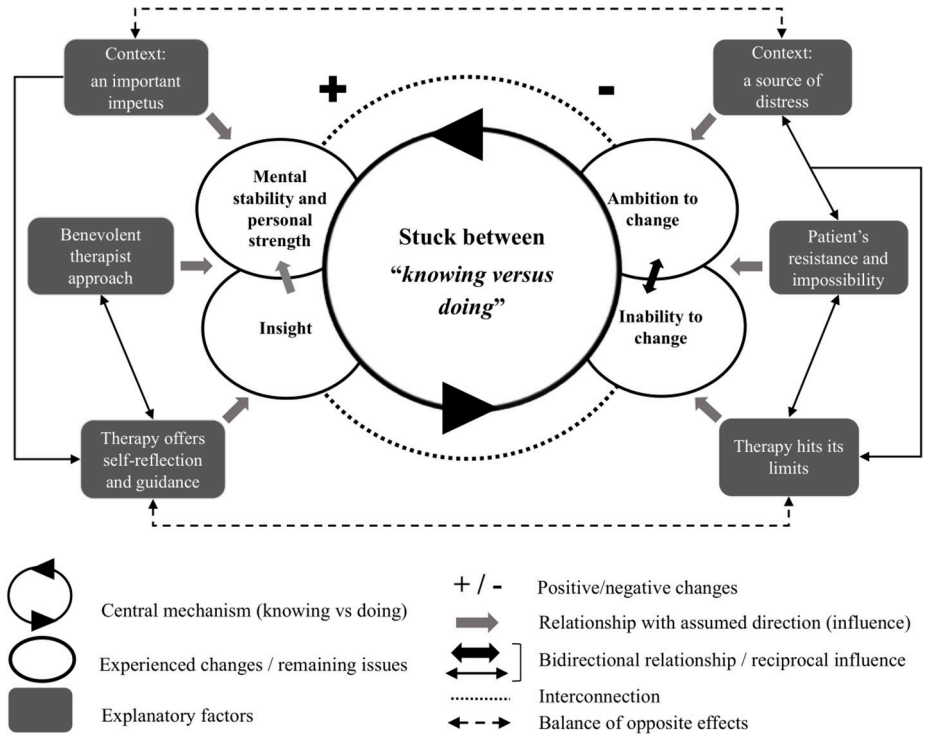

FIGURE 2 | Conceptual model of non-improvement from depressed patients' perspective.

($n = 11$) and being more vigorous ($n = 9$). Patients felt more active, dared to socially interact and felt less anxious and insecure.

> Interviewer: "So you say you are mentally not dispirited anymore. Can you explain the difference with before?"
> Patient: "I think that before I was really struggling with myself, my self-image and now I feel more balanced. I can take a distance. The fights [with partner] are still intense, but I relate it to the relationship now, I've stopped blaming myself." (Patient Q., CBT).

Insight

Increased insight was described on three levels. Patients were able to see things from a different perspective ($n = 9$), understood themselves better ($n = 8$) and had gained insight into the reasons why they experienced difficulties ($n = 8$).

> "Therapy made me reflect upon things and gave me some different ideas about situations that were clear to me but might not have been that clear after all or that needed to be looked at from a different perspective." (Patient A., PDT).
>
> "I have learned more about myself. I already knew I was stubborn, but we talked about it a lot [in therapy], about how I set my standards very high and I don't accept help from anyone and that, by this, I make life very difficult for myself." (Patient H., PDT).

Facilitating Factors

The facilitating factors contributing to these positive changes according to patients include the role of therapy, the therapist and the patients' social and professional context. As indicated in **Figure 2** by unidirectional arrows, these features were described as contributing to patients' mental stability and strength as well as insight.

Therapy offers self-reflection and guidance

Patients in CBT and PDT presented slightly different experiences of therapy. These differences seem in line with the specific nature of both types of therapy, given the explorative and expressive style of PDT and the directive approach in CBT. Especially in the PDT group, weekly therapy sessions were considered important for being able to talk, express feelings and thoughts ($n = 6$) and therapy was seen a as a weekly moment of self-reflection ($n = 11$). This seemed to have stimulated both patients' insight (cf. self-reflection) and mental stability and strength (e.g., letting things out; relief).

> "By saying things out loud in therapy, you start reflecting on them and it becomes a reality that does not only exist in your head. We had one session where the therapist asked some questions about my relationship and because I really did not want to answer them, I started wondering, how I really feel in this relationship, I realised that wasn't very good." (Patient B., PDT).

In the CBT group, similar aspects were mentioned ($n = 4$), but therapy was also valued for actively providing patients with insight and practical help ($n = 5$), making the facilitating role of therapy more guiding than reflective.

TABLE 3 | Taxonomy of non-improvement based on depressed patients' perspective.

Nonimproved outcome	All	PDT	CBT
Core category *Stuck between "knowing vs. doing"*	*n = 19*	*n* = 11	*n* = 8
Positive changes and facilitating factors	***n***	***n***	***n***
Positive changes	*16*	*9*	*7*
Mental stability and personal strength	14	9	5
Insight	15	9	6
Facilitating factors	*18*	*10*	*8*
Therapy offers self-reflection and guidance	*14*	*10*	*4*
Talking and letting it all out	6	5	1
Reflection leading to insight	11	7	4
Provided insight and practical help	12	7	5
Benevolent therapist approach	*17*	*9*	*8*
The right questions	9	8	7
Good relationship	16	9	7
The context as important impetus	*11*	*6*	*5*
Remaining issues and impeding factors			
Remaining issues	*18*	*11*	*7*
Ambition to change	13	9	4
Inability to change	13	8	5
Impeding factors	*19*	*11*	*8*
Therapy hits its limits	*19*	*11*	*8*
Something missing	12	8	4
Mismatch and doubt	17	10	7
The patient's:	*18*	*11*	*7*
Resistance	16	9	7
Impossibility	12	9	6
The context as source of distress	*16*	*9*	*7*

All patients mentioned multiple experienced changes, remaining issues, and explanatory factors. The indicated frequencies near the categories show this multidimensionality and subcategories thus do not add up. The maximum frequency per category is 19 for the total sample, 11 in PDT and 8 in CBT. Italics indicate the number of participants contributing to overarching themes.

> "She [the therapist] helped me to take certain steps. We tried to come up with means to…, like a priority list for my day, because it is difficult for me to…, although I know I have to do lots of things, I'm not organised." (Patient R., CBT)

Benevolent therapist approach

Patients in both therapy groups ascribed important changes more to the therapist's way of being than to the therapy form as such. Therefore, we explicitly describe therapy and therapist separately, even though the factors are clearly intertwined. This reciprocity is indicated in the conceptual model (**Figure 2**) by means of a bidirectional arrow. Firstly, a *good therapeutic relationship* was described by the majority of patients ($n = 16$) as making it easier for them to talk and open up. More specifically, patients valued that the therapist did not judge but rather encouraged and acknowledged them ($n = 10$). Secondly, the therapist had the skill to ask *the right questions* ($n = 15$) that stimulated reflection and provided patients with a different perspective. The previously discussed themes "insight" and "mental stability" were described as influenced by this approach of the therapist. Although the therapist was mentioned as important in both CBT and PDT, the nature of the experienced role of the therapist's different: In PDT, the therapist was described as stimulating a mental process that was ongoing for the patient, while the CBT therapist was characterised as being an active participant or initiator in the therapy sessions.

> "His questions, they often appeared so innocent, but when you think about it afterwards you see things from a different perspective. Very subtle because he does not tend to give his own opinion." (Patient C., PDT).
>
> "After a few sessions, my therapist came up with a scheme that summarised my life until now and where my anxiety comes from. I remember I had to cry for the first time. I noticed how good it felt to finally be understood. I still believe he can help me in the process of accepting it [certain life events]." (Patient S., CBT).

The context as an important impetus

Besides therapy and the therapist, patients mentioned the influence of their social context as a third facilitating factor. Significant others appeared as an important motivation to do something about problems, to find a job or to keep on going ($n = 11$). For some patients, it had been important to be at home for a while (with sick leave) and to have the time for themselves in their own space ($n = 10$). For others ($n = 5$), work (i.e., the professional context) was an important support mechanism, as it gave them a reason to get up in the morning and structure to their day. The motivating context was therefore considered a facilitating factor for patients' mental stability and personal strength and seemingly a potential stimulus for engaging or continuing treatment.

> "My son is one of the reasons for starting and continuing the course [i.e., education]. I want to be able to show him something, instead of being an unhappy person. I want to give him something, something positive. That's actually the only valuable thing in my life that's left. I used to be so materialistic, now the only thing that matters is him." (Patient L., CBT).

Remaining Issues

Despite the positive changes in mental stability, personal strength and gained insight, certain issues remained. Feeling stuck was characterised by the wish or ambition to change yet feeling unable to do so. A reciprocal arrow between the categories "Ambition to change" and "Inability to change" represents this equilibrium.

Ambition to change

The majority of the patients experienced an ongoing struggle and carried hopes for further change ($n = 13$). These aspects implied things they believed they still lacked or they should work on in the near future, such as tackling self-criticism and self-discipline.

> "I wish I could have a more positive stance in life, to be able to counter my negative thoughts. I want to have the discipline to get things done, but the hours just slip away, I see the days pass by

without getting anything done. That's wasted time to me. I want to get a grip of it." (Patient I., PDT)

Inability to change

In spite of and seemingly in conflict with the ambition to change is an overall feeling of inability ($n = 13$). Patients felt as if they were running behind on things, they lacked initiative and could not force themselves to move forward.

"I'm just not on top of things. I constantly feel rushed, but I lose so much time. Searching for things, not able to finish things because you are too distracted. I just can't seem to get out of it. Things pile up, it seems that for every problem I solve I get two in return" (Patient P., CBT)

Some patients described an inescapable cycle they seemed to repeat over and over again ($n = 3$). This inability was also reflected in what seemed like an internal conflict ($n = 7$), for instance, being stuck in the struggle between wanting to spend more time with the kids but at the same time aspiring for a professional career. One patient was highly preoccupied with a long-lost dream, which made it impossible to pursue a new goal in life.

Impeding Factors

Similar to the factors that help explain positive changes, patients brought up potential reasons for why certain issues remained unchanged. These factors include the limits of therapy, the role of the patient and a negative influence coming from patients' social context.

Therapy hits its limits

Notwithstanding its positive effects, therapy was described as hitting a limit by all patients. More specifically, advise or learned techniques were considered valuable, yet only up to a certain point. Patients stated that they were unable to use the techniques when feeling really bad, or they did not find the time to do so. For others, therapy had progressed too slowly, had not been valuable every session, or it had worked for some aspects but not for others. Therapy hit a limit in two ways: *Something was missing* in therapy ($n = 12$) and/or the therapy *mismatched* the patient's needs or expectations at some point ($n = 17$). Noteworthy is the observed difference between the PDT and CBT group. A few patients in PDT were displeased that they had not gained the right tools, were not given any directions ($n = 4$) or stated therapy had a varying impact (sometimes it helped, sometimes it did not) ($n = 3$).

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

Some patients in the CBT group, on the other hand, stated therapy was too superficial and they needed a more intense form of treatment ($n = 5$).

"The first three to four sessions, you tell your whole life story and all that is said about it is just okay, 'you suffer most from the discussions [at home/with your partner] so let's see how we can handle them.' While I thought okay, I just told you my entire life story, about who I am and how I became who I am, that could have been included in therapy, but I actually felt that it wasn't at all, we just looked at one segment." (Patient Q., CBT).

Moreover, therapy as hitting its limits seems to have contributed to a rather ambivalent attitude toward possible continuation of therapy ($n = 11$). One third of the patients had no further need or motivation to continue psychotherapy ($n = 8$). Some of them believed they had dealt with everything or had gotten everything out of therapy that they could, others had lost hope that therapy could help them or were disappointed about the results. Half of the patients indicated they would continue the same therapy, because they felt committed to the process ($n = 6$) or because they had further specific issues they wished to address ($n = 4$). Others, however, were interested in pursuing a different kind of therapy ($n = 7$).

The patient's resistance and impossibility

Patients also reflected on their own role and position in therapy. Most patients described feeling a certain resistance toward therapy ($n = 16$). For instance, they did not take therapy very seriously, had difficulties with opening up or were reluctant to do certain exercises. Several patients saw therapy as a task or an investment that asked too much from them (e.g., energy, time, money) ($n = 6$). This rather ambivalent position in therapy was, for instance, described by patient R:

"I was afraid to fail in therapy. (…) I typically start things but can't manage to continue them. Maybe because (…) when it hasn't gone well one day, I can't let that go. It is all or nothing often, so I was afraid I would not do very well [in therapy] and also, sometimes I put effort into it, but often I was busy doing other things I thought I should be doing, like work." (Patient R., CBT).

Secondly, many patients were convinced about the fundamental nature of their problems and the impossibility to change ($n = 15$), sometimes referring to their own personality. Moreover, some patients indicated that therapy of 20 sessions is in general too little to solve more fundamental problems. The patient's resistance and idea of impossibility seem to correspond to the perspective on therapy as hitting a limit. In **Figure 2** this was indicated by means of a reciprocal arrow, assuming a certain reciprocity between both explanatory factors.

"I think I'm quite a different case, I have quite a big tendency toward depression, if I compare myself to other people in my environment who have depression, they get over it after a year, but I think for me this is a bit more difficult, because of my childhood... I have been conditioned to think in a certain way, I think that matters a lot [for the duration and effect of therapy]." (Patient O., CBT).

Despite a mismatch, some patients described they were able to get passed initial resistance and adjusted to therapy, while for

others, the limits of therapy, their own resistance or feelings of impossibility lasted throughout the therapy process.

> "I might have expected therapy to be a bit more practical, but I noticed quite fast that this wasn't the goal of the sessions and I accepted that, I didn't see the talking as a waste of time" (Patient I., PDT).
>
> "So, I think 'okay, therapy has ended now and *once again* I'm nowhere, it did not help, and it only cost me money, a lot of time and energy, and why? For nothing.' (…) Of course, I know I did make progress, but I it's hard for me to see it that way. I just think, 'it's the umpteenth thing I've tried and what is the use?'" (Patient P., CBT).

The context as a source of distress

Several contextual factors were mentioned as having a negative influence on patients' wellbeing during and after therapy. Firstly, patients' personal context was mentioned as being highly stressful ($n = 16$). Several patients, for instance, encountered a conflict with family members ($n = 6$). These difficulties in relationships were often considered to facilitate or perpetuate certain problems, and consequently they were believed to have influenced the therapy process and patients' progression. Patient F., for instance, described a critical moment in course of therapy:

> "There was a crisis [during treatment]. It was when I just started working there [family business], it became too much with how my brother-in-law always got angry with me. I could not handle it. He yelled at me that I was making him bankrupted, I cost a fortune, I don't work well, I'm too slow. At a certain point I switched off my phone and just ran away, I wanted to disappear, commit suicide." (Patient F., PDT).

Secondly, the professional context appeared as a source of stress or dissatisfaction ($n = 9$). This subtheme contains patients who experienced high amounts of stress due to school-related deadlines, had difficulties adjusting to a corporate culture (e.g., not able to handle the given freedom) or did not experience any fulfillment at work. Finally, many patients mentioned external factors causing distress, like certain events or circumstances ($n = 12$), for instance, dealing with unexplainable physical complaints and an ongoing lawsuit. The reciprocal arrow in the conceptual model between the patient's resistance and impossibility and stressful context indicates that both factors are understood as interacting and influencing the therapy and recovery process.

DISCUSSION

This study investigated the phenomenon of non-improvement in psychotherapy from the perspective of depressed patients in relation to their pre-post outcome scores showing no reliable change. By doing so, we answered the pressing need for further investigation of the phenomenon of negative outcome and the exploration of the relationship between quantitative and qualitative approaches to outcome and treatment evaluation in the field of psychotherapy (McLeod, 2013).

First and foremost, the findings of this study showed that non-improvement as indicated by symptom-based outcome scores did not mean that patients did not experience any changes. Where a lack of change in outcome scores means a status quo on the level of symptom-severity, the interviews of the patients revealed a more nuanced and complex picture. Central to patients' experience of non-improvement is the mechanism of knowing vs. doing. While patients had the ambition to change, they felt unable to overcome certain problems, resulting in a stalemate of knowing what to change but not being able to. Positive changes were offset by substantial remaining issues: Increased mental stability, personal strength and insights were gained, yet these did not result in changes on other levels of patients' lives. From the patients' perspective, "no change" in symptom-based outcome scores seemed to be "not enough" change or a "partial change." The therapy, the therapist, the patient and context facilitated positive changes but at the same time were unable to alter important issues or even impeded patients' progression (resulting in remaining issues). None of these factors can be considered the main or only explanatory reason but must be understood as interacting (cf. Mash and Hunsley, 1993; Werbart et al., 2015). In sum, an equilibrium between a positive and negative pole seems to characterise the depressed patients' experience of non-improvement.

A similar positive-negative balance has been observed by Werbart and colleagues in a study on non-improved patients' experience of psychotherapy (2015). Nonimproved patients perceived their therapy as "spinning one's wheels": Therapy was valued for some aspects but disappointing on others and even though some changes occurred, core difficulties remained. The current study investigated nonimproved patients' experiences of outcome and therapy in a broader context of various potential explanatory factors (i.e., not limited to the effects of therapy). In that sense, the findings of this study and the study of Werbart et al. (2015) can be seen as complementing each other, also because different populations of patients were investigated (i.e., adults and young adults). Notably, the experience of both outcome and therapy are strongly congruent in reflecting a balance between a plus (i.e., positive changes and facilitating factors) and minus (i.e., negative changes/remaining issues and impeding factors).

The positive pole of the resulting conceptual model in this study, including increased mental stability, personal strength and insight, corresponds to findings of other qualitative outcome studies. Mental stability and personal strength relate to what has been described as feelings of empowerment and improved emotional functioning (McElvaney and Timulak, 2013), and more generally, as changes on the level of the self (Timulak and Creaner, 2010). Strikingly and in contrast to findings from studies on patients' experience of positive outcome, our nonimproved sample did not report changes on an interpersonal level (Nilsson et al., 2007; Binder et al., 2009; Timulak and Creaner, 2010); reported positive changes were overall more self-focused. Indeed, we could wonder whether improvement on a symptomatic level enables or coincides with changes on a more interpersonal level. Regarding patients' gained insight, our findings seem partially in contrast to the commonly derived conclusion that insight is

an important acquisition for obtaining positive outcome (see the recently published meta-analysis of Jennissen et al., 2018). In this study, increased insight facilitated patients' mental stability and personal strength, but it did not alleviate patients' self-reported symptoms or alter core difficulties. Similarly, Lilliengren and Werbart (2005) found that self-knowledge does not always coincide with changes in underlying problems. Qualitative studies suggest an important role for agency regarding this link between insight and outcome: Rather than gaining insight as such, it is important to gain the capacity to apply or act upon gained insight in daily life (McLeod, 2013)[3]. Stage models of therapy (see for instance Hill, 2004), state that insight is only valuable to the extent that it leads to action. The absence of this active component could explain the lack of improvement on other levels in our research sample. As already stated by Freud, in order to gain substantial change, a step beyond intellectual insight toward experience might be required (see Bohart, 1993; Castonguay and Hill, 2007). More research on the mechanism of how insight promotes change is, however, warranted.

The helping role of treatment differed depending on the type of therapy. In accordance with the finding of Nilsson et al. (2007), patients valued CBT and PDT for different reasons. In our study, therapy provided a moment of self-reflection for patients in the PDT group, while practical help and guidance was valued in the CBT group. Interestingly, while patients in both CBT and PDT mentioned the central role of the therapist, its specific effectuation differed seemingly. In line with the differentiation between the approach of the respective therapies, the PDT therapist was attributed a rather subtle though powerful technique stimulating reflection in patients. The CBT therapist, on the other hand, was considered an active participant in treatment who offered patients insight via tools such as schematic overviews. A good therapeutic relationship was one of the most important common factors in psychotherapy (Lambert and Barley, 2001) mentioned by the majority of the patients in our study, similar to other qualitative findings (Levitt et al., 2016).

Nonetheless, all patients stated therapy hit a certain limit. Again, in line with the observation of Nilsson et al. (2007), both types of therapy were criticised on a different basis: In our sample, dissatisfied patients criticised CBT for being too superficial while PDT was criticised for not offering the right tools or direction. The latter corresponds to findings from the study of Lilliengren and Werbart (2005), in which patients experienced similar disappointments in psychoanalytic therapy (e.g., wanting a more active therapist, guidance, feedback, and advice). A possible mismatch between certain patients' needs or expectations and the type of therapy supports the increasing emphasis in research to explore which type of therapy works best for whom and focus on the tailoring of treatment to patients' transdiagnostic characteristics (Norcross and Wampold, 2011).

Beyond therapy hitting limits, patients in this study mentioned explicitly that they themselves encountered a certain resistance or hit their own limits and limitations. The patient's in-therapy behavior, such as client involvement and motivation, is the single most important predictor of outcome. Patient motivation has moreover been linked to expectations and hopefulness: Patients who do not believe they can change, and who feel hopeless, may have less motivation to participate in therapy (Bohart and Wade, 2013). Accordingly, the participation in the therapy process seemed rather ambivalent in our sample. Notably, individual differences were observed: Some patients were able to get passed initial doubt about the therapy approach and their own ideas of impossibilities, while others did not. Although not mentioned by patients themselves, it is important to consider that many patients in the sample presented with one or more comorbid disorders, in most cases some kind of anxiety disorder at the start of therapy. Previous research has shown comorbidity in general predicts worse outcome (see Lambert, 2013).

Finally, our findings revealed the therapy process was intertwined with influences from outside the therapy room. Patients' personal context was both considered an important motivation as well as a large source of distress. Again, opposite effects facilitated and impeded changes. It has been outlined that the context plays a central role in sustaining involvement in psychotherapy or undermining this effort (Lambert, 1992; Drisko, 2004). The impact of patients' professional context on their well-being mentioned in this study is in line with robust findings on the impact of job satisfaction on mental health (Faragher et al., 2005). Whilst most qualitative studies tend to focus specifically on patients' experience of psychotherapy, our study provides a valuable additional element of contextualisation.

The resulting negative pole of the conceptual model of non-improvement, including the ambition yet inability to change, shows resemblance to what is considered a central characteristic of experiencing depression: Running behind on things, lacking initiative and motivation (DSM-5; APA, 2013). Feelings of hopelessness and helplessness were unresolved, in line with the remaining average score of severe depression in the sample. However, the question should be posed whether this feeling remained unaltered or rather emerged throughout the process of therapy, for instance, as a response to a lack of improvement. A pre-post research design, even when including retrospective inquiry of patients' experiences prior to treatment, falls short in answering this question. Longitudinal research that includes patients' experiences at the start of therapy as well as monitors changes throughout the process of therapy is needed (cf. De Smet and Meganck, 2018).

The contextual model of psychotherapy as described by Wampold and Imel (2015), offers a valuable framework for interpreting our research findings. In this model, therapy is perceived as a "socially imbedded healing practice" (p. 258) in which the relationship between the therapist and patient is central. According to this model, three pathways lead to change in patients' wellbeing: The first pathway establishes the personal relationship ("real relationship") between patient and therapist, characterised by genuine interest and empathy, the second pathways creates expectations in patients of being able to overcome their difficulties, and the final pathway includes therapy specific features or tasks. Although all three pathways

[3]See McLeod (2013) for a summary of qualitative studies on this topic, Bohart and Wade (2013) on the role of agency, Castonguay and Hill (2007) for an elaboration on the role of insight in psychotherapy.

lead to a certain degree of change, central for the therapy to work is that it can engage patients to follow the treatment rationale and overcome personal beliefs and explanations for distress.

Regarding the first pathway, the contextual model assumes that establishing a real relationship with the therapist leads to general well-being rather than symptom reduction (Wampold and Imel, 2015). Correspondingly, we observed an increased mental stability and personal strength while patients remained unchanged on a symptomatic level. Patients' pessimistic expectations regarding improvement moreover remained unaltered and for many it was difficult to adapt to or engage in specific therapy features; the second and third pathway thus seem not (entirely) fulfilled. The dyadic concept of the patient-therapist working alliance (Bordin, 1979) further demonstrates how "the collaborative purposive work" (Hatcher and Barends, 2006, p. 293) was obstructed by this discordance between patient and therapist or therapy; both by therapy not being able to meet patients' need, as well as by patients' resistance toward the requirements of therapy. This links up to the differentiation between two types of bonds: The work-supporting bond and personal relationship (cf. real relationship). The latter involves affective attachment, liking, trust and respect. The other type of bond is considered necessary for "the difficult work" in therapy, for instance dealing with affective or painful material or executing assignments like exposure and homework (Bordin, 1979). This distinction helps to understand how, in our study, patients experienced a good therapeutic (or real) relationship but failed to engage in the work-supporting bond. Being at ease in therapy and feeling accepted and understood by the therapist thus seem important, for instance leading to increased well-being (Wampold and Imel, 2015), mental stability and personal strength, though not enough to facilitate further life-changes. Correspondingly, gaining insight or self-understanding as such might not be enough when "the hard work" of dealing with affective material has not been worked through. While the contextual model ascribes most of the responsibility to the therapist, the current study and findings give more weight to the role of the patient and his personal context (Wampold and Imel, 2015).

These findings yield a number of clinically relevant implications. Patients who find themselves stuck between knowing versus doing, may hit a certain limit due to a mismatch with the therapy offer, experiencing personal resistance or encountering difficulties outside of the therapy room. As these implications may be brought about by (idiosyncratic) underlying reasons, it may be worthwhile to take this as a particular clinical focus. In light of the increasing use of routine outcome measures in clinical care (see Boswell et al., 2015), a lack of changes in symptom severity could indicate any of these reasons and most likely a combination, yet monitoring instruments clearly require further exploration in dialogue with the patient. However, signs of non-improvement may not always be visible for the therapist. Studies have shown that therapists tend to underestimate negative outcome, as patients tend to keep dissatisfaction about therapy to themselves—possibly because they do not want to offend the therapist (McLeod, 2013; Werbart et al., 2015). Therefore, it may be implicated to work on meta-communication in therapy, to avoid or restore possible ruptures in the therapeutic work and relationship (von Below and Werbart, 2012). On the other hand, a well-established therapeutic relationship could change dissatisfaction about therapy into a negotiation, that is, an active focus point in therapy (cf. Wampold and Imel, 2015). In some cases, referring patients to a different approach that is more in line with patients' own rationale may be warranted (Wampold, 2007), as what may work for 1 patient, might not work for the other (Norcross and Wampold, 2011). Also, the optimal duration of treatment may differ among patients. In the current study, the number of sessions was fixed at twenty, which may have been too little to facilitate changes for some patients (e.g., the average "good enough level" has been estimated at 26 sessions; Barkham et al., 2006). Moreover, patients showing high levels of resistance in therapy may benefit from a less directive approach (see Beutler et al., 2002, for an overview of the literature on resistance) in which therapy is adjusted to patients' own pace. This is supported by authors who warn that uniform time limits for treatment may not adequately serve individual patients' needs (Baldwin et al., 2009).

This study addresses the critical concern about misrepresentation of patients' outcome by means of standard outcome evaluation and statistical classification (Kazdin, 2008; Hill et al., 2013). First of all, no reliable change in outcome scores seemingly masked the significant changes experienced by patients and does not allow to represent the particular balance between remaining issues and positive changes. Furthermore, considering patients to be a uniform group based on a similar pattern of outcome scores might overlook important individual differences. None of the patients in our sample stated they were cured, although they did vary in the extent to which they experienced improvement and whether they wanted to continue treatment. In our study, the pre-post changes in outcome scores seem to give a rough preliminary indication of patients functioning, while the patients' narratives show non-improvement is more complex and diverse than can be grasped by a lack of symptom reduction (in line with Zimmerman et al., 2006, 2012). This observation is not surprising in light of the complexity and heterogeneity of depression experiences (Ratcliffe, 2014). It is plausible to assume that recovering from depression is at least equally diverse and layered (cf. von Below et al., 2010).

Consequently, the findings of this study shed light on the previously voiced question of how negative outcome and non-improvement should be conceptualised. In general, similar to previous research findings, patients' treatment satisfaction and negative outcome did not show a one-on-one correspondence (Werbart et al., 2015); while all patients stated therapy hit a certain limit, a minority was also clearly dissatisfied. Mash and Hunsley (1993) have argued that "without a guiding theoretical framework for considering failing treatments, the assessment task is daunting, because almost any event in therapy might be construed as a possible indication that treatment is currently failing or is about to fail." (p. 293). This study shows how this endeavour benefits from a mixed-methods research format that integrates a grounded theory approach. In line with the strengths of grounded theory (Fassinger, 2005; Mortelmans,

2011; Charmaz, 2014), further theory-building research can mean an important contribution here (cf. Stiles, 2015).

Strengths, Limitations, and Future Directions

The implications of this study address the well-known gap between academic research and clinical practice (Castonguay et al., 2013). RCTs as golden standard research format are limited in providing knowledge that can inform clinical practice (Westen et al., 2004). The value of integrating qualitative research into this type of rigorous research has therefore been emphasised (Midgley et al., 2014). The current study provides an actual example and informs both clinicians and research on the relationship between outcome scores and patients' experiences of non-improvement. It furthermore builds on the literature of helping and hindering therapy features (Paulson et al., 2001; von Below and Werbart, 2012) by placing the experience of therapy in a broader context of potential explanatory factors as mentioned by patients.

The current study is one of few examining the relationship between quantitative and qualitative outcome evaluation of non-improvement (McElvaney and Timulak, 2013; McLeod, 2013). Focusing on this particular subgroup rather than deteriorated or dissatisfied patients allows for the contribution to a lack of specificity in outcome research and the literature on negative outcome (Lambert, 2011). Research suggests non-improvement, deterioration and patient satisfaction do not fully correspond, although they are often used interchangeably (Lampropoulos, 2011). The current study gives an overall conceptual model of non-improvement and potential explanatory factors. Whether this is, however, representative for nonimproved depressed patients cannot be concluded. Further research should focus on investigating differences and similarities between various groups of outcomes (cf. recovery, improvement, no change, and deterioration; Jacobson and Truax, 1991) in order to get a better understanding of the clinical meaningfulness of change from the perspective of patients.

This study contributes to the understanding of non-improvement in psychotherapy and the relationship between quantitative and qualitative outcome evaluation. It cannot, however, answer the question whether outcome scores were representative for every individual patient. The focus of the present study was to provide an overall understanding, (i.e., a conceptual model) of non-improvement relying on a larger group of nonimproved patients. More idiosyncratic information still remains unaddressed and case-study research focusing on individual patients' narratives and outcome scores is warranted (Kazdin, 2011). Similarly, the study cannot offer a fine-grained comparison of the specific effects of CBT and PDT, which could be further addressed in research on specific factors. The mixed methods research format in our study furthermore explicitly favoured the qualitative data over the quantitative outcome classification as focus of investigation, limiting the quantitative strand to a single, although psychometrically sound and often used, outcome measure. Our selection of patients based on self-reported symptoms nevertheless, had a considerable impact on our findings. With use of other means for categorisation, the sample likely would have turned out differently (e.g., using a different measure, multiple measures or relying on patients' satisfaction). Yet, as the use of statistical classification of clinically meaningful outcome (cf. Jacobson and Truax, 1991) is increasingly common in RCTs and standard outcome research at large (De Los Reyes et al., 2011), this study explicitly aimed to relate the exploration of patients' experiences to the much-used classification tool. Therefore, the aim of the current study was not to address the issue of measurement as such, nor the validation of the specific questionnaire that was used, but to deepen the understanding of outcome that is gained by these much used categories. Our conclusions on the relation between quantitative and qualitative appraisals of outcome can however not be generalised to the entire field of quantitative outcome evaluation that undoubtedly has evolved in the past decades, for instance with an increasing focus on person-centered questionnaires (Elliott et al., 2016). For the purpose of our study, an explanatory sequential design was most suited (Hesse-Biber, 2010). Nevertheless, further research aiming at different approaches to mixing methods and including idiosyncratic quantitative outcome evaluation could contribute greatly to our knowledge on outcome and psychotherapy.

Given the controlled context of our study (as data was collected in the context of a broader RCT), it offers a strong level of control for confounds. For instance, the research sample was characterised by a primary disorder of major depression, outcome was systematically evaluated in all patients and treatments were manualised. A potential threat is therefore, however, the external validity of the findings (Westen et al., 2004). Unlike in naturalistic studies, patients with more complex and acute psychopathologies were excluded. Nonetheless, all patients in our study showed comorbid disorders in line with clinical reality; for instance, the co-occurrence of major depression and anxiety disorders observed in this study is a robust finding throughout patient groups (cf. Hirschfeld, 2001). The participants in this study resembled a homogenous and local (predominately Caucasian, Flemish) group of patients, however. Specific (e.g., cultural, ethnic) or more diverse groups of patients could be the focus of complementing research. The research findings might also be biased by a selection of patients willing to participate in the study. Moreover, it is known that patients do not easily disclose negative experiences with therapy or with their therapist, and although interviews can enhance this openness (McLeod, 2000), in general, socially desirable answers cannot be excluded (Thurin and Thurin, 2007).

The model of nonimproved outcome must be considered tentatively, and we do not wish to make strong causal claims regarding the effectiveness of treatment or the causal influence of the therapist. In agreement with Strupp and Hadley (1977), we emphasise that the patient perspective is only one perspective on outcome (e.g., in addition to therapist or societal perspectives), and therefore highlights certain elements while neglecting others. This limits the findings of this study, as previous research has shown patient, therapist, and observers' perspectives on outcome not always converge and all add valuable insights for clinical practice (Altimir et al., 2010). Nevertheless, integrating in-depth inquiry of patients' narratives in the form of mixed

methods research is of considerable value to outcome research and the study of non-improvement. In general, we argue that further research investigating the complex phenomena of outcome and therapy effects should aim at an integration of multiple methods as well as perspectives to grasp the wider picture (McLeod, 2011).

CONCLUSION

Non-improvement in psychotherapy from the perspective of depressed patients can be understood as being stuck between knowing versus doing, resulting in a stalemate. Patients described both positive changes on the level of insight, mental stability and personal strength. The remaining issues were characterised by an ambition to change but feeling an inability to do so. No change in depression symptoms based on standard pre-post outcome evaluation thus becomes a partial change when considering patients' experience and shows a more complex picture in line with the complexity of experiencing depression. Investigating non-improvement by integrating in-depth analyses of patients' narratives in the form of mixed methods research proves to be of considerable value for understanding (negative) outcome and treatment effects more general.

AUTHOR CONTRIBUTIONS

MDS: main author of the manuscript, contribution to data collection, main investigator responsible for data-analysis and interpretation; RM: conception and development of study design, coordinating contribution to data collection, contribution to data-analysis and interpretation, main reviewer of the manuscript; KV: contribution to data collection, contribution to data-analysis and -interpretation, reviewer of the manuscript; FT: contribution to data collection and reviewer of the manuscript revision; MD: conception and development of study design, coordinating contribution to data collection, reviewer of the manuscript.

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SYSTEMATIC REVIEW
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In the Absence of Effects: An Individual Patient Data Meta-Analysis of Non-response and Its Predictors in Internet-Based Cognitive Behavior Therapy

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Background: Negative effects of psychological treatments have recently received increased attention in both research and clinical practice. Most investigations have focused on determining the occurrence and characteristics of deterioration and other adverse and unwanted events, such as interpersonal issues, indicating that patients quite frequently experience such incidents in treatment. However, non-response is also negative if it might have prolonged an ongoing condition and caused unnecessary suffering. Yet few attempts have been made to directly explore non-response in psychological treatment or its plausible causes. Internet-based cognitive behavior therapy (ICBT) has been found effective for a number of diagnoses but has not yet been systematically explored with regard to those patients who do not respond.

Methods: The current study collected and aggregated data from 2,866 patients in 29 clinical randomized trials of ICBT for three categories of diagnoses: anxiety disorders, depression, and other (erectile dysfunction, relationship problems, and gambling disorder). Raw scores from each patient variable were used in an individual patient data meta-analysis to determine the rate of non-response on the primary outcome measure for each clinical trial, while its potential predictors were examined using binomial logistic regression. The reliable change index (RCI) was used to classify patients as non-responders.

Results: Of the 2,118 patients receiving treatment, and when applying a RCI of $z \geq 1.96$, 567 (26.8%) were classified as non-responders. In terms of predictors, patients with higher symptom severity on the primary outcome measure at baseline, Odds Ratio (*OR*) = 2.04, having a primary anxiety disorder (*OR* = 5.75), and being of male gender (*OR* = 1.80), might have higher odds of not responding to treatment.

Conclusion: Non-response seems to occur among approximately a quarter of all patients in ICBT, with predictors related to greater symptoms, anxiety disorders, and

gender indicating increasing the odds of not responding. However, the results need to be replicated before establishing their clinical relevance, and the use of the RCI as a way of determining non-response needs to be validated by other means, such as by interviewing patients classified as non-responders.

Keywords: negative effects, non-response, predictors, individual patient data meta-analysis, Internet-based cognitive behavior therapy

INTRODUCTION

Negative effects of psychological treatments are a relatively unchartered territory in both research and clinical practice. Despite being recognized early in the scientific literature (c.f., Strupp and Hadley, 1977), empirical evidence for their occurrence and characteristics have been quite scarce, but has currently received increased attention (Rozental et al., 2018). Bergin (1966) provided the first report of the "client-deterioration phenomenon" (p. 236), referred to as the deterioration effect, i.e., patients faring worse in treatment. Since then, several studies have investigated the rate of worsening in different naturalistic settings (c.f., Hansen et al., 2002; Mechler and Holmqvist, 2016; Delgadillo et al., 2018), while a number of systematic reviews have assessed deterioration among patients in randomized controlled trials (c.f., Ebert et al., 2016; Rozental et al., 2017; Cuijpers et al., 2018), estimating that ∼5–10% of those in treatment for depression and anxiety disorders deteriorate. In comparison to a wait-list control, the odds ratio for deterioration in treatment is nevertheless lower, suggesting that the benefits of receiving help still outweigh the risks (Karyotaki et al., 2018). Recent attempts to identify variables related to worsening have also revealed that sociodemographics variables like lower educational level are linked to increased odds of deterioration (Ebert et al., 2016), while older age and having a relationship constitute protective factors (Rozental et al., 2017). This implies that certain features might be important to consider in relation to treatment, although more research is needed to determine if and how this could be clinically useful.

Meanwhile, others have stressed the importance of monitoring the potential adverse and unwanted events that may occur in treatment, which are not necessarily related to symptoms (Mays and Franks, 1980). This can include interpersonal issues, stigma, and feelings of failure, identified using therapist checklists (Linden, 2013), self-reports completed by patients (Rozental et al., 2016), or open-ended questions (Rozental et al., 2015). Such incidents have been even less explored, although a few recent attempts have found that almost half of the patients are experiencing negative effects at some time in treatment (Rheker et al., 2017; Moritz et al., 2018; Rozental et al., inpress). Whether or not these are in fact detrimental is an issue that warrants further investigation. Rozental et al. (2018) argued that even though adverse and unwanted events seem to exist, it is still unclear if they affect treatment outcome. Some might even be regarded as a necessary evil, such as temporary bouts of increased anxiety during exposure exercises in Cognitive Behavior Therapy (CBT). In addition, there is also an ongoing debate on how to define and measure adverse and unwanted events occurring in treatment, with different taxonomies having been proposed, which makes it difficult to systematically assess and report such incidents across studies (Rozental et al., 2016).

While most of the scientific literature on negative effects deal with the issue of inflicting something on the patient, e.g., novel symptoms and deterioration, less thought has been given to the *absence* of effects. Dimidjian and Hollon (2010) were early to raise the problem with non-response in treatment, arguing that no improvement at all could potentially have restricted the patient from accessing a more effective treatment. From this perspective, a treatment without any benefits would also be seen as negative given that it may have prolonged an ongoing condition and caused unnecessary suffering, and that "it still may be costly in terms of time, expense, and other resources" (p. 24). However, they also pointed out that this has to be put in relation to the natural course of the psychiatric disorder for which one has been treated, which complicates the issue of classifying non-response. Linden (2013) defined non-response as "Lack of improvement in spite of treatment" (p. 288), suggesting that it could be regarded as negative, but at the same time emphasizing the conceptual difficulties of knowing if it is caused by a properly applied treatment or not. Determining what constitutes non-response is also a question that requires a broader theoretical and philosophical discussion about treatment outcomes. Taylor et al. (2012), for instance, described some of the standards that are currently being used for identifying non-response among patients, arguing that these are often based on arbitrary cutoffs, such as a predetermined level of change or a statistical method. There is currently no consensus on how to reliably classify patients as non-responders, with many studies employing some form of diagnostic criteria, while other rely on the change scores that exceed measurement error, i.e., the Reliable Change Index (RCI; Jacobson and Truax, 1991). In a systematic review of CBT for anxiety disorders (including 87 clinical trials and 208 response rates) by Loerinc et al. (2015), the average response rate to treatment was 49.5%. In other words, about half of the patients did not respond or deteriorated. However, they noted significant heterogeneity across studies, suggesting that the response rates differ partly because of how response and non-response are defined. Looking more closely at how this was determined in the specific clinical trials revealed that 31.3% applied the RCI, 70.7% used a clinical cutoff, and 90.9% relied on some change from baseline (of note: several response rates can be used simultaneously in the same clinical trial, hence not adding up to 100%). Similar response rates have also been found in naturalistic settings when applying fixed benchmarks on self-report measures as cutoffs (Gyani et al., 2013; Firth et al., 2015), meaning that it is not uncommon for patients to experience a standstill in their treatment in a regular outpatient health care setting despite receiving the best available care.

During the last two decades, new ways of disseminating evidence-based treatments have been introduced and become an important addition to the regular outpatient health care setting. One of the most widespread formats is Internet-based CBT (ICBT), in which patients complete their treatment via a computer, tablet, or smartphone (Andersson, 2018). Similar to seeing someone face-to-face, reading material and homework assignments are considered essential components and introduced as one module per week. Patients then work on their problem and receive guidance and feedback from a therapist via email, corresponding to what would be discussed during a real-life session (Andersson, 2016). Presently, the efficacy of ICBT has been evaluated in close to 300 randomized controlled trials and several systematic reviews and meta-analyses, demonstrating its benefits for a large number of psychiatric as well as somatic conditions, including in naturalistic settings (Andersson et al., 2019). The results also seem to be maintained over time, with follow-ups at 3 years showing sustained improvements (Andersson et al., 2018). However, like treatments in general, ICBT is not without negative effects. Recent studies have for example shown that 5.8% of patients deteriorate (Rozental et al., 2017), and that a large proportion report adverse and unwanted events (Rozental et al., inpress). Yet, in terms of non-response, few attempts have been made to specifically explore its occurrence and predictors. A notable exception is a study by Boettcher et al. (2014b), investigating negative effects of ICBT for social anxiety disorder. The results showed that the rate of non-responders on the primary outcome measure varied greatly during the treatment period, with 69.9% in mid-treatment, 32.3 at post-treatment, and 29.3% at 4-month follow-up. No attempt at analyzing predictors was however made. In general, the systematic study of non-response has been lacking in relation to ICBT (Andersson et al., 2014), which makes it unclear what factors might be responsible for its incidence and how this information could be used clinically (Hedman et al., 2014).

Considering the fact that a large proportion of all patients do not respond to treatment, the issue of finding those who are at risk of non-response is important. Still, few studies have explicitly explored if non-response can be predicted. Taylor et al. (2012) made an attempt at summarizing the scientific literature, describing three general factors that might prevent a patient from responding. First, poor homework adherence in CBT seems to be predictive of poorer treatment outcome, at least when it is evaluated using a sufficiently reliable and valid measure (Kazantzis et al., 2016). Second, high expressed emotion, i.e., residing in an environment characterized by hostility and emotional over-involvement, is also associated with poorer treatment outcome, but findings are mixed depending on diagnosis. Third, poorer treatment outcome is more likely if the patient displays greater symptom severity at baseline or suffers from a comorbid condition. However, in all of these cases, the focus of the research has been on responders and not explicitly non-responders, meaning that the conclusions are in fact being back-tracked. In addition, information on the standards for determining non-response have not always been clear or lacking completely. This makes it difficult to interpret the results and draw inferences to the study of non-response *per se*, making a more systematic approach to exploring the issue warranted.

Given the scarcity of research on non-response and its predictors the current study thus aims to investigate its occurrence and predictors. Seeing as ICBT is also becoming more and more common in the regular outpatient health care setting, and because it differs somewhat from seeing someone face-to-face (i.e., no or few physical meetings), it could be important to determine how often and why some patients do not seem to respond to this type of treatment. This was done by specifically looking at those patients who do not seem to benefit from ICBT, as determined using different criteria for determining non-response based on the RCI (Jacobson and Truax, 1991), and then applying a set of variables defined a priori in an analysis of possible predictors. In order to complete such a study, a large sample of individual patient data is however needed to ensure adequate statistical power (Oxman et al., 1995). Data from 29 clinical trials is therefore used, aggregated as part of a similar endeavor regarding deterioration rates (Rozental et al., 2017). The data set consists of a total of 2,866 patients, including three categories of diagnoses: anxiety disorders, depression, and other (erectile dysfunction, relationship problems, and gambling disorder). The hypotheses are that non-response rates similar to those reported by Loerinc et al. (2015) will be obtained, i.e., 44.5%. In addition, it is also hypothesized that the findings by Taylor et al. (2012) will be seen in the current study, that is, symptom severity at baseline and module completion, a proxy for homework adherence, will constitute significant predictors of non-response, i.e., increasing the odds of not responding. Lastly, similar to Rozental et al. (2017), not being in a relationship, younger age, and having a lower educational level are also hypothesized to be associated with increased odds of non-response.

MATERIALS AND METHODS

Individual Patient Data Meta-Analysis

To explore the rates and predictors of non-response, individual-level data from many patients are required. The current study consequently conducted an individual patient data meta-analysis, which is a powerful approach of combining the raw scores from each patient variable across studies instead of only relying on group means and standard deviations (Simmonds et al., 2005). This makes it possible to do more sophisticated statistical analyses, particularly when trying to investigate factors that might be predictive of a certain event (Oxman et al., 1995). Similar to a meta-analysis, this can be done either by performing a systematic review or pooling together data from different sites, such as university clinics. The current study used the latter method, aggregating data from those clinical trials that have been conducted by the authors and where the raw scores of patients were possible to obtain. Data from three sites run by the authors were thus screened for eligibility; (1) patients being allocated to a treatment condition involving ICBT, guided or unguided, consisting of treatment interventions that are based on CBT, including applied relaxation and cognitive bias modification (2) meeting the criteria for a psychiatric disorder or V-codes listed in the Diagnostic and Statistical Manual of Mental Disorders, Fourth or Fifth Edition (American Psychiatric Association, 2000, 2013) (3) receiving

ICBT that lasted for at least 2 weeks or two modules, and (4) completing a validated primary outcome measure assessing the patients' level of distress, for instance, for social anxiety disorder, this involved the Liebowitz Social Anxiety Scale—Self-Report (LSAS-SR; Liebowitz, 1987). Clinical trials not included in the current study were characterized by treatment conditions other than ICBT, namely, bibliotherapy with telephone support, or treatments that are not theoretically linked to CBT, such as, psychodynamic psychotherapy and interpersonal psychotherapy. A limitation of using this method is of course that it is not possible to assess the risk of bias, such as when implementing a systematic review (Simmonds et al., 2005). However, this allowed the retrieval of a majority of all clinical trials of ICBT that have been executed in Sweden, meaning that it should be representative of how it is being administered on a national level at both university clinics and in a regular outpatient health care setting, i.e., screening patients by diagnostic interviews and distributing validated outcome measures, consistent procedures for guidance by therapists, and similar distribution of treatment content.

Once the clinical trials were selected, the raw scores from each patient were put into the same data matrix and coded for consistency, e.g., sick leave (1 = yes, 0 = no) (i.e., in Sweden, receiving disability checks when being absent from work during a time period of at least 2 weeks up to 1 year due to a medical or psychiatric condition). This includes; name of the clinical trial, treatment condition, and including all available sociodemographic variables, outcome measures (primary and additional), ratings of satisfaction, and credibility, previous use of any type of psychological treatment and previous or ongoing use of psychotropic medication, sick leave, number of completed modules and time spent per week on the treatment interventions. To enable as many comparisons as possible in the statistical analysis, given that clinical trials sometimes used different coding schemes, sociodemographic variables had to be collapsed. For instance, only single/relationship were retained in terms of civil status, while the highest attained educational level was restricted to fewer but more coherent categories. Similarly, diagnoses were re-categorized to balance out their proportions: (1) anxiety disorders, and (2) depression and other (erectile dysfunction, relationship problems, and gambling disorder). Meanwhile, those numbers among the raw scores that were unclear, i.e., when information about a nominal variable was missing, published and unpublished manuscripts were obtained and checked so that the data matrix was coded in accordance with the clinical trials. However, it should be noted that the coding schedules for some of the original datasets were impossible to retrieve, whereby a few cells remained blank. For an overview of the patients' sociodemographic variables and the amount of missing data, see **Table 1**.

Statistical Analysis

Given the lack of consensus on how to define and determine non-response in treatment (Taylor et al., 2012), the RCI was chosen based on its widespread use and recognition in the scientific literature for assessing reliable change (Jacobson and Truax, 1991). This was calculated by taking the change score on a clinical trial's primary outcome measure for a specific patient and dividing it by the standard error of difference (Speer, 1992), i.e., $SE_{\text{diff}} = SD_1\sqrt{2}\sqrt{1\text{-}r}$, where SD_1 corresponds to the standard deviation of a condition at pre-treatment, and r is the reliability estimate (Evans et al., 1998). This calculation also takes into account possible regression to the mean effects and is often referred to as the Edwards and Nunally-method (Speer, 1992). According to Bauer et al. (2004), different ways of calculating the RCI yields similar estimates, but here Speer (1992) was chosen given that it was used in the study of deterioration by Rozental et al. (2017). The RCI was then worked out separately for the primary outcome measure for every clinical trial and using their respective test-retest reliability rather than internal consistency (see **Table 2**), in line with the recommendations by Edwards et al. (1978). Essentially, the RCI sets the boundaries for which a change score can be deemed reliable, meaning that it would be unlikely ($p = 0.05$), without a true change actually occurring. For example, considering the first clinical trial in the current study, IMÅ, a change score of ±10.13 is considered reliable on the Beck Anxiety Inventory (Beck et al., 1988). A change score that does not exceed ± 10.13 would then be deemed as non-response. Hence, using the RCI in this way, the change scores for the primary outcome measure in each clinical trial and for each patient was used to classify non-responders, which were dummy coded into a nominal variable (1 = yes, 0 = no). However, it should be noted that a RCI is usually calculated on the basis of a standard deviation unit of change equal to $z = 1.96$. Wise (2004) argued that this is a relatively conservative estimate, at least for investigating improvement and deterioration, proposing reliable change indexes that represents different confidence levels, i.e., $z = 1.28$ for a moderate change and $z = 0.84$ for a minor change. Although affecting the probability of rejecting the null hypothesis, $p = 0.10$ and 0.20, this could be useful for detecting less frequently occurring events, such as deterioration, or to make the boundaries of the RCI narrower, as in non-response (i.e., a smaller change score would be required to be classified as a responder, consequently affecting the non-response rate). Again, using the clinical trial IMÅ as an example, a change score of ± 6.62 is regarded as a reliable change for $z = 1.28$, and 4.94 for $z = 0.84$. In the current study, the non-response rates for each clinical trial and the total estimates are presented for each of the reliable change indexes in order to facilitate a comparison, while only $z = 1.96$ is applied for analyzing possible predictors as it should increase power. All of the non-response rates are based on data for patients receiving treatment and not some form of control condition.

To investigate possible predictors, binomial logistic regression was applied with the dichotomized coding of non-response (1 = yes, 0 = no) used as the dependent variable. All predictors were entered into the model in one single block as independent variables, as no prior evidence exist with regard to building the model. However, in terms of choosing what variables to enter, theoretical assumptions or empirical findings were used as guidance to avoid the risk of finding spurious associations and restrict the type-I-error rate (Stewart and Tierney, 2002). Hence, the same variables used for investigating the predictors of deterioration were implemented (Rozental et al., 2017): (1)

TABLE 1 | Sociodemographics variables of patients included in the individual patient data meta-analysis.

Variable	Treatment (n = 2,118)	Control (n = 748)	Full sample (n = 2,866)	Missing data
Gender: *n* (% female)	1299 (62.1)	501 (67)	1800 (63.4)[a]	27 (0.9)[b]
Age (years): M (*SD*)	38 (12.5)	40.6 (13.2)	38.7 (12.8)	29 (1)
Civil status: *n* (%)				744 (27)
Single	497 (33.5)	171 (28.1)	668 (31.9)	
Relationship	986 (66.5)	438 (71.9)	1424 (68.1)	
Children: *n* (% yes)	554 (53.4)	226 (59)	780 (55)	1,446 (50.5)
Cohabitant: *n* (% yes)	306 (66.5)	48 (69.6)	354 (12.4)	2,337 (81.5)
Highest educational level: *n* (%)				1,099 (38.3)
Elementary school	53 (4.5)	33 (5.7)	86 (4.9)	
High school/college	361 (30.5)	169 (28.9)	530 (30)	
University	757 (64)	380 (65.1)	1137 (64.3)	
Postgraduate	12 (1)	2 (0.3)	14 (0.8)	
Employment: *n* (%)				1,968 (68.7)
Unemployed	74 (10.8)	19 (9)	93 (10.4)	
Student	99 (14.4)	39 (18.6)	138 (15.4)	
Employed	469 (68.2)	138 (65.7)	607 (67.6)	
Other	13 (1.9)	11 (5.2)	24 (2.7)	
Retired	33 (4.8)	3 (1.4)	36 (4)	
Primary diagnosis: *n* (%)				88 (3.1)
Anxiety disorders	1,148 (55.8)	533 (74.1)	1681 (60.5)	
Generalized anxiety disorder	141 (6.8)	138 (19.2)	279 (10)	
Social anxiety disorder	708 (34.4)	257 (35.7)	965 (34.7)	
Anxiety disorder NOS	11 (0.5)	20 (2.8)	31 (1.1)	
Panic disorder (with/without agoraphobia)	86 (4.2)	30 (4.2)	116 (4.2)	
Posttraumatic stress disorder	32 (1.6)	32 (4.5)	64 (2.3)	
Anxiety disorder (with/without depression)	117 (5.7)	56 (7.8)	173 (6.2)	
Specific phobia	53 (2.6)	0 (0)	53 (1.9)	
Depression (with/without dysthymia)	475 (23.1)	69 (9.6)	544 (19.6)	
Other	436 (21.2)	117 (16.3)	553 (19.9)	
Erectile dysfunction	39 (1.9)	39 (5.4)	78 (2.8)	
Relationship problems	80 (3.9)	78 (10.8)	158 (5.7)	
Gambling disorder	317 (15.4)	0 (0)	317 (11.4)	
Sick leave: *n* (% yes)	42 (5.5)	25 (7.6)	67 (6.1)	1,768 (61.7)
Previous psychological treatment: *n* (% yes)	575 (54.1)	214 (56.5)	789 (54.7)	1,424 (49.7)
Previous or ongoing psychotropic medication: *n* (% yes)	366 (31.7)	156 (33.1)	522 (32.1)	1,239 (43.2)
Satisfaction with treatment: M (*SD*)[c]	2.9 (1)	n.a.	2.9 (1)	1,867 (88.2)[e]
Treatment credibility: M (*SD*)[d]	7 (2.4)	n.a.	7 (2.4)	1,535 (72.5)[e]
Modules completed: M (*SD*)[f]	6.5 (1.3)	n.a.	6.5 (1.3)	1,194 (56.4)[e]
Time per week: M (*SD*)[g]	3.6 (3.1)	n.a.	3.6 (3.1)	1,722 (81.3)[e]

n.a., not applicable; NOS, not otherwise specified.
[a] *Valid percent, i.e., percent of available data, excluding missing data.*
[b] *Percent, i.e., percent of complete dataset, including missing data.*
[c] *Self-rated 0–5.*
[d] *Self-rated 0–10.*
[e] *Based on patients receiving treatment.*
[f] *Weighted mean and standard deviation.*
[g] *Number of hours per week.*

symptom severity at baseline, (2) civil status, (3) age, (4) sick leave, (5) previous psychological treatment, (6) previous or ongoing psychotropic medication, (7) educational level, and (8) diagnosis. Two *post-hoc* and explorative variables were also entered: (9) gender, and (10) module completion. Both symptom severity at baseline and module completion, a proxy for homework adherence, have been put forward as predictors for non-response (Taylor et al., 2012). Meanwhile, albeit not specifically linked to non-response, male gender, lower age, and lower educational level have previously been shown to predict dropout in ICBT (Christensen et al., 2009; Waller and Gilbody, 2009; Karyotaki et al., 2015).

TABLE 2 | Test-retest reliabilities used for calculating the RCI.

Primary outcome	Test-retest reliability	Time period	Population	References
Beck Anxiety Inventory	$r = 0.81$	2 weeks	Normal	Saemundsson et al., 2011
Liebowitz Social Anxiety Scale—Self-Report	$r = 0.93$	8 weeks	Normal	Heeren et al., 2012
Panic Disorder Severity Scale—Self-Report	$\rho = 0.94$	2 days	Patient	Lee et al., 2009
Patient Health Questionnaire–9 Items	$r = 0.94$	2 weeks	Patient	Zuithoff et al., 2010
International Index of Erectile Functioning–5 Items[a]	$r = 0.84$	4 weeks	Patient	Rosen et al., 1997
Beck Depression Inventory	$r = 0.77$	[b]	Normal	Beck and Steer, 1996
Impact of Event Scale—Revised	$r = 0.89$-0.94[c] $M = 0.92$	6 months	Patient	Sundin and Horowitz, 2002
Generalized Anxiety Disorder–7 Items	ICC = 0.83	1 week	Patient	Spitzer et al., 2006
Penn State Worry Questionnaire	$r = 0.84$	3 weeks	Normal	Pallesen et al., 2006
Body Sensations Questionnaire	$r = 0.89$	3 months	Patient	Arrindell, 1993
Dyadic Adjustment Scale[a]	$r = 0.87$	2 weeks	Patient	Carey et al., 1993
Snake Anxiety Questionnaire	$r = 0.78$	1 month	Normal	Klorman et al., 1974
Montgomery-Åsberg Depression Rating Scale—Self-Report	ICC = 0.78	1 week	Patient	Fantino and Moore, 2009
Spider Phobia Questionnaire	$r = 0.94$	3 weeks	Normal	Muris and Merckelbach, 1996
The NORC Diagnostic Screen for Gambling Problems	$r = 0.98$–0.99[d] $M = 0.98$	1 week	Patient	Gerstein et al., 1999

RCI, reliable change index; NORC, a National Organization for Research at the University of Chicago.
[a] *Reversed scales, higher scores indicate less problems.*
[b] *Information regarding the time period was unavailable.*
[c] *Separate estimates for the two subscales.*
[d] *Lifetime test statistic and past year test statistic.*

Predictors with a $p < 0.05$ were regarded as significant and presented as Odds Ratios (OR) with their respective 95% Confidence Intervals (CI), reflecting an increase or decrease in odds of non-response in relation to a reference category. For instance, for dichotomous predictors such as sick leave, the OR reflects the adjustment in odds of non-response when the patient goes from not being on sick leave (no) to being on sick leave (yes). For the three predictors that were on continuous scales, that is, symptom severity at baseline, age, and module completion, the OR represents an increase of one standard deviation above their respective mean, i.e., these variables were standardized and centered within each clinical trial. All statistical analyses were performed using jamovi version 0.9.2.9 (Jamovi project, 2018), and on a complete case basis given that it is unclear how missing data should be treated when investigating non-response.

Ethical Considerations

The data in the current study were aggregated from several clinical trials, all with written informed consent, and all having received ethical approval from the Regional Ethical Review Board at their respective study location (please refer to the original articles for more information). The data included only the raw scores from various patient variables and no sensitive or qualitative information. Moreover, all patients were given an automatically assigned identification code in each clinical trial, e.g., abcd1234, making it impossible to identify a particular individual. In terms of the ethical issue related to the assessment of non-response in ICBT, the current study used only the raw scores from already completed clinical trials, making it impossible to, in hindsight, detect and help patients that may not have benefitted from treatment. However, because the aim of the current study is to explore the occurrence and possible predictors of non-response, future clinical trials may be better able to monitor and assist those patients who are not responding.

RESULTS

Study Characteristics

Data from 29 clinical trials were reviewed according to predefined inclusion and exclusion criteria and deemed eligible for the current study. Raw scores from all patients were then entered into the data matrix. In total, 2,118 (73.9%) had received treatment (ICBT). The following diagnoses were included (clinical trials, k): social anxiety disorder ($k = 9$), depression (with/without dysthymia; $k = 5$), generalized anxiety disorder ($k = 3$), anxiety disorder (with/without depression; $k = 3$), mixed anxiety disorders (e.g., panic disorder as well as social anxiety disorder; $k = 2$), specific phobia ($k = 2$), post-traumatic stress disorder ($k = 1$), panic disorder (with/without agoraphobia; $k = 1$), gambling disorder ($k = 1$), erectile dysfunction ($k = 1$), and relationship problems ($k = 1$). In terms of recruitment, self-referrals from the general population were most common, 27 clinical trials, but one was conducted in primary care, and another at a university clinic. With regard to screening interviews, the Structured Clinical Interview for DSM-IV-Axis I Disorders (First et al., 1997), was mostly applied, followed by four clinical trials that implemented either the MINI-International Neuropsychiatric Interview (Sheehan et al., 1998), or a diagnosis-specific instrument, e.g., Clinician-Administered PTSD Scale (Blake et al., 1995). The length of treatment ranged from four to 10 modules ($M = 8.28$; $SD = 1.36$), 4–12 weeks ($M = 8.45$; $SD = 1.66$), and two to 10 sessions ($M = 5.40$; $SD = 3.58$), with specific phobia being shortest, while various anxiety disorders and relationship problems were the longest. The total amount of

missing data for the primary outcome measures at post-treatment was 12.9%. For a complete overview of the clinical trials, please refer to **Table 3**.

Non-response Rates

Of the 2,118 patients, 567 (26.8%) were classified as non-responders when using a RCI of $z = 1.96$. In comparison, the numbers were a bit lower, 356 (16.8%) for $z = 1.28$, and a mere 239 (11.3%) for $z = 0.84$, indicating that the non-response rates vary depending on what reliable change indexes are being employed, each step being statistically significant, $\chi^2_{(2)} = 64.89$, $p < 0.05$, and $\chi^2_{(2)} = 27.57$, $p < 0.05$. The lowest rates of non-response ($z = 1.96$) can be found in clinical trials for gambling disorder (3.5%), specific phobia for snakes (7.6%), and depression (10.9%). Meanwhile, the highest rates were obtained in clinical trials on erectile dysfunction (74.4%), and anxiety disorders (with/without comorbid depression; 58.8 and 56.6%, respectively). See **Table 3** for an outline of the non-response rates in each clinical trial, sorted according the respective reliable change indexes.

Predictors of Non-response

A binomial logistic regression was performed with the predefined variables entered as predictors for non-response. The results can be seen in **Table 4**, together with their respective OR and 95% CI. Overall, the output seems to suggest that patients receiving treatment had increased odds of non-response if they had higher symptom severity on the primary outcome measure at baseline. Similarly, there were increased odds for not responding in treatment when having an anxiety disorder as compared to depression and other (erectile dysfunction, relationship problems, and gambling disorder), and if the patient was of male gender. None of the other variables were predictive of non-response.

DISCUSSION

The current study examined the occurrence of non-response in clinical trials of ICBT for three categories of problems including anxiety disorders, depression, and other (erectile dysfunction, relationship problems, and gambling disorder). In total, 2,118 patients in 29 clinical trials received treatment and were analyzed, indicating that 567 (26.8%) were classified as non-responders when using a RCI of $z = 1.96$, but fewer when implementing a narrower criterion, 356 (16.8%) for 1.28, and 239 (11.3%) for 0.84. This goes against the initial hypothesis of finding a similar estimate as the systematic review of CBT for anxiety disorders by Loerinc et al. (2015), which found an average response rate of 44.5%, indicating that non-response could be less frequent in ICBT. However, concluding that non-response is more common in CBT is highly speculative given that such numbers may not be possible to back-track, i.e., the opposite of response also includes patients who deteriorate. Thus, it would be more correct to compare it to attempts at determining non-response more directly. For example, Gyani et al. (2013) demonstrated that 29.0% did not respond among 19,395 patients receiving treatment within Improving Access to Psychological Therapies (IAPT) in the United Kingdom, with a majority undergoing CBT. Similarly, Firth et al. (2015) analyzed 6,111 patients from IAPT using the same method, demonstrating that 32–36% were classified as non-responders. Hence, at least according to these estimates, the rate obtained in the current study on ICBT closely resemble those for treatments delivered face-to-face, at least when using a RCI of $z = 1.96$. However, in these two cases a composite measure of non-response was in fact used, incorporating both the Patient Health Questionnaire-9 Items (PHQ-9; Löwe et al., 2004) and the Generalized Anxiety Disorder Assessment-7 Items (GAD-7; Spitzer et al., 2006). In addition, they also applied a predetermined cutoff for distinguishing responders from non-responders, which is quite different from using the RCI as it only sets one boundary, i.e., determining non-response based on having a treatment outcome *above* a certain threshold as compared to a change score *within* a particular range. In comparison, Hansen et al. (2002) used the RCI for the Outcome Questionnaire-45 (OQ-45; Lambert et al., 1996), i.e., "*no change*, meaning a patient's OQ-45 score had not changed reliably in any direction over the course of therapy" (p. 337), having a non-response rate of 56.8%. Meanwhile, Mechler and Holmqvist (2016) used the RCI in relation to the Clinical Outcomes in Routine Evaluation—Outcome Measure (Evans et al., 2002), with non-response rates being 61.2–66.6% (the range in the latter depending on whether patients were in primary care or a psychiatric outpatient unit). The number of patients not responding to treatment thus seems to vary greatly depending on how this is being classified, making it difficult to draw any definite conclusions on what estimates may be more accurate. This is especially true when different studies use different categories of treatment outcome, such as when improvement is also divided into improved and recovered, thereby obfuscating the results and making direct comparisons more complicated. In addition, it is important to keep in mind what population was explored. Patients in naturalistic settings may differ from those in clinical trials, where inclusion and exclusion criteria may prevent the most severe patients from being included, hence the much higher rates. The numbers from the current study should thus be interpreted cautiously and perhaps only be compared to patients who receive treatment in a tightly controlled research setting where the internal validity is increased and the samples highly selected.

As for ICBT more specifically, comparing non-response rates is difficult. Systematic reviews have not yet explicitly investigated the issue and clinical trials do not generally determine non-responders as a separate categorical outcome. However, a few exceptions exist. Boettcher et al. (2014b) found that 32.2% of the patients receiving CBT via the Internet for social anxiety disorder did not respond when analyzing the primary outcome measure and using the RCI with an intention-to-treat principle. Likewise, Probst et al. (2018) showed that in a treatment for tinnitus distress, 20.4% could be identified as non-responders (27.2% if using an intent-to-treat analysis where missing data was classified as non-response), although, in this case, a predetermined cutoff was utilized. Based only on these examples, findings from the current study seem to be similar, but it would be useful if future clinical trials reported non-response rates more regularly to facilitate systematic reviews.

TABLE 3 | Characteristics and non-response rates for the clinical trials included in the individual patient data meta-analysis.

Study	Recruitment	Screening interview	Primary diagnosis	Treatment (*n*)	Control (*n*)	Modules/weeks or sessions	Primary outcome	Additional outcomes	Non-response 1.96 *n* (%)	Non-response 1.28 *n* (%)	Non-response 0.84 *n* (%)
IMÅ (Boettcher et al., 2014a)	General population	SCID-I	Panic disorder, social anxiety disorder, generalized anxiety disorder, anxiety disorder NOS	Unguided mindfulness with FAQ (42)	Wait-list with discussion forum (46)	8 modules/8 weeks	BAI	BDI, QOLI, ISI	12 (28.6%)	8 (19.0%)	5 (11.9%)
ACT Smart (Lindner et al., 2013)	General population	SCID-I	Panic disorder, social anxiety disorder	Unguided ACT (48), guided ACT (48)	Wait-list (47)	8 modules/10 weeks	LSAS-SR, PDSS-SR[a]	PHQ-9, GAD-7, QOLI	36 (37.5%)	25 (26.0%)	17 (17.7%)
ACTUA (Nyström et al., 2017)	General population	SCID-I	Depression	Guided physical activity (164), guided behavioral activation (158)[b]	n.a.	8 modules/12 weeks	PHQ-9	GAD-7, QOLI[c]	35 (10.9%)	15 (4.7%)	15 (4.7%)
ADAM (Andersson et al., 2011)	General population	Semi-structured interview, IIEF-5	Erectile dysfunction	Guided CBT (39)	Wait-list with discussion forum (39)	7 modules/7 weeks	IIEF-5	IIEF, RAS, BDI, BAI	29 (74.4%)	22 (56.4%)	18 (46.2%)
Challenger (Boettcher et al., 2018)	General population	MINI	Social anxiety disorder	Unguided CBT with smartphone application (68), unguided bibliotherapy (70)	Wait-list (69)	9 modules/6 weeks	LSAS-SR	GAD-7, PHQ-9, QOLI, BBQ, Mini-SPIN	46 (33.3%)	26 (18.8%)	19 (13.8%)
Stella (Andersson et al., 2013a)	General population	SCID-I & II	Depression	Guided CBT (33), group therapy (36), guided CBT as preferred choice (16)	n.a.	8 modules/8 weeks, 8 sessions	BDI	MADRS-S, BAI, HAM-D, QOLI,	47 (55.3%)	34 (40.0%)	18 (21.2%)
Depressionshjälpen (Carlbring et al., 2013)	General population	SCID-I	Depression	Guided CBT (40)	Wait-list (40)	7 modules/8 weeks	BDI	MADRS-S, BAI, QOLI, WAI	13 (32.5%)	8 (20.0%)	7 (17.5%)
Tellus (Ivarsson et al., 2014)	General population	CAPS	Posttraumatic stress disorder	Guided CBT (31)	Wait-list with support (31)[d]	8 modules/8 weeks	IES-R	PDS, BDI, BAI, QOLI	6 (19.4%)	3 (9.7%)	3 (9.7%)
Klara (Vernmark et al., 2010)	General population	SCID-I	Depression	Guided CBT (29), guided CBT via email (30)	Wait-list (29)	7 modules/8 weeks	BDI	MADRS-S, BAI, QOLI	8 (13.6%)	7 (11.7%)	3 (5.1%)
Oroshjälpen (Dahlin et al., 2016)	General population	SCID-I	Generalized anxiety disorder	Guided ACT (52)	Wait-list (51)	7 modules/9 weeks	GAD-7	PSWQ, GAD-Q-IV, BAI, MADRS-S, PHQ-9, QOLI	14 (26.9%)	5 (9.6%)	3 (5.8%)
Nova 1 (Carlbring et al., 2011)	General population	SCID-I	Anxiety disorder with/without comorbid depression	Guided CBT (53)	n.a.	10 modules/10 weeks[e]	BAI	MADRS-S, CORE-OM, QOLI	30 (56.6%)	21 (39.6%)	13 (24.5%)
Nova 2 (Nordgren et al., 2014)	Primary care	SCID-I	Anxiety disorder with/without comorbid depression	Guided CBT (51)	Wait-list (50)	10 modules/10 weeks[f]	BAI	MADRS-S, CORE-OM, QOLI	30 (58.8%)	20 (39.2%)	10 (19.6%)

(Continued)

TABLE 3 | Continued

Study	Recruitment	Screening interview	Primary diagnosis	Treatment (*n*)	Control (*n*)	Modules/weeks or sessions	Primary outcome	Additional outcomes	Non-response 1.96 *n* (%)	Non-response 1.28 *n* (%)	Non-response 0.84 *n* (%)
Origo 1 (Almlöv et al., 2011)	General population	SCID-I	Generalized anxiety disorder	Guided CBT (44)	Wait-list (45)	8 modules/8 weeks	PSWQ	GAD-Q-IV, STAI, BAI, BDI, MADRS-S, QOLI	15 (34.1%)	10 (22.7%)	6 (13.6%)
Origo 2 (Andersson et al., 2012)	General population	SCID-I	Generalized anxiety disorder	Guided CBT (27)[g]	Wait-list (27)	8 modules/8 weeks	PSWQ	GADQ-IV, MADRS-S, BDI, BAI, STAI, QOLI	10 (37.0%)	10 (37.0%)	10 (37.0%)
Panik 2 (Carlbring et al., 2005)	General population	SCID-I, CIDI	Panic disorder	Guided CBT (25), face-to-face CBT (24)	n.a.	10 modules/10 weeks, 10 sessions	BSQ	ACQ, MI, BAI, BDI, QOLI	12 (24.5%)	5 (10.2%)	1 (2.0%)
Pia (unpublished)	General population	SCID-I	Relationship problems	Guided CBT (80)	Wait-list with discussion forum (78)	10 modules/10 weeks	DAS	MSI, BDI, BAI, QOLI	40 (50.0%)	25 (31.3%)	17 (21.3%)
Progredi, (Ström et al., 2013)	General population	SCID-I	Depression	Guided CBT with physical activity (24)	Wait-list (24)	9 modules/9 weeks	MADRS-S	BDI, BAI, QOLI[c]	7 (29.2%)	3 (12.5%)	1 (4.2%)
Fobal orm (Andersson et al., 2013b)	General population	SCID-I	Specific phobia	Guided CBT (13), face-to-face CBT (13)	n.a.	4 modules/4 weeks, 2 sessions[h]	SNAQ	ADIS, FSS, BAI, BDI	2 (7.6%)	1 (3.9%)	1 (3.9%)
Sofie 13 (Boettcher et al., 2013)	General population	SCID-I	Social anxiety disorder	Guided CBT with CBM (61), Guided CBT without CBM (65),	n.a.	9 modules/9 weeks[i]	LSAS-SR	SIAS, SPS, MADRS-S, QOLI	26 (20.6%)	12 (9.5%)	4 (3.2%)
Sofie 9 (Kuckertz et al., 2014)	General population	SCID-I & II	Social anxiety disorder	Guided CBT (40)	Attention bias modification (39)	9 modules/9 weeks	LSAS-SR	SIAS, SPS, SPSQ, BAI, MADRS-S, QOLI	9 (22.5%)	7 (17.5%)	3 (7.5%)
Sofie 12 (Dagöö et al., 2014)	General population	SCID-I, MINI	Social anxiety disorder	Guided CBT with smartphone application (24)[j]	n.a.	9 modules/9 weeks	LSAS-SR	[k]	6 (25.0%)	2 (8.3%)	1 (4.2%)
Sofie 1 (Andersson et al., 2006)	General population	SCID-I	Social anxiety disorder	Guided CBT (32)	Wait-list (32)	9 modules/9 weeks	LSAS-SR	SIAS, SPS, SPSQ, BAI, MADRS-S, QOLI	7 (21.9%)	4 (12.5%)	2 (6.3%)
Sofie 2 (Carlbring et al., 2007)	General population	SCID-I	Social anxiety disorder	Guided CBT (29)	Wait-list (28)	9 modules/9 weeks	LSAS-SR	SIAS, SPS, SPSQ, BAI, MADRS-S, QOLI,	10 (34.5%)	6 (20.7%)	4 (13.8%)
Sofie 3 (Tillfors et al., 2008)	Students	SCID-I	Social anxiety disorder	Guided CBT (19), guided CBT with group sessions (18)	n.a.	9 modules/9 weeks, 5 sessions	LSAS-SR	SIAS, SPS, SPSQ, BAI, MADR-S, QOLI	16 (43.2%)	12 (32.4%)	11 (29.7%)
Sofie 4 (Furmark et al., 2009)	General population	SCID-I & II	Social anxiety disorder	Guided CBT with discussion forum (40), unguided bibliotherapy (40)	Wait-list (40)	9 modules/9 weeks	LSAS-SR	SIAS, SPS, SPSQ, BAI, MADR-S, QOLI	34 (42.5%)	20 (25.0%)	12 (15.0%)

(Continued)

TABLE 3 | Continued

Study	Recruitment	Screening interview	Primary diagnosis	Treatment (*n*)	Control (*n*)	Modules/weeks or sessions	Primary outcome	Additional outcomes	Non-response 1.96 *n* (%)	Non-response 1.28 *n* (%)	Non-response 0.84 *n* (%)
Sofie 5 (Furmark et al., 2009)	General population	SCID I	Social anxiety disorder	Guided AR (29), guided CBT with discussion forum (29), unguided bibliotherapy (29), unguided bibliotherapy with discussion forum (28)	n.a.	9 modules/9 weeks	LSAS-SR	SIAS, SPS, SPSQ, BAI, MADR-S, QOLI	37 (32.2%)	21 (18.3%)	12 (10.4%)
Elsa (in preparation)	General population	SCID-I	Anxiety disorder with/without comorbid depression	Guided CBT (33)	Wait-list with support (33)	8 modules/8 weeks[l]	BAI	MADRS-S, CORE-OM, PHQ-9, GAD-7, QOLI	16 (48.5%)	12 (36.4%)	12 (36.4%)
Fobal spindel (Andersson et al., 2009)	General population	SCID-I	Specific phobia	Guided CBT (13), face-to-face CBT (14)	n.a.	5 modules/4 weeks, 2 sessions[h]	SPQ	ADIS, FSS, BAI, BDI	3 (11.1%)	1 (3.7%)	0 (0.0%)
Gamble (Carlbring et al., 2012)	General population	n.a.	Gambling disorder	Guided CBT with discussion forum (317)	n.a.	8 modules/8 weeks	NODS	HADS, QOLI	11 (3.5%)	11 (3.5%)	11 (3.5%)
Total non-response rates									567 (26.8%)	356 (16.8%)	239 (11.3%)

SCID-I, Structural Clinical Interview for DSM-IV Axis I Disorders; NOS, Not Otherwise Specified; FAQ, Frequently Asked Questions; BAI, Beck Anxiety Inventory; BDI, Beck Depression Inventory; QOLI, Quality of Life Inventory; ISI, Insomnia Severity Index; n.a., not applicable; ACT, Acceptance and Commitment Therapy; LSAS-SR, Liebowitz Social Anxiety Scale–Self-Report; PDSS-SR, Panic Disorder Severity Scale–Self-Report; PHQ-9, Patient Health Questionnaire–9 Items; GAD-7, Generalized Anxiety Disorder–7 Items; BA, Behavioral Activation; MADRS-S, Montgomery-Åsberg Depression Rating Scale–Self-Report; IIEF-5, International Index of Erectile Functioning–5 Items; CBT, Cognitive Behavior Therapy; IIEF, International Index of Erectile Functioning; RAS, Relationship Assessment Scale; MINI, The MINI-International Neuropsychiatric Interview; BBQ, Brunnsviken Brief Quality of Life Inventory; Mini-SPIN, Mini-Social Phobia Inventory; HAM-D, Hamilton Rating Scale for Depression; WAI, Working Alliance Inventory; CAPS, Clinician-administered PTSD Scale for DSM-IV; IES-R, Impact of Event Scale–Revised; PDS, Posttraumatic Diagnostic Scale; PSWQ, Penn State Worry Questionnaire; GAD-Q-IV, Generalized Anxiety Disorder Questionnaire; CORE-OM, Clinical Outcome in Routine Evaluation–Outcome Measure; STAI, State-Trait Anxiety Inventory; CIDI, Composite International Diagnostic Interview; ACQ, Agoraphobic Cognitions Questionnaire; BSQ, Body Sensations Questionnaire; MI, Mobility Inventory; DAS, Dyadic Adjustment Scale; MSI, Marital Status Inventory; SNAQ, Snake Anxiety Questionnaire; ADIS, Anxiety Disorders Interview Schedule; FSS, Fear Survey Schedule; CBM, Cognitive Bias Modification; SIAS, Social Interaction Anxiety Scale; SPS, Social Phobia Scale; SPSQ, Social Phobia Screening Questionnaire; AR, Applied Relaxation; SPQ, Spider Phobia Questionnaire; NODS, The NORC Diagnostic Screen for Gambling Problems.

[a] *Separate analyses of deterioration were conducted for the two primary outcome measures depending on the diagnosis of the patient.*

[b] *Four treatment conditions were included in the study, with/without treatment rationale, respectively, but are pooled in the current analysis.*

[c] *An additional outcome measure, International Physical Activity Questionnaire, IPAQ, was used in the study, but is not included in the current analysis.*

[d] *Passive control with the possibility to contact the research team if needed.*

[e] *Patients were able to choose ten out of 16 modules to be completed during ten weeks.*

[f] *Patients were able to choose ten out of 19 modules to be completed during ten weeks.*

[g] *An additional treatment group, guided psychodynamic therapy, was also used in the study, but is not included in the current analysis.*

[h] *One brief orientation session and one session of three-hour prolonged exposure.*

[i] *In addition to two weeks of CBM.*

[j] *An additional treatment group, interpersonal psychotherapy, was also used in the study, but is not included in the current analysis.*

[k] *Additional outcome measures were included in the original study but lost in the raw data file.*

[l] *Patients were able to complete up to eight modules selected by the therapist.*

TABLE 4 | Significance level, odds ratios, and 95% Confidence Intervals (CI) for predictors of non-response.

Predictor (reference)	*p*	OR	Lower CI	Upper CI
Symptom severity at baseline (lower severity)	<0.001	2.04	1.53	2.72
Diagnosis, anxiety disorders (depression and other)	<0.001	5.75	2.92	11.32
Module completion (fewer)	0.12	1.09	0.98	1.22
Civil status (single)	0.13	0.66	0.39	1.13
Gender (female)	0.03	1.80	1.05	3.10
Previous psychological treatment (no)	0.99	1.01	0.57	1.77
Previous or ongoing psychotropic medication (no)	0.08	1.72	0.94	3.14
Sick leave (no)	0.51	0.54	0.08	3.45
Educational level (below university level)	0.49	1.20	0.71	2.04
Age (lower age)	0.73	1.00	0.98	1.02

p, p-value; OR, odds ratio; CI, 95% confidence interval.

The current study also looked at how the application of different reliable change indexes affected the non-response rate, demonstrating a range of 15.5% between the widest and narrowest criterion. This approach was based on the recommendations by Wise (2004), contending that it can be useful to assess treatment outcome using different confidence levels: "…would be of considerable help in more accurately identifying and studying those who are not unequivocal treatment successes but who are nonetheless improving and on their way to a positive outcome as well as those who are not responding to treatment." (p. 56). However, this approach was primarily proposed for improvement and deterioration, while it is less clear if it should be applied to non-response. According to Loerinc et al. (2015), the RCI also seems to be one of the less frequently used classifications of non-response, with only one-third of the clinical trials using it in their systematic review. The results presented here are therefore tentative and need to be replicated, but they do warrant some caution as to how non-response rates are interpreted in the scientific literature (Taylor et al., 2012). Moreover, different reliable change indexes result in different rates of non-response, but what standard deviation unit of change might be most accurate depends on theory and reliability, i.e., is almost two standard deviations too broad a measure of non-response? Looking closer at one of the clinical trials included in the current study, Sofie 1, a change score within ±15.79 on the LSAS-SR (Liebowitz, 1987) classifies a patient as a non-responder when using a RCI of $z = 1.96$, but only 6.77 points for 0.84, thereby decreasing the non-response rate from 21.9 to 6.3%. More research is needed to explore what level is clinically meaningful, that is, when a statistically determined non-response is in fact seen as something negative by the patient. This could, for instance, include interviewing those who do not respond according to the RCI regarding their experiences of treatment, similar to the study by McElvaney and Timulak (2013) who addressed the issue of good and poor outcomes using a qualitative approach.

Lastly, the current study examined possible predictors of non-response in ICBT by entering a set of variables determined a priori into a binomial logistic regression. The results from this analysis suggest that patients with higher symptom severity on the primary outcome measure at baseline, having an anxiety disorder, and being of male gender might have higher odds of not responding in treatment. The fact that greater symptoms may be a predictor is not particularly surprising given that it implies more distress and potential comorbidity, similar to what was proposed by Taylor et al. (2012), which is also in line with the initial hypothesis. Higher symptom severity could also be a sign to extend the treatment period to achieve adequate treatment dosage for those patients who do not improve as expected (Stulz et al., 2013), which is seldom possible in clinical trials. As for anxiety disorders possibly being predictive of non-response, the evidence is less clear. No direct comparisons between diagnoses have previously been made for any treatment, making it difficult to evaluate if and why this would increase the odds for not responding. One idea is that non-response occurs more often among patients with anxiety disorders in ICBT because it is more difficult for a therapist to notice and adjust the treatment without a face-to-face contact (Bengtsson et al., 2015), such as when exposure exercises need to be tweaked to target the correct stimulus or more help is required to increase motivation. Meanwhile, treating depression via the Internet might be more straightforward for the patient and therefore less probable to result in non-response. However, these findings are among the first of its kind and need to be replicated before any definitive conclusions can be drawn. It should also be noted that the third category of diagnoses, other, only consisted of three randomized clinical trials. Still, both erectile dysfunction and relationship problems had among the highest rates of non-response in the current study (74.4 and 50%), which is similar to what was found for deterioration (Rozental et al., 2017), but gambling disorder did on the other not display the same pattern (3.5%). Further research is thus warranted to see if certain diagnoses are more likely to predict non-response in ICBT. Finally, none of the other hypotheses were confirmed, i.e., module completion, not being in a relationship, younger age, and having a lower educational level were not associated with higher odds of non-response. However, being of male gender could constitute a potential predictor, which is in line with the results by Karyotaki et al. (2015) indicating that men tend to drop out from ICBT. Here, a possible difference in coping strategies was proposed as an explanation, where women may put in more effort in trying to overcome their distress, thereby exhibiting a better compliance in treatment. If this somehow also explains the difference in non-response between the genders in ICBT remains to be seen. Yet it could be that male patients have different expectations of what the treatment entails, resulting in poorer response and dropout when these are not met, something that would be interesting to explore in the future via interviews.

Limitations

The current study is relatively unique in that it has explicitly investigated non-response in treatment and the first using individual patient data meta-analysis. This is considered a gold

standard for examining effects above those found by using group means and standard deviations, particularly in relation to discovering potential predictors (Simmonds et al., 2005). However, there are several limitations that need to be considered when interpreting the results. First, few similar examples exist in the scientific literature, making it somewhat difficult to interpret both the rates of non-response and its predictors, especially since there exists no consensus on how to define and classify patients who do not respond. The findings should therefore be interpreted cautiously and warrant replications, although they might help inform researchers of what estimates to expect and variables to explore (Clarke, 2005). Here, a particular caution should be made with regard to the OR's that have been provided, as they may be difficult to interpret and use clinically. In essence, they represent a probability of an event, similar to how odds are used in betting, but cannot be directly translated into a risk of something occurring in the future (Davies et al., 1998). Also, using binomial logistic regression in investigating predictors poses several challenges, such as how to deal with continuous scales, multicollinearity, and the assumptions regarding the relationship between the independent and dependent variables. Second, the current study consists of data from 29 clinical trials with 2,118 patients receiving treatment (2,866 in total), but the aggregation was not based on a systematic review, which could introduce different biases (Stewart and Tierney, 2002), e.g., availability bias and reviewer bias. However, the authors went to great length to ensure that all available data was used and set up predefined inclusion and exclusion criteria as a way of tackling these issues (Rozental et al., 2017). Nevertheless, this means that the results should be explored in additional context, particularly since the clinical trials included in the current study do not have to be representative of how ICBT is conducted in other settings. Third, the patients receiving treatment can be seen as characteristic of most examples of ICBT (Titov et al., 2010), but are nonetheless more often women, in their late thirties, and having a higher education level. However, compared to treatment face-to-face, this is not particularly uncommon either (Vessey and Howard, 1993), probably reflecting a greater tendency to seek help for mental health problems among this group. Still, it does limit the generalizability of the results, particularly in terms of finding predictors of non-response. Future research should thus include patients with a more heterogeneous sociodemographic background and who have not only been self-recruited to clinical trials. This problem is also relevant regarding the diagnoses that were analyzed. Albeit including a broad spectrum of conditions, some were over-represented, e.g., social anxiety disorder, while others were less represented or even lacking completely, e.g., post-traumatic stress disorder and obsessive-compulsive disorder. Depression and other (erectile dysfunction, relationship problems, and gambling disorder) were also re-categorized to balance out their proportions, which risks losing valuable information as to where the difference lies. Thus, it is probably premature to suggest that anxiety disorders constitute a predictor for non-response before a more comprehensive investigation has been made. Fourth, the implementation of the RCI as a way of determining non-response is not without criticism and should be seen as a major limitation. It is presently unclear whether it is the best way to identify those patients who do not respond in treatment, even if there exist a statistical rationale for its use. Furthermore, although the current study followed the recommendations by Edwards et al. (1978) on establishing valid test-retest reliabilities from the literature to calculate the RCI, most estimates relied on relatively short time periods, e.g., 2–4 weeks. This might be more relevant for assessing deterioration or improvement, but not for non-response which may need to take into account longer time frames to determine the natural fluctuation of a diagnosis. It could also be argued that the application of a cutoff or diagnostic criterion is more clinically relevant. However, those thresholds might be more useful in relation to response than non-response, i.e., defining when a patient goes from a clinical to a non-clinical population (Jacobson and Truax, 1991). Predefined numbers, such as being above a certain score, also tend to be arbitrary (Taylor et al., 2012). Still, the use of the RCI to assess non-response needs to be validated by other means. This can for instance be performed by checking if a non-responding patient still fulfills diagnostic criteria or a clinician-rating remains unchanged, e.g., the Clinical Global Impressions Scale (Busner and Targum, 2007). Non-response should also be explored in a direct comparison to deterioration and improvement in future systematic reviews. This is due to the fact that non-response is a quite heterogenous category that could include both those patients who fare worse and achieve some positive results, even though they are, statistically speaking, seen as non-responders. Lastly, the idea of non-response representing a negative effect is not clear and warrants further debate. Both Dimidjian and Hollon (2010) and Linden (2013) argued that it might prolong an ongoing condition and prevent the patient from seeking a more helpful treatment, but that it is also important to consider the normal fluctuations of many diagnoses. In most cases, lack of improvement would probably be regarded as a failure, at least by a clinician. On the other hand, with regard to more serious conditions, lack of improvement may not necessarily be equated with something detrimental for the patient, but rather a perfectly reasonable result, i.e., remaining at a certain level of functioning in chronic pain. Also, as discussed by Linden (2013), non-response does not have to be linked to treatment, but rather other circumstances that occur simultaneously. In sum, regarding non-response as a negative effect clearly needs a discussion that considers not only the approach to classifying patients as non-responders, but also a broader theoretical and philosophical perspective of treatment outcome.

CONCLUSIONS

Among 2,118 patients in 29 clinical trials receiving treatment, 567 (26.8%) were identified as non-responders in ICBT when applying a RCI of $z = 1.96$. This is somewhat in line with other investigations in the scientific literature, although the lack of consensus on how to define non-response make it difficult to compare the results. Meanwhile, possible predictors were explored using variables set a priori, indicating that patients with higher symptom severity on the primary outcome measure at baseline, having an anxiety disorder, and being of male gender could potentially have higher odds of not responding in ICBT.

However, additional research is required to replicate the findings and to determine how to best classify non-response in treatment.

DATA AVAILABILITY

The data that support the findings of this study are available from the corresponding author, [PC], upon reasonable request.

AUTHOR CONTRIBUTIONS

All the authors contributed in the process of completing the current study and writing the final manuscript. AR conducted the aggregation of raw scores into a single data matrix and completed the statistical analysis with input from GA and PC. AR drafted the first version of the text, while GA and PC provided feedback and reviewed and revised it.

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Successful and Less Successful Psychotherapies Compared: Three Therapists and Their Six Contrasting Cases

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Despite the general effectiveness of bona fide psychotherapies, the number of patients who deteriorate or fail to improve is still problematic. Furthermore, there is an increased awareness in the field that the therapists' individual skills make a significant contribution to the variance in outcome. While some therapists are generally more successful than others, most therapists have experienced both therapeutic success and failure in different cases. The aim of this case-series study was to deepen our understanding of what matters for the therapists' success in some cases, whereas other patients do not improve. How do the patients and their therapists make sense of and reflect on their therapy experiences in most successful and unsuccessful cases? Are there any distinctive features experienced by the participants at the outset of treatment? To explore these issues, we applied a mixed-method design. Trying to keep the therapist factor constant, we selected contrasting cases from the caseloads of three therapists, following the criterion of reliable and clinically significant symptom reduction or non-improvement at termination. Transcripts of 12 patient interviews and 12 therapist interviews (at baseline and at termination) were analyzed, applying inductive thematic analysis and the multiple-case comparison method. The comparisons within the three therapists' caseloads revealed that in the successful cases the patient and the therapist shared a common understanding of the presenting problems and the goals of therapy and experienced the therapeutic relationship as both supportive and challenging. Furthermore, the therapists adjusted their way of working to their patients' needs. In non-improved cases, the participants presented diverging views of the therapeutic process and outcome. The therapists described difficulties in the therapeutic collaboration but not how they dealt with obstacles. They tended to disregard their own role in the interactions and to explain difficulties as being caused by the nature of their patients' problems. This could indicate that the therapists had difficulty in reflecting on their own contributions, accepting feedback from their patients, and adjusting their work accordingly. These within-therapist differences indicate that taking a "third position" is most needed and seems to be most difficult, when early signs of a lack of therapeutic progress appear.

Keywords: unsuccessful treatments, non-improvement, negative processes, therapeutic relationship, patient and therapist perspective, outcome and process research, qualitative research methods, psychoanalytic psychotherapy

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INTRODUCTION

Most psychotherapy research focuses on the validation of treatment effects for patients with various psychological problems. However, psychotherapy is not always helpful. While the general effectiveness of bona fide psychotherapies is well established, the number of patients who fail to improve or even deteriorate is still problematic (Hansen et al., 2002; Lambert, 2007, 2011, 2013; Warren et al., 2010). Failure in psychotherapy is a complex topic, and the term has been used for a broad array of disparate unwanted effects, such as attrition, non-response, deterioration, adverse outcomes, harmful or iatrogenic effects, and side effects (Lilienfeld, 2007; Dimidjian and Hollon, 2010; Linden, 2013; Parry et al., 2016). Inadequate treatment choice, the patient's particular mental conditions, or the therapist's technical mistakes are typical variables related to unsuccessful and negative outcomes. In recent years, there has also been an increased awareness in the field that the therapists' individual skills make a significant contribution to the variance in outcome (Baldwin and Imel, 2013; Owen et al., 2015; Hill et al., 2017). While some therapists are generally more successful than others, most therapists have experienced both therapeutic success and failure in different cases (Okiishi et al., 2003; Wampold and Brown, 2005; Kraus et al., 2011; Baldwin and Imel, 2013). However, therapists often have difficulties in identifying their own shortcomings and are unfamiliar with the methods and criteria for identifying and preventing negative outcomes (Dimidjian and Hollon, 2010; Gold and Stricker, 2011; Hilsenroth et al., 2012; Kächele and Schachter, 2014). Accordingly, we need to learn more about within-therapist differences in order to understand what makes even well-trained psychotherapists fail in some cases (Merten and Krause, 2003; Baldwin and Imel, 2013). Recognition of treatment failures is a characteristic of good therapists and may significantly improve clinical outcomes (Hatfield et al., 2010; Linden, 2013; Budge, 2016).

To explore and test putative mechanisms of unsuccessful psychotherapies, we need both quantitative assessments and individual idiographic approaches (Barlow, 2010). These were attempts made early in the history of psychotherapy research. Bent et al. (1976) studied correlates of successful and unsuccessful psychotherapy and found that patients who were satisfied with therapy described their therapists as warmer, more likable, active, and involved than those who were less satisfied. Strupp's systematic comparison of contrasting cases demonstrated that therapeutic success was connected to the patient's ability to take advantage of the therapist's particular relational stance. He also found that the therapist might be able to adapt the relational style to the needs of some patients, but not others (Strupp, 1980a). In successful treatment, the patient could form a productive working relationship early in the therapy, whereas the patient's deep-seated characterological barriers gave rise to insurmountable barriers in the unsuccessful treatment (Strupp, 1980b). The therapeutic outcome was a function of the patient's character pathology in interaction with the therapist's ability to manage his or her own countertransference reactions (Strupp, 1980c).

Nowadays, decades later, research is slowly returning to the issue of contrasting outcomes, mostly confirming the early researchers' conclusions. Comparing a good and poor outcome case of psychoanalysis, Gazzillo et al. (2014) found striking differences in their therapeutic processes. In good outcome case, the patient could disclose and reflect about her experience of the therapeutic relationship. Her analyst was more oriented toward relatedness and could make active use of adequate interventions (such as clarifications and interpretations of conflicts, defenses, and transference). In poor outcome case, the analyst was not able to deepen the patient's understanding of her psychic life, and the analyst's interventions were general and not clearly enunciated. Hayes et al. (2015) found that countertransference reactions were evoked, in successful and unsuccessful cases alike, when therapists' unresolved personal and professional issues were activated by their perceptions of patient characteristics and behaviors. However, in successful, but not in unsuccessful cases, the therapists' countertransference management gave them new understanding of what was going on in therapy and allowed them to adjust their work to their patients' predicament. Accordingly, Schattner et al. (2017) compared two contrasting cases, and found, in the less successful case a clash between the patient's and the therapist's relational patterns, negatively impacting each of them. In more successful case, such hindrances were made explicit and negotiated, and the therapist could adapt in a flexible way to the patient's relational difficulties. Hjeltnes et al. (2018) compared young adult patients with the highest and lowest symptomatic changes after taking part in a mindfulness-based stress reduction program, confirming the importance of the match between the participants' preferences and needs and the treatment modality. The improved participants found the program to be helpful in moving toward an active stance of personal agency, whereas the less-improved participants had difficulties in understanding the treatment principles, which hindered them from finding new ways of dealing with their problems.

To conclude, regarding the psychotherapy process as a multifarious interaction involving the patient, therapist, and the specific therapy method can help us understand what can lead to improvement, stalemate, or deterioration. This might include such factors as the dynamics of the therapeutic relationship, the working alliance, rupture, and repair of collaboration (Safran et al., 2014); as well as the patient-therapist match and both participants' capacity to form a satisfying relationship (Zilcha-Mano, 2017). A more extensive and systematic review of relevant literature is beyond the scope of this discovery-oriented study.

Prompted by these issues, the present study aimed to examine why therapists were successful in some cases, whereas some of their other patients remained non-improved. How did the patients and their therapists make sense of and reflect on their therapy experiences in good outcome and poor outcome cases? Were there any distinctive features experienced by the participants at the outset of treatment? To explore these issues, we applied a mixed-method design.

While the definition of "successful" and "unsuccessful" outcomes in psychotherapy may vary depending on the specific research questions, study design, and the perspective of the researcher (Ogles, 2013), it may be argued that such outcomes

should involve a significant reduction in patients' self-reported distress levels (e.g., Goodyear et al., 2017). Therefore, we started by selecting contrasting cases, obtained from the same therapists, following the criterion of reliable and clinically significant symptom reduction or non-improvement at termination, thus controlling for the therapist effects. Next, we analyzed patient and therapist interviews concerning their experiences of psychotherapy, and we compared successful and less successful cases within each therapists' caseload and in toto. Knowing the outcomes at termination, the baseline interviews enabled us to investigate whether any particular differences were already observable early in the treatment.

MATERIALS AND METHODS

Setting

The present study uses archival data from the naturalistic, prospective Young Adults Psychotherapy Project (YAPP). Of the total of 134 patients (73% female; mean age = 22; range = 18–25; *SD* = 2.2), 92 were offered individual psychotherapy and 42 were offered group therapy at the former Institute of Psychotherapy, at that time a specialist unit within the publicly financed psychiatric care services in Stockholm County, Sweden. The patients reported low self-esteem (97%), conflicts in close relationships (66%), depressed mood (66%), and anxiety (55%) (Wiman and Werbart, 2002). Moreover, about one-third of the patients had personality disorders according to the *DSM-IV and ICD-10 Personality Questionnaire* (DIP-Q; Ottosson et al., 1998).

The open-ended psychotherapies in YAPP were aimed at overcoming developmental arrest and improving the patient's adaptive capacity. The mean duration of individual psychotherapies was 22.3 months (*SD* = 17.2; *Mdn* = 20; range = 0–85) with a frequency of one or two sessions per week. The non-manualized treatments were conducted by 34 psychoanalytically oriented therapists who met weekly in clinical teams to discuss clinical experiences and treatment problems. Treatment outcomes were studied at termination, after 1.5 years, and at a three-year follow-up (Philips et al., 2006; Lindgren et al., 2010).

Categorization of Outcomes and Inclusion of Cases

Trying to keep the therapist factor constant, we selected contrasting cases from the caseloads of three therapists. As we wanted to explore the experiences of the most improved and least improved patients and their therapists, we followed the procedure of extreme or deviant case sampling (outlier strategy; Teddlie and Yu, 2007). The categorization of outcomes was based on the Global Severity Index (GSI) of the Symptom Checklist-90-R (Derogatis, 1994). To be regarded as a "successful case," the patient had to belong to the clinical range at baseline and to the functional distribution at termination. Moreover, the improvement had to be statistically reliable, according to Jacobson and Truax's (1991) criteria. We defined "less successful cases" as patients in the clinical range at baseline who lacked reliable improvement or were reliably deteriorated at termination. As the distribution of the clinical and the functional population overlapped, we calculated the cut-off (0.90) following the criterion "c" and comparing the pretreatment YAPP sample to Swedish norms.

Reliable change (RC) was achieved if the reliable change index (RCI; based on the difference between two time points divided by the standard error of difference) was equal to or larger than 1.96 ($p < 0.05$). For clinically significant improvement (CI), the patients had to achieve both RC and move out of the clinical distribution into the functional distribution. RCI above 1.96 was regarded as deterioration. Seventy patients (80.5%) belonged to the clinical range at baseline; 29 of them showed CI and two RC only at termination, while 20 patients had no RC and three had deteriorated (missing outcome data in 16 cases).

Of the 34 therapists in YAPP, two had only patients who never started therapy after the initial contact, seven therapists had one patient each, and 25 therapists had more than one patient (range = 2–7; *Mdn* = 3). In the latter group, eight therapists had only patients with clinically significant improvement, a further eight had only non-improved patients, whereas nine therapists had both clinically significant improved and non-improved patients. In six cases, some of the patient or therapist interviews were missing. Thus, three therapists with two patients each could be included in the present study (**Figure 1**). One of these therapists had one further patient with CI and one with reliable deterioration; another therapist had one further patient with CI and three patients with no reliable change. In these two cases, we selected the treatments with the largest difference in outcome.

Participants

The three highly experienced therapists (called A, B, and C) had between 9 and 13 years of experience after being licensed. There were two social workers and one psychiatrist; two were female and one male, aged 50–60 years. Their respective patients have been given names with the corresponding initial letters, ending "y" indicating clinically significant improvement and "n" indicating non-improvement. All the six patients were female and between 18 and 25 years old at baseline. Their axis I DSM-IV-TR diagnoses (American Psychiatric Association, 2000) were major depressive disorder and dysthymia, and their axis II diagnoses were borderline, avoidant, depressive, and not other specified personality disorders. The three patients with clinically significant improvement, but not the three non-improved patients had previous psychotherapy experience.

Interviews

All patients and their therapists in YAPP were interviewed at baseline (shortly after the initial consultative sessions) and at termination (close to the last therapy session). Thus, the present study is based on 24 interviews. The semi-structured *Private Theories Interview* (PTI; Werbart and Levander, 2006) is aimed at collecting narratives, concrete examples, and illustrative episodes concerning the patient's complaints and their

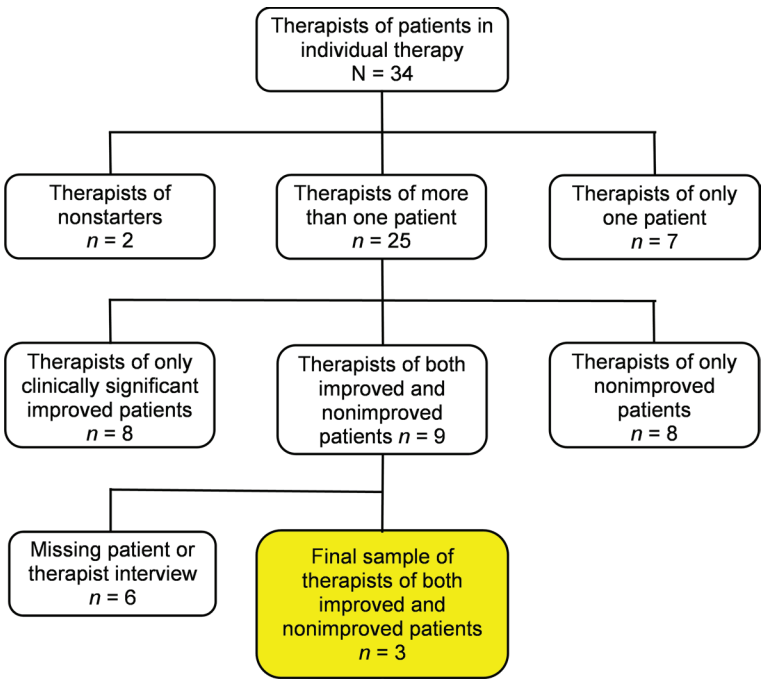

FIGURE 1 | Flow chart from the initial sample of therapists in YAPP to the final sample of therapists of both clinically significant improved and non-improved patients.

background, ideas of cure, descriptions of changes, and what fostered or hindered improvement. This interview technique is designed to elicit the informant's own, open-minded thinking and reduce the influence of the interviewer's construction of meaning. Furthermore, two questions from the *Object Relations Inventory* (ORI; Diamond et al., 1990; Huprich et al., 2016) were included: "Please give a description of yourself" and "of your therapist" (patient interviews), and "Please give a description of your patient" and "of yourself as just that particular patient's therapist" (therapist interviews). Upon the spontaneous response, the interviewer encouraged elaboration on each adjective or descriptive phrase, for example, "You said *confused*?" The patients were interviewed by trained clinicians and the therapists by researchers. The audio-recorded interviews lasted about 60 min.

Qualitative Analysis

Based on the verbatim interview transcripts, we conducted systematic case studies, applying the multiple-case comparison method (McLeod and Elliott, 2011; Yin, 2018) and inductive, experiential thematic analysis (Braun and Clarke, 2006). The case-series methodology enables in-depth examination of cases within their real-life context and of similarities and differences between cases. Experiential thematic analysis is concerned with how people experience and make sense of their life world. Our step-by-step procedure was inductive, as it was grounded in the data and not shaped by pre-existing hypotheses or theories. Moreover, it was explanatory as it involved the researchers' interpretative activity.

1. The interview transcripts were read line by line. After a first perusal, all relevant sections and paragraphs in each interview were sorted into relevant thematic domains, corresponding to our research questions: the participants' view of early treatment (inclusive of the patient's problems and initial ideas of cure), experienced outcomes, retrospective view of psychotherapy, and of the therapeutic relationship.
2. Each interview transcript was coded separately. Similar statements within each domain were clustered into "tailor-made" condensates of central themes that were formulated to be closely related to the participant's own wording, without interpretation.
3. These condensates were elaborated into narrative accounts, outlining the meanings inherent in each participant's experience. Here, the thematic domains were explained and nuanced, exemplified by verbatim quotations from the interview transcripts.
4. The contrasting cases of each therapist were compared with each other within each thematic domain. The similarities and differences between the patient's and the therapist's narratives were scrutinized.
5. Finally, we compared the three successful and the three less successful psychotherapies.

The analysis was carried out independently by the second and third authors as a part of their master thesis for a five-year psychology program. In the three first stages of data analysis, the coders were blind to the outcomes of psychotherapy. The narrative accounts and comparisons were audited and revised by the first author, a male psychoanalyst and senior psychotherapy researcher. The authors discussed differences in opinions in relation to the original textual data until consensus was reached.

RESULTS

We start by presenting the three therapists' contrasting cases from the viewpoint of the patient and the therapist. We then move on to compare each therapist's successful and less successful case. Finally, we look at what was common for the three successful and the three less successful treatments.

Therapist A

A's patient Ally showed clinically significant symptom reduction after ca. 4 years of therapy once or twice a week, whereas Ann was non-improved at the termination of her less than 1 year's once weekly therapy.

Ally's View of Psychotherapy With A

At baseline, Ally said that she was depressed and pondered immensely. She had knocked about a lot, which she thought was hard—when her circumstances had become a safe spot in her life, she had to change them. She thought it might help to talk about and understand more of the relationship with her dad, but she was worried about not getting help, as her previous treatment did not help.

At termination, Ally described feeling much better, and she relied on her ability to resolve her remaining problems. She was very satisfied with the therapy and felt great confidence in A, even if ending the therapy was tough. It was helpful that the therapy went on for a long time that she dared to open up and that A had always been there. A became an important guide who helped Ally to think differently, and they could laugh together. Sometimes A could be distant, but Ally thought that the therapeutic relationship by its nature includes distance.

> ... at first I felt so astonished at her being so quiet. Was it only me who had to talk? I did not know how it was to be in therapy. I thought … it's different for different people, but I had expected her to talk more. But I had to get used to this, and afterwards or after a while I was content with this. (Termination)

A's View of Psychotherapy With Ally

A said at baseline that Ally had an unsettled life and felt lost, and she hoped that therapy could provide a firm ground for Ally. A was unsure of how Ally's problems manifested themselves in her everyday life, and A was unsure of Ally's endurance and expectations for psychotherapy. They had talked about whether Ally was prepared for regular sessions and how therapy works. Ally expected A to be more active, but she said that it might be useful in the way A described therapy. From the outset, they started to work with Ally's maternal transference and A was pleased with Ally being so involved in that work. A described herself as focused on understanding, listening, not being too motherly, and partially holding back her concern, as Ally was on the point of freeing herself from her mother.

At termination, A said that she felt a strong interest in and really liked Ally, which she believed contributed to the improvement. She allowed herself to feel maternal affection, and it was very exciting and rewarding to work with Ally. Initially, A did not understand the extent of Ally's problem and it was difficult to establish a bond. Ally had a tough time, as she was unfamiliar with the situation. After half a year in therapy, they had a crisis, as Ally thought it was hard to focus so much on her problems, and it was a real eye-opener for A. A began to ask for positive memories, and that became a turning point in their relationship.

> I thought I changed, becoming more active. I thought I had been active right from the beginning trying to get her started a little more, her own thinking, etc. But I became more supportive and encouraging after this crisis following my—as I also felt—a rather insensitive intervention, which she experienced as criticism. (Termination)

Ann's View of Psychotherapy With A

At baseline, Ann said that she made high demands of herself and had difficulty feeling she was good enough, especially with boys. Rationally, she could understand that she was just as good as anyone else, and she believed that others perceived her as happy and confident. One of her problems was pondering too much. Perhaps it might help to talk to someone, but it was the pondering she had to change. She knew it would help if she did not make such heavy demands on herself, and it also could help a little to meet a boy.

At termination, Ann said that her problems remained, even if therapy had been a bit helpful. She did not want to be critical, but it was not the right therapy for her, and she did not know if it was due to the method or to A. She knew she had to address her problems but she did not get that help in therapy.

> ... but I have pondered so much on my problems and my relationship with dad and men and myself so I would gladly accept some more advice on how to think. (Termination)

It was hard that A was so silent, and Ann felt that it was entirely up to her to bring the conversation forward. She got the feeling that A did not know what Ann's goals in therapy were and she was also doubtful whether A had any of her own goals. Ann perceived A as kind-hearted, but a little meek, awkward, and unsure.

A's View of Psychotherapy With Ann

At baseline, A described jealousy as Ann's core problem and she wondered if there was something Oedipal in her relationship with her dad. A believed it could be helpful for Ann to talk over her problems.

> ... she is very reflective herself, this girl, but I think she needs someone listening to her, someone mirroring this, an adult not involved in her sphere. (Baseline)

A perceived Ann as well motivated but having unrealistic ideas of therapy. They had talked a lot about this, including how much support she needed and how fast it would work. Intellectualization was a possible obstacle, as Ann herself said she pondered a lot, but her pondering was filled with emotions, thus indicating an opening. As Ann's therapist, A described herself as listening, understanding, and adopting a wait-and-see policy.

At termination, A reported that Ann had chosen to prematurely end the therapy. One contributing factor may have been that Ann's pain and motivation decreased when she met a new boyfriend. Furthermore, it may have been important that Ann wanted more advice, feedback, and quick results and was considering cognitive therapy. A had never given direct advice, but she tried to find a balance between giving and playing back to Ann to make her think herself. Ann missed a good number of sessions, which made it difficult to deepen their work. Her low self-esteem also emerged in their relationship, but they could not talk about it. As Ann's therapist, A listened a lot with a keen ear and tried to think about the transference. In future, there would be a risk of Ann feeling bad again, but A believed in Ann's capabilities.

Comparison of A's Two Cases

Early in Treatment

Ally and A had more convergent views of her problems and of what could be helpful, thus facilitating their subsequent work. Ann expressly wanted more than talking, as she thought her pondering was an obstacle, whereas A believed that talking over Ann's jealousy would be helpful. In both cases, A stressed the importance of listening, mirroring, and firm therapeutic boundaries. However, in case of Ally, A was keen on not being too motherly and concerned, whereas in case of Ann, A wanted to be cautious and maintain a wait-and-see attitude. A described early in-session enactments of Ally's problems and Ally's active contributions to the resolution. They talked about their different ideas about A's activity in treatment, and they were able to come to an agreement. Even Ann and A had talked about their divergent ideas of therapy; however, neither of them mentioned what their talking led to. Furthermore, A described more feelings and stronger initial involvement in the case of Ally than with Ann.

Experienced Outcomes

At termination, Ally and A had a more convergent view of changes and described the treatment as successful, whereas both Ann and A described the treatment as unsuccessful. Ally was very satisfied with her therapy and was confident in doing well on her own, whereas Ann felt that her core problems remained and she wanted to find an alternative way. A believed in Ally's ability to cope with future stress. In case of Ann, A's view of the outcome was vaguer and more contradictory; she noticed limitations in their work and was hesitant about whether Ann could deal with her remaining problems but believed in her resources.

Retrospective Views of Psychotherapy

Also, the views of what was going on in therapy were more similar in the case of Ally and A. A common theme in both patients' narratives was A's degree of activity and silence, but they experienced it in different ways. Ally felt that she profited a lot from their work, even though she initially wondered about A's silence and even though ending therapy was tough. Ann was dissatisfied with the therapeutic approach and with A; too much was left to Ann. A experienced her work with Ally as exciting and rewarding, whereas in case of Ann, it was difficult to deepen the contact. A gave several concrete examples of her work with Ally, whereas she focused on what was impossible to work through with Ann. Productive work with Ally's maternal transference could start early on, whereas A's thoughts about Ann's (paternal) transference did not seem to result in any joint exploration. A significant turning point in therapy with Ally was a crisis in their collaboration and its resolution, when A gained a new understanding of how Ally experienced her interventions and adjusted her technique accordingly. Furthermore, A described how her view of Ally evolved throughout the treatment, whereas she did not mention such developments in case of Ann. A knew that Ann wanted more advice and feedback, but she did not reflect in her interview on confronting Ann with their incompatible views or adjusting her approach. Instead of ruptures and resolutions, Ann missed several sessions and initiated premature termination.

Therapeutic Relationship

Ally felt great confidence in A; A cared for her, and there was space for humor. They also seemed to have done some work on difficulties in separating and in ending therapy. Even though Ann mentioned that A probably cared for her, she described A in negative terms and she emphasized their poor match. A described her maternal feelings, personal involvement, and own gains in her relationship with Ally, whereas her relationship with Ann was more distanced and marked by insecurity.

Therapist B

B's patient Bonny showed clinically significant symptom reduction at termination of her more than two and half year's twice weekly therapy, whereas Brynn was reliably deteriorated in terms of symptom severity after 4 years in twice weekly therapy.

Bonny's View of Psychotherapy With B

Bonny described at baseline that she was depressed, on sick leave and taking antidepressant medication. She was ashamed of her parents, and she believed that their big problems had given rise to hers. Consequently, she never allowed herself to have a boyfriend, never let others get close to her, and she felt incredibly lonely. She wanted to regain her self-esteem, to work on her relationship with her parents, and to move on. She was aware that she had barriers hindering her from really telling everything in therapy.

> I am just so afraid of not getting any help. Because I didn't get it earlier in my life … it feels like connected

> with the fact that I never felt understood, like it does not matter how many times I am sitting here and telling things about myself, because it feels like no one can understand how I feel it anyway. (Baseline)

At termination, Bonny felt much better and did not have any problems. She believed both the therapy and her everyday life contributed to improvements. She was satisfied with her therapy; it was good to talk over her thoughts with B. Nevertheless, she wished B was more like a mother and gave her advice. Bonny had confidence in B and that B cared for her; often she felt relieved after sessions. However, it was difficult to speak out and maybe she had not done it yet. Bonny described B as considerate, understanding and helpful; they could have fun together.

B's View of Psychotherapy With Bonny

B thought at baseline it was strange that Bonny had done so well despite her parents' major shortcomings. Now she had broken down, and B was very worried about her. B hoped therapy could be a safe place and help Bonny get to her feet again. Perhaps she overestimated this prospect and was uncertain if Bonny would continue in therapy. Bonny had a very negative view of adults; she was hostile and suspicious and tried to manipulate B to abandon her therapist role.

> … when I presented her case to our team, I could understand that she, in a way, recreated with me a climate where it was very difficult to feel empathy for her, to feel commitment. So she wants help and at the same time she is counteracting it. (Baseline)

This understanding helped B, and thenceforth a challenge was to create a confiding relationship. B had to be extra careful and educative about therapy, about therapeutic boundaries, and what she could expect from Bonny. She could understand that Bonny wanted to know who B was and if she could help her. Bonny's reaction to B's recently cancelled session was a good sign, as it showed she could express her anger. B thought she had to be patient and endure challenges, but she was also impressed by Bonny being so open with her fantasies.

At termination, B believed it had been helpful for Bonny to meet a sensible adult who allowed Bonny's needs to guide their work, even though Bonny also had to wrestle with B being an adult. Bonny progressed from having a lot of contempt to being increasingly open with B. B referred to several helpful interpretations, for example, when she addressed Bonny's distrust. It was helpful not only to be explicit with the boundaries but also to be flexible when required, and to develop a close, trusting mutual relationship, where Bonny could fill up the gaps and go in search. Love in the therapeutic relationship was also important, as well as shared humor.

Brynn's View of Psychotherapy With B

At baseline, Brynn complained that she had lost her curiosity. She was stuck in her thoughts, had difficulty focusing, and thought she behaved badly and nastily. She had been going downhill for a long time, acting in a way that did her harm. Her relationship with her family was complicated, and she blamed them for her problems; they helped her too much, and she became incapable. Her relationship with her boyfriend was in a muddle; both were unfaithful, and Brynn did not know why she was with him. She has had sex with many guys, even those she did not want, and she felt it had ruined her. Brynn wanted help to remove focus from herself and from thinking so much. She wanted to cleanse herself to be able to move on.

At termination, Brynn said that her problems remained, and she was feeling worse. She believed therapy had contributed to the deterioration, and she did not agree with B that it was a pity to stop. She did not trust B because of things she said.

> She also said once that I am a whore, but she said she did not, so I told her I must be very seriously ill if I hear voices… and she said it does not belong to her vocabulary, possibly "promiscuous." And the second time, she was just quiet, but when I picked this up again three weeks later she said she had not said that either. I mean I could not get these two great things all wrong. (Termination)

B was distant, and Brynn wondered if B really cared for her. Sometimes Brynn saw emptiness in B's eyes, and there was no closeness. She had repeatedly claimed she needed more support, but it was like B did not understand. Brynn wanted more of a dialogue, more structure in their conversations, as she often talked about unnecessary things. She was stuck in old patterns and wanted help to move ahead. Brynn did not want to blame B, but she believed B had her own problems.

B's View of Psychotherapy With Brynn

B described at baseline that Brynn avoided taking responsibility and laid the blame for her problems outside herself. Her parents had failed in their responsibility and allowed Brynn to play around, without providing a "holding environment" and without setting limits. B saw Brynn as both strong and at a breaking point; she was worried that Brynn was in big trouble. Brynn needed help daring to trust others and to see that she had value. B wanted to be the one that Brynn had missed, "holding" Brynn and at the same time setting limits, which would be difficult. There was a connection very early between them, although it was uncertain whether Brynn trusted B. As Brynn's therapist, B described herself as curious and moved.

At termination, B experienced Brynn's decision to end the therapy as an unfortunate tragedy, because they had just started to come closer to each other. Brynn acted as in other relationships, she destroyed. B also wondered if her sick leaves had made Brynn worried that B would leave for good, so that Brynn felt forced to break up. They had done a good preparatory job, and it would be good if Brynn could resume therapy. Initially, B had difficulty getting space to say something, but it became more of a dialogue and closeness developed.

> Our relationship changed over time in a noticeable way, toward an increased closeness. But when it became too close I could see how she actually turned against me by saying that she had started to analyze me and she claimed "how can you say that I'm a whore," for example. I mean there were such strains of paranoia, it sneaked into the room and was impossible to deal with; it could not be interpreted or talked about, and this was escalating. (Termination)

It was sad that Brynn felt such distrust, but B thought they still had a sustainable and loving relationship. B believed Brynn wanted more support and advice than she received. B found it hard to tell about this therapy; the sessions had often been fragmented and confusing. B had to fight; this therapy required both immense presence and containing. Brynn was the one who had affected her most in 30 years.

Comparison of B's Two Cases

Early in Treatment

In both therapeutic dyads, the participants described the patient's life circumstances in a similar way and the therapist expressed her great concern. However, B elaborated and provided a contextualized conceptualization of Bonny's problems, whereas she repeatedly questioned Brynn's view and interpreted what Brynn told her in a different way. As to their initial ideas of cure, Bonny and B were more in accord. Bonny expressed her hope that the therapy might help her, and B had clear ideas of her stance working with Bonny—it would be necessary to work in a way she usually did not and to adjust her approach to Bonny. By contrast, B's ideas were more general in the case of Brynn—she wanted to compensate Brynn for parental failures rather than adjusting herself to the patient. B did not mention Brynn's most important goal, getting help in being less self-focused and in pondering less, and to cleanse herself. B described an early and loaded situation when she and Bonny had to talk about what Bonny could expect in therapy, and she expressed her understanding of Bonny's emotional reactions in sessions. In case of Brynn, B thought it would be difficult to give her what she lacked. B expressed both her insecurity and an awareness of challenges in the work with Bonny, whereas she seemed to be more confident in the case of Brynn, without being specific about her tasks.

Experienced Outcomes

At termination, both Bonny and B described the treatment as successful. Brynn described her therapy as a failure, whereas B thought they had just started fruitful work. B was more confident of positive changes and what contributed to them in the case of Bonny, whereas her picture of Brynn's outcome was more inconsistent—it was good preparatory work, which B described in a similar way as in the baseline interview.

Retrospective Views of Psychotherapy

Bonny and B had convergent views of their joint work, whereas Brynn's and B's views were incompatible. Bonny presented a positive picture of her therapy and B, although she also mentioned what she had lacked. Brynn, on the other hand, was upset talking about her therapy, giving many examples of what gave rise to her dissatisfaction and what she would like to have instead. B described how she and Bonny could work at overcoming obstacles and how her interpretations could be helpful, whereas this was impossible with Brynn—B felt overwhelmed with things that just happened.

Therapeutic Relationship

Likewise, the pictures of the therapeutic relationship were similar in the case of Bonny and contradictory in the case of Brynn. Both Bonny and B described their deep relationship with for a shared sense of humor. Brynn experienced distance and emptiness, instead of the closeness and mutuality described by B. With both patients, B mentioned love in the therapeutic relationship; however, there was a difference in how involved B was with her patients—Brynn was the one who had affected her most in her career.

Therapist C

C's patient Cindy showed clinically significant symptom reduction at termination of her 19 one and half year's once-a-week therapy, whereas Caitlin remained unchanged in terms of symptom severity after less than 2 years in once or twice weekly therapy.

Cindy's View of Psychotherapy With C

Cindy said at baseline that she felt depressed, unsure, and without a consistent identity. Instead, she was putting up a harsh façade and setting high goals. She could not let anybody get closer to her, as she knew that losses hurt. Cindy thought she tried to be perfect to gain control of the situation in her childhood, when both her parents were sick and her father died. However, she had difficulty remembering her childhood, which she thought was a defense mechanism. She had been in therapy before, which did not help, and now she had to try risking failure. She wanted help to feel normal, to gain better self-esteem, to be able to maintain close relationships, and to find less demanding things to do. A positive change started prior to therapy when her boyfriend found a way to get close to her, as no one had been before.

At termination, much had improved, and the problems were small. It was helpful to talk and think about certain things, which gave understanding and insight into what she wanted. Occasionally, she felt worse, and the silence was tough, but she could get on with things without being forced.

> We could sit silently for fifteen minutes maybe, because I refused to start talking, but C did not start either. Then he could say just *hmm*, and I said *hmm*, and then we waited for me to think of something, because sometimes it felt like my head was completely empty. But he was convinced that in psychotherapy you should talk yourself … I had to associate freely; he was very stubborn, not leading me in any direction. (Termination)

Much in her life became more stable, which also helped her feel better. Cindy experienced C as patient, persistent, and helpful, not controlling the conversation. Cindy was afraid of deterioration and of not being able to get along without therapy, but hopefully, it would go well.

C's View of Psychotherapy With Cindy

At baseline, C described Cindy's background as traumatic. In addition to the parents' illnesses, he also mentioned other possible traumas, but Cindy did not pick up on this. In therapy, Cindy needed to get in touch with her feelings. She was already on her way, feeling more pleasure in things and less pressure. She was likable, keen, and could put her foot down. She used strong defenses, such as intellectualization, and silence in therapy made her unsure. As Cindy's therapist, C was understanding, empathetic, and committed.

At termination, C thought that talking about traumas that eventually came up was most helpful. Cindy seemed to deteriorate for a while and was critical and lacking confidence for a long time, but this changed. C had to resist Cindy's vehement attacks on him and the therapy. A turning point was when he realized how unhappy she was, and prolonged therapy. This, along with him not flinching from talking about trauma, fostered her confidence.

> When she talked about what she was exposed to and then did not want to talk more about it, anyhow, I forced her to come back by saying that this is important, you need to talk about this if anything is to happen, if there is any meaning to this. (Termination)

When Cindy was offended by something he said he could handle it. He had not only interpreted psychoanalytically but also used positive reframing, which had a good effect. At termination, Cindy remained skeptical of the method but still satisfied. The improvement seemed to be lasting, and Cindy had great potential to cope with new stresses.

Caitlin's View of Psychotherapy With C

At baseline, Caitlin talked about a turbulent relationship with a woman, and she thought she lacked a clear sexual identity. She was unsure; she adapted to others and put them on a pedestal. Another problem was that she easily got embarrassed, had trouble meeting people, and shut herself up. She easily became absorbed by problems instead of dealing with them. She had few childhood memories, and there were things she did not dare to think about. In therapy, Caitlin wanted to reclaim and understand herself better.

At termination, many of her problems remained unchanged, but there were some improvements. She got help to discover her repetitive patterns, turn negative perspectives into positive ones, and mourn her relationship with the woman. It was helpful to have had someone by her side; she could come out with her opinions and sorrows, even though she did not tell everything.

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

Ending therapy was hard at first because she felt nothing had happened, but later on, she took the view that she could talk in therapy without making changes and would be able to continue on her own with her new tools. Caitlin thought that the improvement was partly due to the passage of time and that she might improve even without therapy. Sometimes she felt that the therapy was disturbing rather than helpful, and she became more self-focused than she wanted. She described C as calm, confident, amusing, and perspicacious; he made her feel seen, but owing to her fear of conflict, she could not say anything negative about him. The sessions were never tough, but on occasion, she had been angry at him without expressing it, for example, when he asked about change, whereas she wanted to grumble.

C's View of Psychotherapy With Caitlin

At baseline, C said that he knew only a little about Caitlin's background and nothing about any trauma, but he had an idea that her parents influenced her identity development. Caitlin had difficulty showing anger, and she would be helped by acting out her feelings and finding her identity. Outside therapy, she had to sort out her relationship with the woman and finish her studies. Caitlin was nice, and C wondered if she idealized and tried to please him. She talked a lot and sometimes needed to be stopped. C said it was difficult to describe himself as Caitlin's therapist, but he tried to listen, understand, and confront her in a sympathetic way.

At termination, C said they prolonged the therapy by 1 year and he thought she still needed more therapy. However, without a time limit she would keep harping on the same theme.

> She could talk for 45 minutes without stopping, and I would wonder how much feeling was there behind it, and this changed during the course of therapy, so you can say there was a certain obstacle, her intellectual defense. (Termination)

It was difficult to understand her problems, as she never mentioned any trauma. Working through the termination gave Caitlin tools, although she was afraid of not being able to make choices without therapy. Caitlin had been helped by making positive changes outside therapy. C's countertransference was impatience when nothing happened. Rather than making interpretations, he was supportive but also confronting when she said something contradictory, difficult to understand, or did something self-destructive.

Comparison of C's Two Cases

Early in Treatment

Both Cindy and Caitlin mentioned difficulties in remembering childhood. Cindy thought this could be a defense, whereas Caitlin did not understand why it happened. C noticed

traumatic experiences in Cindy's background and not being able to see any traumas in Caitlin's background. Both Cindy and C mentioned concrete changes that Cindy should make. Caitlin's view of the therapeutic goals was more diffuse, whereas C had a definite view of what she needed to change in her life. Cindy talked about a change process that had already started before therapy, whereas Caitlin described her increasing problems. C was hopeful about Cindy's therapy but wondered how Caitlin's would go. He felt that Cindy could stand up to him but suspected Caitlin of being compliant and idealizing him. He experienced himself as confronting Cindy but found it difficult to describe his way of working with Caitlin.

Experienced Outcomes

At termination, both Cindy and C described Cindy's positive changes, whereas Caitlin and C experienced Caitlin as mostly unchanged, even though she had some new tools. Both patients linked their improvements to factors outside of therapy, but Cindy stressed that the therapy had contributed. Cindy was afraid of deteriorating without therapy, whereas Caitlin believed in the change process starting after termination. C's views were the opposite: he thought Cindy needed to end her therapy, whereas Caitlin needed more therapy, as she was afraid of not coping on her own.

Retrospective Views of Psychotherapy

Cindy and Caitlin were both skeptical of the therapeutic method. Nevertheless, Cindy felt therapy helped and wondered how to get along, whereas Caitlin was more critical, saying that the therapy did not contribute to change and that it was good to end it. Cindy described the sessions as periodically tough and Caitlin as never tough, but there were things Caitlin could not bring up with C. Both Cindy and C thought it was helpful to prolong the therapy and not to flinch from addressing ticklish subjects. Neither Caitlin nor C described prolonging the therapy as positive and both of them experienced setting a time limit as helpful. C described dealing with Cindy's criticism and attacks on him and the therapy, whereas with Caitlin he had to deal with her rumination and intellectualization. In both the cases, he deviated from the psychoanalytic method and was more supportive. C emphasized the work on traumatic experiences in the case of Cindy and the lack of it in the therapy with Caitlin.

Therapeutic Relationship

Cindy's view of her relationship with C covered both positive and negative aspects. C could see and appreciate this. Caitlin's view was clearly positive, but she revealed her fear of conflict, which hindered her from showing anger or saying something negative. C seemed not to be aware of her being skeptical of him and the therapy. In case of Cindy, C described how he worked to gain her confidence and with his negative countertransference. In case of Caitlin, he focused on her avoidance and defenses, but he mentioned that he sometimes felt impatience.

Successful Therapies

The comparisons within the three therapists' contrasting cases revealed that in the successful treatments, the patient and the therapist shared an early common understanding of the presenting problems and what could be helpful. At baseline, the therapists experienced good comprehension of the patient's difficulties and developed an individualized conceptualization of their problems and background. From the beginning, the therapists presented a clear picture of their ways of being with the particular patient. All the therapists described an early staging of the patient's problems or a crisis in their relationship, which together they could work through. Both Ally and Bonny were anxious about not getting help, and their therapists referred to their work on the patients' fears and expectations. In all successful cases, the therapists actively fostered a confident relationship and were personally interested in their patients. The participants shared a view of the therapeutic relationship as both supportive and challenging. The patients experienced their therapists as helpful and considerate. Ally and A, as well as Bonny and B had a good time together; however, Cindy presented a more critical view. In all successful cases, the therapists provided a clear picture of their therapeutic work, giving several specific examples of dealing with obstacles to collaboration and how they worked actively on important aspects of the patient's difficulties, as these unfolded in sessions. They adjusted their working style to their patients' needs, deviating from their usual stance or from the method. They presented a positive picture of their patients, of successive developments, and of the deepening of the therapeutic relationship, although this process was not without obstacles. At termination, the patients and their therapists had a convergent view of improvements; they were satisfied with their work and confident with each patient's future, even though they also expressed some concern about how the patients would deal with new stresses after therapy.

Less Successful Therapies

Early in the less successful treatments, the therapists seemed to have missed some important aspects their patients regarded as important parts of their problems, interpreted them differently, or did not acquire an accurate conceptualization of the patient's problems and their background. Later on, these missing aspects and expected difficulties had an essential influence on the therapeutic process. The participants' views of what could be helpful were mostly incompatible. The therapists' picture of the future therapeutic work was indistinctive and formulated in general terms. The therapists described obstacles to the therapeutic collaboration but not their way of dealing with them. They tended to disregard their own role in the interactions and to explain difficulties as a consequence of their patients' problems. At termination, the patients and their therapists had contradictory views of the therapeutic work and gave diverging descriptions of the outcomes. Both A and B focused on what was not possible to work on or to deepen, and they attributed the hindrances to the patient. They also thought that their patients wished for another approach; however, they did not

draw conclusions from this or alter their approach. Ann and Brynn were openly dissatisfied and lacking confidence in their therapists, whereas Caitlin stressed some positive aspects. Both Ann and Brynn decided to end their therapies and to look for other treatments, whereas Caitlin thought she could do better even without therapy and would start the change process after termination. At termination, the patients expressed dissatisfaction with their therapies and experienced that the therapy did not help or contributed to impairments. They wanted to quit the therapy, whereas the therapists thought that their patients needed more therapy.

DISCUSSION

This study aimed to explore contrasting cases of successful and less successful psychotherapies conducted by three therapists. Comparing the patients' and the therapists' accounts of their therapy experiences, we found both differences and similarities, both between the contrasting cases and between the therapists, indicating the uniqueness of the therapeutic interactions and the multitude of factors influencing the therapy process in a complex, synergistic, and mutually reinforcing manner. Nevertheless, the main differences were already manifest at the outset of treatment. Within the constraints of a journal article, we are able to contextualize our results only in relation to the selected choice of relevant research literature.

Differences Between Successful and Less Successful Therapies

Early in Treatment

In the successful cases, the therapists gave an elaborate picture of their patients' problems and background, consistent with the patients' presentations. In less successful cases, the therapists misinterpreted or disregarded some aspects that the patient described as important and could present an unclear image. According to Oddli and Halvorsen (2014), experienced therapists are able, early in treatment, to provide contextualized, individualized conceptualizations of their patients' problems. If a therapist does not pay attention to some core aspects of the patient's difficulties, as experienced by the patient herself, this may be a major obstacle in the future therapeutic work. Accordingly, Silberschatz (2017) found that if the patient experiences the therapist as sensitive to her problem presentation, she may feel more support and have a more positive view of the therapy, which is linked to a better outcome.

Consequently, in the successful therapies, both parties were more in accord about what would be helpful. From the outset of treatment, the therapists could flexibly adapt their therapeutic stance to their patients' expectations, needs, and capacities, and in two of these cases (A and B), this involved the therapist's active attempt to discuss with the patient what to expect in psychotherapy. In this way, the therapists contributed to building a "good enough" sense of collaboration, preventing dropout and creating a "working space," with room to introduce new ways of addressing the patient's concerns (Horvath et al., 2011). All the patients in the successful cases overtly expressed their fears, inner barriers, or determination to make an effort. This was not found in the less successful cases, and the therapists seemed unable to establish a sustainable sense of mutual collaboration. A further contribution to effective processes in successful cases was early staging of the patient's problems, or a crisis in their relationship, followed by repair of collaboration (cf., Safran et al., 2014). This was not reported in the less successful cases.

One reason for the therapist missing important aspects of the patient's difficulties or ideas of what would be helpful can be the therapist's strong positive or negative countertransference (Hayes et al., 2015). Many therapists react adversely to a patient's negativism and hostility. In such cases, the therapists' ability to curb countertransference reactions and their skills in eroding barriers to human relatedness might play an important role in the outcome (Strupp, 1980b). For example, therapist B described her early strong countertransference feelings with both of her patients. In successful case, reflecting on the patient's transference and her own countertransference guided her in modulating her stance to suit the patient's needs, capacities, and expectations. In deteriorated case, B wanted, from the very beginning, to compensate her patient for what she had missed but anticipated difficulties in setting limits. At termination, B described this patient as the one who touched her most of all. This "exceptional" patient seems to have hooked into the therapist's fears and desires, rendering it difficult for her to take a "third position" (Benjamin, 2009; Bimont and Werbart, 2018). Furthermore, in the successful case, B paid attention early on to potential obstacles and her own hesitation, whereas her expectations were more positive in the unsuccessful case.

In a previous study of non-improved cases, the therapists experienced the therapeutic collaboration, early on, as especially stimulating. They seemed to underestimate their patients' problems and their unprocessed positive countertransference contributed to the view of being on the right track. At termination, they concluded that the patients needed more time in therapy, attributing the limited progress to the patients' resistance rather than their own limitations (Werbart et al., 2018). On the other hand, in successful cases, the therapists described active, relational work that included paying attention to incongruities in the patient's self-presentation and being mindful of the patient's avoidant behavior. Their early dual focus on both possibilities and hindrances to the therapeutic task seemed to strengthen both the patient's and the therapist's motivation (Werbart et al., 2019). Accordingly, Hayes et al. (2015) found *fewer* unpleasant feelings and problematic countertransference reactions expressed in interviews by therapists in unsuccessful cases than by therapists whose outcomes were successful, whereas Oddli and Halvorsen (2014) reported that successful therapists expressed their own uncertainty, especially at the outset of therapy.

Experienced Outcomes

In the successful cases, both parties presented similar pictures of positive changes. In less successful cases, all therapists saw more improvements and paid less attention to remaining

problems than their patients; however, two of them hoped for post-therapeutic developments. Such myth of improvements initiated by termination could make the therapists blind to failure to progress in treatment. According to Lambert (2011), non-response to treatment seems to be connected with the therapists' tendency to neglect lack of change and await future improvements, and a failure to take necessary measures. At termination, the non-improved patients were clearly dissatisfied. Two of them thought that they would needed another form of therapy, whereas their therapists thought that they needed more of the same. Thus, lack of early negotiation regarding the patient's ideas of cure had lasting consequences for the patients. Preparing patients for psychotherapy and negotiating divergent perspectives on treatment goals and tasks can contribute to a stronger working alliance and improved outcome (cf., Horvath et al., 2011; Schattner et al., 2017).

Retrospective Views of Psychotherapy

In the successful cases, all the therapists gave a rich picture of their therapeutic work, providing multiple specific examples, whereas in the less successful cases, the descriptions were vague and unspecific. Furthermore, in the successful cases, the therapists described how they adjusted their therapeutic stance to their patients and balanced between giving support and challenging. By contrast, in the less successful cases, the therapists failed to adapt to their patients' needs. Therapist C thought he was doing it even in the less successful case; however, he disregarded his patient's need for more challenge and less support. Therapist B seemed to be too challenging in the unsuccessful case, and her therapeutic stance was marked by unresolved countertransference issues; thus, she was unable to keep an optimal balance between professional and personal aspects of involvement (cf., Schröder et al., 2015).

Both in successful and less successful cases, some patients experienced periods of impairment. When working on painful issues, adequate interventions might result in more unstable defenses and increased symptoms. In such periods, the therapist's task is to help the patient to process the emerging feelings without fearing the patient's strong reactions, being there for the patient in charged moments (Barber et al., 2013). In less successful cases, the patients did not experience such help. This could be interpreted as indicating the therapists' difficulties in reflecting on their own contributions to their patients' failure to improve, taking in negative feedback from their patients, and adjusting their work accordingly.

Therapeutic Relationship

In successful cases, the patients presented at termination a more positive picture of the therapist and their relationship. In case C, however, the patient in the successful therapy gave a mixed picture of the therapist, being explicit about negative aspects of the therapeutic relationship, whereas the patient in the less successful therapy was openly positive but hinted at unvoiced negative experiences. The therapists in the successful therapies, but not in the less successful ones, described how they worked with emerging difficulties in the therapeutic collaboration; they monitored the patient's resistance from the beginning, as well as their own ways of being with the patient. Both parties seemed to contribute to the patient's secure attachment to the therapist, providing the patients with a secure base for expression and exploration of their painful feelings and thoughts (Mallinckrodt, 2010). In cases A and B, both parties in the successful therapies gave examples of corrective emotional experiences, resulting in the patients finding new ways of relating to others. On the other hand, the patients in the less successful cases experienced a poor match with their therapists. In case B, the patient felt her relationship with the therapist was a repetition of her problematic family relationship, whereas the therapist wanted to be the one the patient missed in her family of origin. The therapeutic relationship in the less successful case of C seems to have been grounded in both parties' distorted views. The therapist was looking for absent traumas and believed he matched his stance to his patient's needs. The patient thought she could do as well without therapy. She concealed her negative views, behaving in a compliant way. These cases are clear examples of a clash between the patient's and the therapist's relational patterns, a clash that negatively impacts each of them (Schattner et al., 2017). What hindered open statement and negotiation of differences and disagreements seems to have been collusion between the patient's transference and the therapist's countertransference.

Factors Outside of Therapy

Even though the present study focuses on within-therapy factors, alternative interpretations of the results might take into consideration a broader context of the patients' life circumstances. Successful therapeutic work could be facilitated by the fact that all the recovered patients had previous disappointing therapy experiences. It is possible that people undertaking a new therapy commit themselves to being open, honest, and vulnerable in ways that enable their therapists to do good work with them (cf., McKenna and Todd, 1997). Accordingly, in our previous studies, the proportion of patients with previous psychotherapy experience was higher in the successful cases than in cases of non-improvement (Werbart et al., 2018, 2019). Furthermore, in the successful cases, the patients mentioned supportive life circumstances and getting support in close relationships (Palmstierna and Werbart, 2013), whereas non-improved patients reported both helpful life conditions and negative impacts of life events (Werbart et al., 2015). Thus, from the patients' perspective, psychotherapy can be considered as one component in a life-long process of working through of psychological stresses rather than a place for a decisive and complete cure.

Within- and Between-Therapist Differences

Looking at within-therapist differences, we found that the therapists could function in a highly experienced way (cf., Oddli and Halvorsen, 2014; Hill et al., 2017) in successful, but not in less successful cases. What differed between the contrasting cases was slightly different for each therapist, but substantial

differences appeared early in the treatment. For example, therapist A adjusted her way of working more to her patients' needs in the successful therapy, whereas the ruptures in collaboration (Safran et al., 2014) were not resolved in the less successful case. Therapist B described the therapeutic alliance as stronger, and the parties' view of the alliance was also more convergent, in the successful case. Therapist C managed to balance between supporting and challenging only with his recovered patient. These differences can be interpreted as due to the quality of the therapeutic relationship (as experienced by both protagonists) rather than to patient psychopathology. The difference between good and poor quality of the therapeutic relationship seems to be due to some aspects of the patient-therapist dynamic match. These aspects might be understood in terms of specific transference-countertransference configurations. Thus, the therapists' capacity to "mentalize" countertransference seems to be decisive (Barreto and Matos, 2018).

Furthermore, we found marked differences in how consistently the three therapists worked with different patients. It is easy to recognize therapist C's self-description of his work regardless of which case he was describing. For example, in both cases, he was looking for previous traumas and seemed to adapt the same therapeutic stance. In less successful case, he did not notice how much his patient did not disclose to him. Therapist A seemed to be the most flexible, and there were obvious differences in her two self-descriptions. Therapist B can be placed in a midway position: in the successful case, her therapeutic stance was more suited to her patient's characteristics, whereas in the deteriorated case, her early countertransference affected her view of the therapeutic goals and tasks. This contradicts the idea of keeping the therapist factor constant. How "constant" the therapist factor is, is itself a therapist factor.

Accordingly, we found differences in how flexibly the therapists could adapt to their patients' relational patterns. Comparing two contrasting cases treated by the same therapist, Schattner et al. (2017) found that the therapist's ability to deal with difficulties in the therapeutic relationship was decisive in the development of the therapeutic alliance and influenced the outcome. In case of negative development, the patient's and the therapist's relational patterns clashed, whereas in case of positive development, the disagreements and differences were openly negotiated. These two interconnected aspects are congruent with our findings: in the poor outcome cases, the therapists were less able to flexibly adapt to their patients' relational patterns, whereas in the good outcome cases, they were able to contribute to repair of ruptures in collaboration (Safran et al., 2014).

Zilcha-Mano, (2017) distinguished the patients' more stable, "trait-like" tendencies to form satisfying relationships from "state-like," interaction-related changes in the relational patterns, the former enabling treatment to be effective, and the latter making the alliance therapeutic. Accordingly, in our study, the therapists could more successfully adjust to the patients' "trait-like" relational patterns in the successful than in the less successful cases. We also found between-therapist differences in this respect, from therapist A's more flexible interpersonal stance through the clash of relational patterns in case B, to therapist C who did not alter his ways of being working with different patients.

Our study confirms Strupp's (1980b) conclusion that the therapeutic relationship becomes established and fixed very early in treatment and that it influences its course and outcome. In some of Strupp's contrasting cases, the quality of the therapeutic relationship was determined by the therapists' capacity to adapt their relational stance to the needs of the patients (Strupp, 1980a) and, in other cases, by the patients' respective character structure and way of relating (Strupp, 1980b). The patient's capacity to form a therapeutic relationship and be involved in productive work following the therapist's approach interplayed with the therapist's ability to deal with his or her own personal reactions to the patient's pathology (Strupp, 1980c). In less successful cases in our study, we found both patients who wanted another therapeutic approach (and lack of negotiation on this issue) and therapists who had difficulties managing their countertransference reactions. To conclude, some patients are not the right patients for the kind of therapy offered by the particular therapist. At least some, if not most therapists are unable to adapt their therapeutic technique and the relational stance to the needs of some patients (cf., Strupp, 1980a). These within-therapist differences indicate that taking a "third position" is most necessary and seems to be most difficult, when early signs of lack of therapeutic progress appear.

In our study, the same therapist could differ with different patients in her capacity to establish a collaborative relationship, to actively use therapeutic interventions, and to promote resolution of therapeutic impasses (Safran et al., 2014). Katz and Hilsenroth (2018) found that encouraging the patients' emotional experiences, in combination with interpretations of the patients' interpersonal patterns, was particularly beneficial early in psychodynamic treatment for depression. In line with our findings, Gazzillo et al. (2014) showed that in the good outcome case the therapist used active and correct interventions and at the same time adopted a relational stance. We fully agree with the authors' conclusion that successful therapeutic work presupposes an interaction between relational and technical focus, especially early in the treatment.

Strengths and Limitations

One asset of the present study is the focus on contrasting cases within the therapists' caseload, thereby contributing to our growing knowledge about within-therapist differences. Furthermore, the prospective research design made it possible to explore the participants' experiences at the outset of treatments that were later classified as successful or less successful, thus it was not necessary to rely solely on retrospective recall. Another advantage is the use of an "objective" quantitative outcome criterion, namely reliable and clinically significant symptom reduction at termination. However, this criterion does not take into consideration other dimensions of improvement, other outcome measures, and improvements as assessed by the therapists or as experienced by the patients. The inductive thematic analysis of interviews opened access the patients' and their therapists'

unvoiced experiences of therapeutic processes in contrasting cases. On the other hand, the pre-post design and lack of session recordings prevented a closer study of in-session interactions and the development of the therapeutic relationship.

Furthermore, only three therapists were included. As the present study was based on archival data, inviting the therapists to offer their understanding of contrasting cases was not possible. The therapy duration varied between 9 and 46 months. However, we could not see any apparent patterns in this regard. One of the non-improved patients was in the shortest treatment and the deteriorated patient in the longest; in both cases, the termination was initiated by the patient. Moreover, there was no relation between therapy duration and the outcome in the total YAPP sample (Philips et al., 2006).

Our study indicates that a therapist works differently with different patients and that the differences cannot be explained by patient factors alone. Rather than studying the patient and the therapist variables independently, focusing on the patient-therapist dyad as a unit (Silberschatz, 2017) can give us new knowledge that is highly relevant to clinicians. We still need more research, with larger number of therapists treating several patients, and sophisticated methodology to study what in the patient-therapist match and interaction results in contrasting outcomes. We also need studies differentiating between lack of improvement and adverse or harmful effects. Another area for further studies could be contrasting cases of effective and ineffective therapeutic dyads in more directive therapeutic modalities.

Clinical Implications

Despite its limitations, the present study might have important implications for clinical practice and psychotherapy training. Looking for within-therapist effects, we found both effective and ineffective therapeutic dyads. Our findings suggest that the therapist's expertise has to be viewed as "case-dependent" (cf., Palmstierna and Werbart, 2013; Werbart et al., 2015, 2018, 2019). In order to prevent suboptimal outcomes, the therapists have to be observant of cases when they, from the beginning, have difficulties in conceptualizing the patient's problems and their ideas of the coming therapeutic work. Scrutinizing their own and their patients' way of being together might be more difficult but especially important early in therapy. Negotiating both participants' ideas of therapeutic goals and tasks might in itself be a mechanism of change. Ongoing metacommunication with the patient about what is going on in the therapeutic relationship might enable therapeutic impasses to be worked through and could prevent unsuccessful treatments (cf., Safran et al., 2014). Such communication can be facilitated by use of formalized feedback instruments (cf., Lambert, 2013; Miller et al., 2015).

In order to find the right interventions, the therapist has to continuously assess the patient's functioning and be open to reconsidering the initial assessment of the patient's problematic areas and capabilities (cf., Markowitz and Milrod, 2015). Our study indicates that an important ingredient in psychotherapy training might be guidance on how to balance support and challenge in the therapeutic process and how to adjust to the patient's needs and relational patterns. This includes training in being attentive to and making active use of the therapist's positive as well as negative countertransference (Hayes et al., 2011). Furthermore, continuing education has to implement the implications of current research on the therapists' contributions to negative processes (Castonguay et al., 2010; Hilsenroth et al., 2012). Even the most skilled therapists can learn much from their least successful cases and their own treatment failures.

It is incumbent upon the therapist to differentiate between the therapist's and the patient's wishes, fears, and reactions. Doing so involves the therapist intentionally bringing to mind personal experiences that somehow relate to the patient's suffering, before responding with an exploration of what the patient cannot contain. The therapist's response has to be "marked" by the difference between the patient's and the therapist's perspective, thus making possible a "third position" (Benjamin, 2009). Such a position includes alternating between participation in the patient's inner world and observation, starting with the self and going to the patient.

ETHICS STATEMENT

The project has been approved by the Regional Research Ethics Committee at the Karolinska Institutet. All participants gave written informed consent in accordance with the Declaration of Helsinki.

AUTHOR CONTRIBUTIONS

AW was project leader and principal investigator in the YAPP and in the present study. He planned and designed the work, was responsible for acquisition of all the data included, continuously scrutinized the data analysis, interpretation of results, and early drafting, and prepared the version to be submitted. AA and JH contributed primarily with analysis and interpretation of the data for the work, early drafting, and with critical revision in the later stages of the work. They have also given final approval of the version to be published and agreed to be accountable for all aspects of the work.

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Ambivalence Predicts Symptomatology in Cognitive-Behavioral and Narrative Therapies: An Exploratory Study

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Background: The identification of poor outcome predictors is essential if we are to prevent therapeutic failure. Ambivalence – defined as a conflictual relationship between two positions of the self: one favoring change and another one favoring problematic stability – has been consistently associated with poor outcomes. However, the precise relationship between ambivalence and clients' symptomatology remains unclear.

Objective: This study aims at assessing ambivalence's power to predict symptomatology, using a longitudinal design.

Methods: The complete 305 sessions of 16 narrative and cognitive-behavioral cases have been analyzed with the Ambivalence Coding System and outcome measures have been used for each session.

Results: Ambivalence emerged as a significant predictor of subsequent symptomatology suggesting that ambivalence is not only related to treatment outcomes, but that it represents a strong predictor of subsequent symptomatology.

Discussion: The implications of ambivalence's power to predict outcomes for research and clinical practice are discussed.

Keywords: ambivalence, ambivalence coding system, ambivalence resolution, poor outcome predictors, innovative moments

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While research has revealed the efficacy of psychotherapy in dealing with a variety of psychological problems (e.g., Wampold and Imel, 2015; Cuijpers et al., 2016; Karyotaki et al., 2016), studies have consistently revealed that around 50% of clients experience no change in psychotherapy (Lambert, 2007), about 20% of clients abandon the process prematurely (Leahy, 2012; Swift and Greenberg, 2012), and 5–10% of clients present some level of deterioration (Lambert and Ogles, 2004). In this context, the study of the factors that may contribute to non-improvement and deterioration assumes utmost importance.

When reflecting upon these factors, the concept of resistance assumes unavoidable clinical and empirical significance as "one of the most crucial, pointing toward perhaps the single most important factor—or, more accurately, set of factors—in determining the success or failure of the therapeutic enterprise" (Wachtel, 1999, p. 103). In fact, a robust body of research

suggests that higher levels of resistance are consistently associated with poor therapy outcomes and premature treatment termination (see Beutler et al., 2001 for a review), supporting the need for empirical studies that aim at understanding the specific relationship between resistance and therapeutic failure. Resistance can be defined as a set of behaviors that hinders the progress toward desired changes (Beutler et al., 2002, 2011; Leahy, 2012) and may assume different features in distinct therapeutic models. However, most clients do not simply resist change but are hesitant or ambivalent about change so we often observe movements away from and movements toward change in resistant clients. Thus, many of the aspects that are conceptualized as resistance are probably better understood as ambivalence (Engle and Arkowitz, 2008).

Ambivalence is a common human experience and involves simultaneously evaluating an attitude object both in a strong negative and a strong positive way (Kaplan, 1972). Attitude ambivalence is often experienced as unpleasant as it involves the simultaneous accessibility of conflicting thoughts or feelings. Studies have revealed that this may be related to the anticipation of negative emotions – like guilt, fear, disappointment, and regret – that may arise in the wake of a "wrong" decision (see Van Harreveld et al., 2009 for a review).

Distinct consequences have been associated with attitude ambivalence. For example, it involves systematic information processing (Rydell et al., 2008) – which has been argued to serve as a way to reduce anxiety in the face of uncertainty (Maio et al., 1996; Jonas et al., 1997). Attitude ambivalence has also been shown to be more pliable (Bassili, 1996; Armitage and Conner, 2000), to have lower memory accessibility (Bargh et al., 1992), and to be less predictive of behavior (Armitage and Conner, 2000; Sparks et al., 2004).

In psychotherapy, ambivalence involves simultaneous movements toward and away from change – as an approach-avoidance conflict (Dollard and Miller, 1950) – a conflict of the self that, if not properly solved, tends to negatively impact treatment (Miller and Rollnick, 2002; Braga et al., 2016, 2018). Ambivalence – and the importance of its resolution so that real change can be attained – assumed a significant role in clinical practice and research with the Stages of Change Model (Prochaska and DiClemente, 1983; DiClemente and Prochaska, 1985). This model also contributed to the development of Motivational Interviewing (Miller and Rollnick, 1991; DiClemente, 1999), which was designed to deal with ambivalence toward change.

In process research, the acknowledgment of ambivalence's central role in the process of psychotherapeutic change stirred the development of an empirical marker – the ambivalence marker (AM, previously termed return to the problem marker, Gonçalves et al., 2009) – that allowed for the processual study of ambivalence. AMs are present when after the occurrence of an innovative moment (that is, a novelty or an exception to the maladaptive pattern, see Gonçalves et al., 2017) in the therapeutic dialogue, clients immediately attenuate the meaning of the novelty through a return to the problematic pattern. For example, if a given client's problematic pattern is characterized by passiveness and submissiveness to others, the following sentence would be coded as an IM: "I do not care what she thinks anymore, I have to tell her how I feel, my feelings matter!" However, if the client continued by saying: "But I'm afraid that I will be feeling very guilty and ridiculous after I say it," this last sentence would be coded as an ambivalence marker.

Studies that tracked AMs along treatment revealed that in unchanged cases AMs' frequency is higher – keeping stable or even increasing as the psychotherapeutic process evolves – while for recovered cases the frequency of AMs is generally lower and decreases as treatment progresses (Gonçalves et al., 2011b; Ribeiro et al., 2014, 2015; Alves et al., 2015). Overall, these results suggest that (1) ambivalence – as measured by AMs – is a frequent process both in unchanged and recovered cases; and (2) its persistence along treatment is associated with therapeutic failure. In fact, as change typically involves abandoning entrenched and problematic functioning patterns, ambivalence may, on the one hand, represent a natural "*byproduct of the process of changing complex behaviors*" (Moyers and Rollnick, 2002, p. 187). However, on the other hand, if successful therapy is to take place, the inner conflict expressed by ambivalence must also be properly addressed and overcome (Braga et al., 2016, 2018). This is in line with the argument that ambivalence may constitute not only a hindrance but also an opening for change (Mahalik, 2001), providing that it is effectively dealt with and overcome during therapy (Wachtel, 1999; Braga et al., 2016, 2018; Westra and Norouzian, 2018).

As previously mentioned, studies with the Ambivalence Coding System (Gonçalves et al., 2009, 2017) have been revealing that AMs are associated with poor outcomes. These studies used various samples with different clinical problems and distinct therapeutic models. Yet, most of these models shared a predominantly constructivist or phenomenological approach such as narrative therapy (Ribeiro et al., 2015), meaning reconstruction approach to grief (Alves et al., 2015), and emotion-focused therapy (Ribeiro et al., 2014). Thus, the present study firstly aims at contrasting ambivalence between a sample of narrative therapy and a sample of cognitive-behavioral therapy. Also, studies with AMs (Gonçalves et al., 2011b; Ribeiro et al., 2014, 2015; Alves et al., 2015) have suggested that persistent ambivalence is in some way related to unsuccessful outcomes. However, the precise relationship between AMs and clients' symptomatology remains unclear as all previous studies associated AMs with pre-post change. In this context, using a longitudinal design, the present study aims at evaluating ambivalence's power to predict outcomes, assessing the relationship between AMs and outcomes on a session-to-session basis.

As Lambert (2007) advises, preventing therapeutic failure demands the ability to predict poor outcomes. In general, studies conducted by Lambert and collaborators have been revealing that clients' levels of distress are able to predict deterioration (Lambert et al., 2002; Hannan et al., 2005; Ellsworth et al., 2006; Lutz et al., 2006; Spielmans et al., 2006). In this vein, other variables have been examined such as clients' dropout, non-adherence, and resistance (e.g., Beutler et al., 2011; De Panfilis et al., 2012; Taylor et al., 2012). The current study adds to this literature by investigating AMs' impact on subsequent symptoms.

MATERIALS AND METHODS

Samples

The sample of the present study is composed of 16 cases conducted with cognitive-behavioral therapy (CBT) (n = 6) and narrative therapy (NT) (n = 10) for depression. In the NT sample, seven clients were female and three were male and were, at the time of the study, an average of 41 years old (SD = 14.97). In the CBT sample, five clients were female and one was a male and were an average of 34 years old (SD = 8.48). Both the NT and the CBT samples had integrated a clinical trial (Lopes et al., 2014). All clients had been diagnosed with major depression according to the DSM-IV-TR (American Psychiatric Association, 2000), agreed to have their sessions recorded, and had provided a written informed consent. Clients with: (1) any axis II disorder; (2) any other axis I disorder constituting the central focus of clinical work; (3) severe suicidal ideation; (4) psychotic symptoms; and (5) bipolar disorder were not included in the study. Psychotherapy was delivered individually: nine clients completed 20 sessions, three clients completed 19 sessions, one client completed 18 sessions, one client completed 16 sessions, one completed 15 sessions, and one client completed 12 sessions. Differentiation of recovered and unchanged cases was computed in accordance with a RCI (Jacobson and Truax, 1991) of the BDI-II (McGlinchey et al., 2002). The 16 clients were selected from the wider sample randomly (recovered and unchanged cases balanced) for process research purposes.

Various process research projects have previously analyzed this sample (see Gonçalves et al., 2017 for a description of the studies). In what relates to AMs specifically, a study by Ribeiro et al. (2015) analyzed the NT sample for the association between AMs and treatment outcome (measured by pre-post change). This is the first study to analyze AMs in the CBT sample and to analyze AMs' power to predict outcomes longitudinally.

Therapy and Therapist

The CBT group followed the CBT treatment manual for depression (Rush et al., 1977; Beck et al., 1979). The NT manual (Gonçalves and Bento, 2008) was specially developed for Lopes et al. (2014) study and is based on the work of Michael White (White and Epston, 1990; White, 2007). Adherence to the manual and therapist competence were monitored through weekly supervisions (using session's audiovisual material) and assessed by external judges (see Lopes et al., 2014).

Two therapists integrated the study: one for the CBT and another one for the NT sample. The CBT therapist was a PhD student with 3 years of experience as a cognitive-behavioral psychotherapist. A senior CBT therapist offered weekly supervision and ensured adherence to the CBT model of intervention. The NT therapist had a PhD in clinical psychology and 7 years of clinical practice – three in NT – and was trained in the intervention manual specifically designed for the study, which was inspired on the work of White and Epston (1990).

Process Measures

The Innovative Moments Coding System

The Innovative Moments Coding System (IMCS) allows for the identification of exceptions to the clients' problematic pattern (Gonçalves et al., 2011a). All sessions had been previously coded with the IMCS by previous studies. Results of this coding can be found in Gonçalves et al. (2016a) for NT and in Gonçalves et al. (2016b) for CBT. The agreement between the two independent judges on overall IM proportion was 0.90 in the CBT sample and 0.89 in the NT sample, with Cohen's kappa values of 0.94 and 0.91, respectively, revealing strong agreements between judges.

Ambivalence Coding System

The Ambivalence Coding System (ACS) allows for the identification of ambivalence markers, that is, the immediate reoccurrence of the problematic pattern after an IM (Gonçalves et al., 2009). The ACS was applied to all sessions of the NT sample in the context of a previous study (Ribeiro et al., 2015), with a Cohen's Kappa of 0.91, and to all the sessions of the CBT sample in the context of the present study – with a Cohen's Kappa of 0.94. Both values reveal strong inter-rater agreements.

Outcome Measures

Outcome Questionnaire-10.2

Clients from both samples filled in the Outcome Questionnaire-10.2 (OQ-10.2) at the beginning of every session (Lambert et al., 2005). The OQ 10.2 is a 10-item (rated on a 5-point Likert scale) questionnaire that measures symptomatic change – higher scores indicate higher distress levels. Adequate values of internal consistency and test retest reliability have been demonstrated.

Analyses

Hierarchical Linear Modeling Analyses

A HLM analyzed the longitudinal association between AMs (predictors) and outcomes (OQ-10.2, filled in by clients at the beginning of every session) as a response variable. The model aimed at testing the hypothesis that AMs are able to predict OQ-10-2 scores in the next session (OQ-10-2 score at lag +1) both for NT and CBT. As AMs constitute a proportion of IMs (the IMs that are immediately followed by a return to the problematic pattern), IMs' proportion was also inserted in the model so we could understand if the impact of AMs on outcomes was still significant when IMs' proportion was taken into account. Treatment (NT or CBT) was also inserted as a predictor variable in this model. HLM is particularly appropriate for the analysis of nested or hierarchically structured data as is the case in the present study – data collected in different sessions were nested within each client. As HLM allows for effects estimation of both within-clients and between-clients (Woltman et al., 2012), HLM was fitted into a regression model with two hierarchies: (1) within-clients – outcomes estimated to be a function of time – and between-clients.

Generalized Linear Mixed-Effects Modeling Analyses

As AMs represent a proportion of IMs, GLMM was used to assess the longitudinal association between symptomatology (OQ10.2 at the beginning of each session) as predictor and AMs as a response variable (i.e., to reverse the prediction direction). This is because GLMM is a type of regression that allows response variables with arbitrary distributions – as is the case with proportions (McCullagh and Nelder, 1989). Thus, A GLMM was fitted, taking into account a subject-specific random effect, assuming variability among individuals, and considering symptomatology (OQ-10.2 score) in each session as predictor of the proportion of AMs in the following session. Generalized linear mixed models (lme4) package for R (Version 3.2.4, R Development Core Team, 2016) was used to perform the analyses.

RESULTS

As mentioned earlier, AMs represent an immediate return to the problematic pattern after the occurrence of an innovative moment. Thus, AMs are computed as the percentage of IMs – from the total universe of IMs – that constitute AMs. For unchanged cases, the mean percentage of AMs was 15.53% in the first session and 10.91% in the last session. For recovered cases, the mean percentage of AMs in the first session was 17.32%, while in the last session the mean percentage of AMs was 4.11%.

AMs and IMs as Predictors of Symptoms

AMs emerged as a significant predictor of symptoms in the subsequent session ($p = 0.009$; $R^2_{adj} = 0.665$) (**Table 1**). Hence, AMs were positively associated with symptomatology (OQ-10.2) in the subsequent session, meaning that lower ambivalence in a given session was associated with lower symptomatology in the next session. IMs were also a significant predictor of symptoms in the next session ($p < 0.0001$; $R^2_{adj} = 0.665$), but IMs negatively associated with symptomatology. Thus, a higher proportion of IMs in one session was associated with lower symptomatology (OQ-10.2) in the subsequent session. Treatment was not a significant predictor ($p = 0.253$; $R^2_{adj} = 0.665$), meaning that the association found between AMs and symptoms was the same for NT and CBT.

TABLE 1 | HLM with treatment condition (NT or CBT), IMs' proportion, and the proportion of AMs as predictors of symptomatology (OQ 10.2 scores) in the next session.

Models and fixed effects	Coefficient	SE	*t*	*p*
AMs and IMs predicting OQ-10.2 model				
Intercept	18.892	2.484	7.605	<0.0001
AMs	5.769	2.191	2.633	0.009
IMs	–0.127	0.027	–4.705	<0.0001
Treatment	3.622	3.035	1.193	0.2526

TABLE 2 | GLMM with treatment condition (NT, CBT) and symptomatology (OQ 10.2) predicting AMs proportion in the subsequent session.

Models and fixed effects	Coefficient	SE	*z*	*p*
OQ-10.2 predicting AMs model				
Intercept	–1.982	0.204	–9.715	<0.0001
Treatment	0.302	0.218	1.388	0.1652
OQ10	0.021	0.006	3.594	0.0003

Symptoms (OQ-10.2) as Predictors of AMs

In order to understand if symptoms exert an impact in the subsequent session's AMs, a GLMM analysis was performed – as AMs are computed as a proportion, the use of a regular HLM is impeded (**Table 2**). Symptomatology (OQ-10.2) emerged as a significant predictor of AMs in the subsequent session ($p = 0.009$; $R^2_{adj} = 0.060$). Treatment was not a significant predictor ($p = 0.253$; $R^2_{adj} = 0.060$), which means that the association between symptomatology (OQ-10.2) and AMs in the subsequent session was the same for NT and CBT.

DISCUSSION

While former studies analyzed the relationship between AMs and pre-post change (Gonçalves et al., 2011b; Ribeiro et al., 2014, 2015; Alves et al., 2015), this study examined the predictive effect of AMs on symptomatic change in the subsequent session. Ribeiro et al. (2015) studied the narrative subsample, integrated here with the CBT subsample, and found a similar proportion of AMs at the beginning of therapy and a decreasing tendency of these markers along the treatment for both unchanged and recovered cases. However, as expected, recovered cases revealed a more pronounced reduction when compared to unchanged cases, suggesting that in recovered cases ambivalence tended to be resolved, while it remained problematic in unchanged cases.

In the present study, we expanded former studies by carrying out a longitudinal design, testing the relationship between ambivalence (AMs) and symptoms' improvement (OQ-10.2) (Lambert et al., 2005) with two distinct models. One model tested AMs (and IMs) in a given session as predictors of symptoms in the subsequent session, and another model reversed the prediction direction by testing if symptoms in a given session predict AMs in the subsequent session. Results from the former model suggested that IMs and AMs were predictors of symptoms, curiously with similar amount of variance explained. As such, sessions with more IMs were associated with lower symptomology and sessions with lower AMs were also associated with lower symptomatology. The second tested model supports the idea that symptomatology in one session also has an impact on the following session's ambivalence, in the expected direction (that is, higher symptomatology predicts higher ambivalence in the following session). Thus, results suggest a bidirectional relationship between ambivalence and symptomatology. However, the models also suggested that ambivalence's ability to predict symptoms in the

next session was substantially more adjusted to the data, explaining considerably more variance than the set of models testing the reverse direction. This implies that AMs are not only related to treatment outcomes, but that they represent a strong predictor of posterior symptomatology (i.e., in the next session) – exposing the clinical significance of the ambivalence phenomenon.

As previously mentioned, along with a number of distinct consequences, attitude ambivalence has been linked to systematic processing (Rydell et al., 2008). The authors on social psychology studies have argued that this systematic processing may serve as a way to reduce anxiety in the face of uncertainty (Maio et al., 1996; Jonas et al., 1997). In the context of psychotherapy, ambivalence may constitute a sign that clients are having difficulties progressing in therapy as changing complex and well-settled patterns of functioning often implies a threatening *leap of faith* into the unknown. Also, ambivalence is often an unpleasant state *per se* which seems to relate to the anticipation of negative emotions (see Van Harreveld et al., 2009 for a review) should a "wrong" step be taken – and one could argue this may be one of the routes by which ambivalence relates to treatment outcomes. Ambivalence may trigger other transdiagnostic variables associated with psychopathology – such as rumination (Nolen-Hoeksema and Watkins, 2011) – as a strategy to reduce anxiety, or uncertainty intolerance (Rosser, 2019). In any case, as they signal the probability of the occurrence of a subsequent week characterized by greater psychological suffering, sessions with higher proportion of AMs may be particularly important targets of therapeutic attention.

Dealing with ambivalence requires its understanding in the same intersubjective context in which it occurs – the therapeutic interaction. Although the process of ambivalence has been conceptualized as an intrapersonal process, when it occurs in the therapeutic context, it is not disengaged from the quality of the client-therapist interactive process. Ribeiro et al. (2013) suggest that ambivalent responses from clients may indicate that the therapeutic intervention exceeded the client's capacity to integrate novelty. In a case study by Ribeiro et al. (2013), the therapist inadvertently stimulated the client's ambivalence by frequently using challenging interventions after the client expressed ambivalence. *Responsiveness* – defined as "behavior that is affected by emerging context, including emerging perceptions of others' characteristics and behavior" (Stiles et al., 1998, p. 440) – thus takes a central role when we are dealing with ambivalence in the therapeutic context. Thus, therapists should be able to identify, assess, and appropriately respond to their clients' ambivalence, balancing supporting, and challenging interventions in a responsive way (see Ribeiro et al., 2013) so as to avoid the promotion of resistance and facilitate the process of change.

Besides attending to moments when clients express ambivalence, therapists should also be alert to potential moments of ambivalence resolution. Studies on ambivalence resolution (Braga et al., 2016, 2018) have identified distinct processes (dominance and negotiation) that are involved in the overcoming of ambivalence. These processes reflect distinct relationships between the two positions that are involved in the ambivalence conflict (favoring change versus favoring problematic stability). In the dominance process, the innovative position strives to regulate the problematic position by affirming the innovative position's control. In the negotiation process, the conflicting positions are able to communicate with one another, promoting a dynamic flow between opposites, rather than the dominance of one of them (Braga et al., 2016). Retrieving the previously given example of a problematic pattern characterized by passiveness and submissiveness to others, the following sentence exemplifies a dominance type: "I am very clear on this – I will not submit to her will anymore." In contrast, the following example would be coded as a negotiation type: "It is important for me to feel she is ok with my decision, but I also need to feel this is the right thing for me to do." These are simple illustrations of what Braga et al. (2016) termed momentary resolutions, that is, "moments when there is an agentic and determined resolution of ambivalence, even if it is a momentary one" (Braga et al., 2016, p. 9). The authors suggest that it is the repetition of these momentary resolutions that allows for the progressive resolution of the conflictual relationship between both positions of the self involved in ambivalence. While both dominance and negotiation exert an impact on ambivalence reduction, negotiation revealed an impact that is nearly five times higher (Braga et al., 2018). Also, negotiation tends to increase from the initial to the final sessions of recovered cases and to be virtually absent in unchanged cases (Braga et al., 2016, 2018), advocating the need for the negotiation and integration between the problematic and the innovative positions of the self involved in ambivalence in order to resolve it. This is consistent with the need for increasing assimilation of problematic experiences proposed by the assimilation model (Stiles, 2002). Thus, therapists should be able to identify and promote ambivalence resolution moments. Particularly, therapists should aim to be responsive to the concerns of both the innovative and the problematic positions of the self – actively avoiding side taking – and promoting moments of communication between the two opposing positions of the self, since the presence of moments of negotiation between the positions has revealed a significant impact on the reduction of ambivalence (Braga et al., 2018).

LIMITATIONS AND CONCLUSION

This study has a diversity of limitations that should be overcome in future studies. Besides the small sample size (although the number of observations is quite significant), part of the sample was previously studied (the NT subsample) on the impact of ambivalence on pre-post change. Also, the low number of therapists prevents the isolation of treatment effects from therapist effects. On the other hand, this study involved the intensive analysis of ambivalence in 305 complete sessions of therapy, which allowed for the study of this process in a highly innovative way. In the same vein, we hope that future studies will balance the necessity of empirical rigor with the need for an in-depth analysis of this phenomenon.

In conclusion, improving treatment results for clients who are predicted to get worse has significant consequences for

client care. Although the results from the present study should be taken with caution, if future studies with distinct and larger samples replicate these findings, ambivalence – as measured by the ambivalence marker – may constitute a transtheoretical, significant, and easily detectable aspect of the therapeutic process that therapists may use both as a signal of their clients' difficulty to integrate novelty and as a developmental opportunity to facilitate the process of change.

ETHICS STATEMENT

Every participant has previously agreed to the recording of the sessions and to the use of this material for research purposes and has been informed of the confidential nature of the information provided. The sample collecting procedures have been approved by the Conselho de Ética of University of Minho.

AUTHOR CONTRIBUTIONS

CB implemented the study and developed the theory. AR and MG conceived the concept of AMs, encouraged the investigation of ambivalence's role as a predictor of symptoms, and supervised the findings of this work. IS performed the computations and supervised the result's description. All authors discussed the results and contributed to the final manuscript.

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Analyzing Psychotherapeutic Failures: A Research on the Variables Involved in the Treatment With an Individual Setting of 29 Cases

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The effectiveness of psychotherapeutic treatments has been widely demonstrated and confirmed by many studies in recent decades. The research focused on the factors of change influencing the positive outcomes of a psychotherapy, putting those that are crucial in cases of failure into the background. The dimensions of this phenomenon are relevant as well as the side effects of the psychotherapeutic interventions that reach the same percentages of the pharmacotherapeutic treatments. The study of the variables involved in failure cases therefore seems important to prevent or moderate the negative effects of treatments with a negative outcome. Impasse and deadlock situations, which may result in an early interruption of psychotherapy, are often complex and involve situational, relational, and personal factors at different levels and with different weight. A research was conducted, with a mixed approach, aimed at exploring the situational factors involved in dropout cases. In addition, the evaluation of the psychotherapist's emotional responses related to patients who terminated psychotherapy prematurely was investigated. The study was attended by a sample of 29 psychologists, experienced psychotherapists from different frameworks. Recent or salient cases of a hesitated psychotherapy with an early interruption were examined. For the first objective, a structured interview (Impasse Interview) was used, while the second one was reached by the administration of the TRQ (Therapist Response Questionnaire). The transcripts of the interviews were analyzed through a textual analysis software and five salient thematic clusters were identified. These were then assimilated to different areas of meaning: severity of the diagnosis, procedural aspects and lack of understanding of the stall in progress. Two other important themes emerged: the critical aspects concerning relational dynamics and a focus on maternal theme. Overall these five thematic areas seem to play an important and specific role compared to dropout cases. Finally, statistical analysis on emotional responses have highlighted some values above the average in these four countertransference factors: Helpless/Inadequate, Parental/Protective, Positive/Satisfied, and Overwhelmed/Disorganized. It is hypothesized that particular emotional responses of the psychotherapist may be prognostic with respect to the outcome of psychotherapy.

Keywords: psychotherapeutic treatments, psychotherapeutic alliance, psychotherapeutic failures, countertransference, dropout

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INTRODUCTION

Linden (2013) states that psychotherapy is considered a treatment modality that has positive effects and that both risks and side effects are limited (Nutt and Sharpe, 2008). However, as shown by various studies, the undesirable effects of psychotherapies treatments range between 3 and 15% of cases; percentages similar to those found for the side effects of pharmacotherapeutic treatments (Mays and Franks, 1985; Mohr, 1995; Roback, 2000; Moos, 2005; Boisvert and Faust, 2006; Jarrett, 2007; Berk and Parker, 2009). The premature conclusion of treatment is generally considered a critical element for the provision of services dedicated to mental health (Wierzbicki and Pekarik, 1993); indeed, in cases of premature abandonment there is a reduction in the effectiveness of the treatment and the cost-benefit ratio is also reduced (Pekarik, 1985; Garfield, 1986). One of hand, while the efficacy of psychological and psychotherapeutic treatment has been solidly confirmed by numerous studies (Roth and Fonagy, 1996, 2004; Nathan and Gorman, 1998, 2007; Kazdin and Weiss, 2003), as Barlow (2010) emphasize, on the other hand, the analysis of the negative outcomes of psychotherapy has been dealt with more recently. Nevertheless, this is still not enough (Linden, 2013), especially considering the need to take into consideration many variables. They can refer not only to the characteristics of the patient or the therapist (for example, age or diagnosis of the patient), but also to elements external to them (for example, public or private setting) (Edlund et al., 2002; Schottenbauer et al., 2008; Olfson et al., 2009; de Haan et al., 2013).

The meta-analysis by Kächele and Schachter (2014) compared to the size of the dropout phenomenon, i.e., the premature termination of therapy, shows percentages that oscillate between 32% of the study of Sledge et al. (1990) of psychotherapy with a limited duration and 67% for short psychotherapies (Sledge et al., 1990). The average percentage of dropouts of all the studies presented by Kächele and Schachter (2014) is in the order of 48%. In another meta-analysis on 11 researches on individual treatments of adults terminated with a dropout, Sharf et al. (2010) highlight (1) how there is a moderately strong relationship between therapeutic alliance and abandonment of therapy and (2) such as patients with a weaker therapeutic alliance have a higher chance of terminating therapy with a dropout. Moreover, the emotional response of the therapist during the treatment plays an important role in the dropout: the Frayn's (1992) study shows a significant correlation between the patient's abandonment of therapy and the attitudes of fear, hostility, and worry of the therapist.

On a more general level, an analysis of the literature gives an idea of the factors associated with the impasse (Weiner, 1974; Watkins, 1983; Taylor, 1984; Grunebaum, 1986; Atwood et al., 1989; Mordecai, 1991; Elkind, 1992; Nathanson, 1992; Pulver, 1992; Strupp, 1993; Omer, 1994; Newirth, 1995); Hill et al. (1996) aggregated them highlighting how, according to clinicians, impasse situations can be linked to:

- Pathology of the client, which prevents the latter from being able to benefit from the treatment.
- Contrasts between patient and therapist caused by the respective periods of life, different personalities, theoretical orientation or ultimately personal issues and preferences.
- Problematic aspects of the therapeutic relationship, as a weak to the therapeutic alliance, a rigid or unrecorded relationship or an infringement in the attachment bond.
- Failure to agree on the goals of the therapy or a failure in the communication of the same.
- Patient transference or inappropriate gratification of the patient.
- Countertransference of the therapist or personal issues that interfere with their ability to adequately deliver therapy.
- Errors of the therapist such as: a wrong diagnosis, acting-out, inappropriate interventions, collusion, pejorative communication or even the non-recognition of the goals achieved or reachable by the patient.
- Feelings of the patient's shame in addressing some issues related to cultural reasons.
- Irreconcilable conflicts and power struggles.
- Real issues related to the situation or external, such as the death of a relative.

In a few years' work, Kächele and Schachter (2014) report a list of factors generally associated with therapeutic failures, taken from a work by Stein (1972). Here they are:

- Incorrect diagnosis with the consequent administration of an unsuitable treatment.
- Inappropriate external conditions; such as those in which it is noted that external conditions are so unfavorable that it seems preferable to maintain a morbid state rather than to heal. Still those in which the behavior of the family supports every neurotic or psychotic manifestation of the patient. And finally, a series of real factors such as education, social class, economic status, and the effects of a trauma such as illness or mourning.
- Constitutional factors of the patient.
- Unwanted changes of the patient's ego with relapses in terms of personality disorder.
- Aspects related to transference and countertransference.

According to Kächele and Schachter (2014) the most neglected factor in almost all psychotherapies is countertransference, confirming the position of Frayn (1992) and pointing out that it is in fact the only factor significantly attributable to the therapist present in the list just mentioned. A study of single cases (Bergin and Strupp, 1972) and an idiographic approach, compared to the nomothetic one, seems more profitable than the case study methodology of bankruptcy cases. According to Barlow (2010) this method allows a series of advantages from the point of view of results, namely: (1) prevents important data from being diluted in group averages and (2) allows to identify cause/effect relationships for negative outcomes. As reported by Berk and Parker (2009), a longitudinal and retrospective approach would also give greater possibilities to discern specific factors from non-specific factors linked to negative outcomes.

As mentioned above, the therapist's reactions to the patient, whether conscious, unconscious, emotional and cognitive, internal or external, can be useful in diagnosis but can also negatively or positively influence the course of treatment (Winnicott, 1949; Heimann, 1950). According to Betan et al. (2005) the therapist's responses to the patient could provide an *in vivo* understanding of the patient's relational patterns. The patient could indeed inspire in the therapist those feelings that he is not able to recognize (Klein, 1946), but he could also urge the clinician to put into practice the agitation consistent with his expectations regarding the relationship (Ogden, 1982; Gabbard, 2001). In this sense, the concept of role-responsiveness, proposed by Sandler (1976), makes reference to the fact that the therapist acts coherently with the patient's relational paradigms, re-proposed by the latter in the psychotherapeutic relationship. Therefore, another aspect related to the phenomenon of the transference, is the one which sees the patient manipulating or provoking situations that are a concealed re-issue of past relationships and experiences with others (Sandler et al., 1973).

In order to operationalize the countertransference construct, Betan et al. (2005) have put in place the TRQ (Therapist Response Questionnaire or Countertransference Questionnaire). It is a tool that aims at evaluating the cognitive, affective, and behavioral response of a clinician in the interaction with a specific patient. This tool has been realized starting from a revision of the clinical, theoretical, and empirical literature on the concept of countertransference and the items it is composed of have been formulated with a common language and therefore they are used by clinicians who refer to clinical and theoretical different approaches. The TRQ identifies eight possible countertransference dimensions that can be stimulated by the patient during psychotherapeutic treatment. They represented the different reactions that therapists can have toward patients and that probably reflect a mixture of the therapist's own dynamics, responses evoked by the patient and by therapist-patient interactions. Furthermore, the different countertransference factors show a significant association with the DSM-IV TR cluster A, B, and C, which classify personality disorders; in particular, cluster A is correlated with the Criticized/Devalued countertransference, but it is not correlated with the Disengaged countertransference; cluster B is correlated with the countertransference Overwhelmed/Disorganized, Helpless/Inadequate, Disengaged, and Sexualized and is negatively correlated with the positive countertransference; cluster C is correlated with the Parental/Protective countertransference. What the authors point out is that the countertransference framework is very complex and more nuanced than a generic distinction between positive and negative countertransference. The significant correlations between the eight transference dimensions and the symptoms that characterize personality disorders show that the therapist's emotional responses are expressed in coherent and predictable patterns (Betan et al., 2005).

Therefore, not only do patients evoke specific responses in the therapist, related to his personal history and to the interaction in therapy, but also they elicit an average predictable response and probably similar to that of others important people in their life. The correlation between the activation of specific countertransference dimensions and the characteristics of the different personality disorders makes the countertransference very useful for a diagnostic understanding of the patient's dynamics and of the repetition of certain relational patterns (Betan et al., 2005).

MATERIALS AND METHODS

Aims of the Study

(1) Analyze the transcripts of the interviews, questioning the possible variables identified by the psychotherapist as causes of the dropout.
(2) Explore the linear associations between specific countertransference responses and dropouts.

Research Hypothesis

(1) It is expected that dropout cases are positively correlated with specific countertransference responses.
(2) It is expected that there are significant differences among therapist's countertransference responses, according to some structural variables related to the therapist (gender and orientation) and to the patient (gender and diagnosis).

Stages of Research

(1) 2018, February – March. Participants recruitment.
(2) 2018, April – May. Conducting interviews and data collection.

Sample Recruitment

The participants in this research were recruited through four modalities (1) informal network of contacts (2) the Google search engine (3) two professional sites gathering profiles with curricula and services offered by psychologists and psychotherapists: https://www.psicologi-italia.it and https://www.guidapsicologi.it/finally (4) Facebook group composed by psychologists and psychotherapists: https://www.facebook.com/groups/854281581289546/.

The participants were contacted both by telephone and by e-mail address. Later, an e-mail was sent to the therapists contacted by telephone with the request for participation in the research with an interview *de visu*. For the others, the e-mail was sent directly with the request for participation. To avoid possible bias, detailed information on the research design was provided at the end of the meeting. Before the interview, each participant was asked to sign the informed consent form and was asked to record the audio of the interview; all the participants agreed to both requests.

At the end of the interview, each participant was asked to fill in the TRQ with reference to the case illustrated during the interview; at the end, information and details regarding the research design were provided in a brief debriefing; only in one case the TRQ was completed after the meeting and withdrawn after 1 week from the interview. In another case only the interview was carried out, but it was not possible to administer

the TRQ. In one case, the question n° 22 of the fourth section of the interview and, in another case, the question n° 20 of the fourth section of the interview could not be formulated.

Sample of Therapists

The sample consists of a total of 29 psychologists – psychotherapists, among with there are 22 female and 7 male; 28 of these are Italian and 1 is Spanish. The average age is 44.7 years (SD = 9.2) with a range of 34–76 years. All recruited participants are registered in the professional register of psychologists and have been annotated in the Register of Specialization in Psychotherapy for at least 5 years. The general sample is composed of three subgroups that differ according to the psychotherapeutic orientation: Group 1 is formed by psychodynamic psychotherapists ($N = 10$), Group 2 by cognitive-behavioral guidance psychotherapists ($N = 9$), and Group 3 by psychotherapists to orientations not related to the first two ($N = 10$).

Dropout Cases

The sample of patients, examined in this survey and whose individual therapy ended with a dropout, is 29 subjects; of these 16 of females and 13 of the male gender. Compared to the diagnosis, referring to the DSM-IV TR, 17 patients had a symptomatology attributable to Axis I, 11 patients a disorder attributable to Axis II and 1 patient with no diagnosis. For 27 patients the setting was the private study, whereas for 1 patient the therapy was provided through an advisory service and for another one the therapy was provided via teleconference through the Skype software.

The average number of weekly sessions provided is 1.07; the number of sessions delivered ranges from 2 to 640 sessions (median = 26, $M = 55.79$, SD = 119.18) for a period ranging from 1 to 108 months (median = 6, $M = 15.08$, SD = 25.60). Sessions characterized by an impasse situation range from 0 to 80 (median = 3, $M = 6.67$, SD = 14.41).

Instruments

Impasse Interview

Hill et al. (1996) have put The Questionnaire On Impasse into Individual Therapy, a self-report tool to compile paper and pen, developed from a review of the literature on stalemates in psychotherapy and from the Rhodes et al. (1994) questionnaire. The questionnaire retrospectively investigates a salient or recent case that occurred to the terminated therapist. The questionnaire consists of four sections: (1) General information about the therapist, regarding his training and his psychotherapeutic orientation (2) general information on the situations of impasse experienced by the therapist (3) general information about the patient involved in recent or salient impasse situation (4) in-depth analysis of the impasse with the chosen patient.

The definition of impasse proposed to the therapists was that of a situation of difficulty or stalemate that leads the therapy to become so difficult and complicated as to make it impossible to progress and to cause an interruption. Furthermore, the impasse situation was accompanied by feelings of anger, disappointment, or sense of failure on the part of the therapist or patient.

For the present study, the questionnaire by Hill et al. (1996) was translated into Italian, revised by a doctor in English mother tongue psychology, and culturally adapted to the Italian context. The original questionnaire was then reshaped into a structured interview with the same four thematic sections; no questions have been added or deleted from the Hill et al. (1996).

Therapist Response Questionnaire

The Italian version of the TRQ (Zittel Conklin and Westen, 2003; Betan et al., 2005) has been translated and validated by Tanzilli et al. (2016). Like the original version, it is composed of 79 items that investigate a wide range of thoughts, feelings and behaviors of the therapist toward the patient. Compared to the version of Betan et al. (2005) in the Italian version there was the introduction of a ninth factor, obtained through the split of the Criticized/Mistreated factor in: "Criticized/Devalued" and "Hostile/Angry." The Hostile/Angry factor refers to items that indicate anger, hostility and irritation toward the patient. In the Italian version an analysis was also performed to verify the correlation between the nine factors and the specific personality disorder with the SWAP – 200 scales (Westen and Shedler, 1999a,b; Shedler and Westen, 2004, 2007) in the version Italian by Shedler et al. (2014); in the version of Betan et al. (2005) was carried out only at the level of Clusters A, B, and C. The criterion validity test showed a strong significance between the therapist's response and the patient's personality disorder.

Data Analysis

The questionnaire was analyzed performing statistical analyzes with SPPS 22.0 for Windows (IBM, Armonk, NY, United States). Descriptive, correlational, and *post hoc* analysis were performed.

The interview was audio-recorded and then transcribed electronically using an online transcription software and its application[1]. The transcriptions were subsequently supervised in analog mode. The *verbatim* of the interviews was analyzed with T-LAB (version 7.3.0; Lancia, 2004). It is a Computer Assisted Data Qualitative Analysis Software (CAQDAS), based on a mixed-method (i.e., quantitative and qualitative) and consisting of a set of linguistic, statistical and graphical tools, that allow, through several algorithms, to carry out different operations both an exploratory as well as an interpretative level to deepen the texts. In particular, it allows to evaluate the relations among words (i.e., lexical units) within a entire text (i.e., the *corpus*), or within specific sections of the text (i.e., the elementary context – that is, the segmentation of the corpus automatically done by the software, or the context units – that is, the segmentation of the corpus done by the researcher on the basis of some independent variables). Unlike theory-driven software, that store information produced by the researcher and return it in an orderly manner, T-LAB is a word-driven software able to create new data (e.g., occurrence and co-occurrence matrices). They have to be interpreted. In this perspective, the software T-LAB, combining linguistics and statistics, offers advantages in term of rigor and reliability of the analyses (Lancia, 2004).

[1] transcribe.wreally.com

TABLE 1 | Mean values of the nine countertransference of the TRQ.

Types of controtransfert	Overall mean (SD)	T. men mean (SD)	T. women mean (SD)	P. men mean (SD)	P. woman mean (SD)	Axis 1 mean (SD)	Axis 2 mean (SD)
Helpless/Inadequate	2.81 (0.93)	1.86 (0.60)	3.13 (0.80)	2.61 (1.00)	2.98 (0.86)	2.50 (0.76)	3.27 (1.03)
Parental/Protective	2.78 (0.91)	2.66 (0.83)	2.83 (0.95)	2.57 (1.03)	2.98 (0.78)	2.91 (0.93)	2.51 (0.85)
Positive/Satisfying	2.59 (0.62)	2.71 (0.32)	2.55 (0.69)	2.56 (0.46)	2.62 (0.73)	2.72 (0.42)	2.37 (0.81)
Overwhelmed/Disorganized	2.35 (0.90)	1.80 (0.57)	2.55 (0.92)	2.04 (0.65)	2.62 (1.02)	1.95 (0.57)	2.90 (1.01)
Criticized/Devalued	2.14 (0.77)	1.71 (0.53)	2.29 (0.80)	1.84 (0.67)	2.41 (0.78)	1.82 (0.55)	2.65 (0.84)
Hostile/Angry	2.08 (0.63)	1.88 (0.38)	2.15 (0.70)	2.00 (0.66)	2.14 (0.63)	1.81 (0.54)	2.43 (0.62)
Disengaged	1.88 (0.60)	1.66 (0.50)	1.94 (0.63)	1.89 (0.66)	1.85 (0.57)	1.81 (0.57)	1.87 (0.63)
Special/Overinvolved	1.68 (0.56)	1.74 (0.80)	1.66 (0.48)	1.43 (0.44)	1.89 (0.58)	1.80 (0.65)	1.53 (0.38)
Sexualized	1.33 (0.62)	1.39 (0.57)	1.31 (0.65)	1.58 (0.82)	1.12 (0.25)	1.39 (0.66)	1.11 (0.38)

In this study, the corpus was composed by the 29 interviews. Before starting the analyses, the corpus needs to be cleaned, following the rules of cleaning and adaptation of the text, as foreseen by the developers of the software. For the aims of this study, sections 3 and 4 of each interview were used, i.e., those that concerned the chosen case of dropouts in its general aspects and then specific with respect to what happened. Specifically, three different analyses were performed: the thematic analysis of elementary contexts, the correspondence analysis and the specificity analysis. The thematic analysis of the elementary contexts allows to build a representation of the corpus content through the identification of significant thematic clusters (from a minimum of 3 to a maximum of 50): each cluster consists of a set of elementary contexts (i.e., sentence or paragraph) characterized by the same keywords patterns and is described through the lexical units and variables that most characterize the elementary contexts of which it is composed. The result of these analyzes allows a mapping of general or specific themes characterized by the co-occurrence of semantic traits.

The correspondence analysis allows to detect the similarities and the differences among the context units; in particular with respect to the words for categories of a variable with occurrence values. Similar to factor analysis, this analysis extracts a set of new variables (i.e., factors), each of them setting up a spatial dimension on the negative and positive endpoints: the elements (levels of variables and words) that are placed on opposite ends of the factor are most different from each other. Finally, the specificity analysis allows to identify which lexical units are typical (i.e., statistically over-used) or exclusive in a portion of the corpus identified by a categorical variable. Both the correspondence analysis and the specificity analysis are comparative analyses that allow to make a comparison among different segments of the corpus: the first one is possible only with variables that have at least three levels, while the second one can be performed also with two levels variables. In our study, these following independent variables were examined:

(1) Orientation of the therapist: Psychodynamic, Cognitive-behavioral and Other orientations (three levels).
(2) Diagnosis: Axis I, Axis II, and No Diagnosis (three levels).
(3) Post dropout supervision: Yes, No (two levels).
(4) Method of interruption of treatment: *de visu* (communicated during a session), mediated (through a telephone communication or with a mobile phone message), therapist (when the therapist communicates the impossibility of continuing treatment), and none failure to communicate of the end of therapy by the patient (four levels).
(5) Triangulation (Hill et al., 1996): Yes, No (two levels).

RESULTS

Twenty-eight therapists filled in the TRQ. It is made up of 21 females and 7 males. The average age of the group is 44.9 years (SD = 9.3), with a range from 34 to 76 years. With respect to orientation, 10 therapists had a psychodynamic approach, 9 a cognitive-behavioral approach and 9 referred to other approaches. The group of dropout cases examined is therefore 28 patients, of which 13 (46.4%) of the male gender and 15 (53.6%) of the male gender. Compared to the diagnosis, 16 (57.1%) of these patients reported symptoms referring to Axis I, 11 (39.3%) to Axis II and 1 (3.6%) no diagnosis.

Emotional Responses of Therapists in Dropout Cases

The mean values of the sample compared to the nine countertransference dimensions are reported in **Table 1**. In particular, we have indicated the overall values; the values by the therapist's gender (second and third columns); the values by the patient's gender (fourth and fifth columns); the values by the patient's diagnosis (sixth and seventh columns).

The therapist's gender differences, as well as the patient's gender and diagnosis differences by the therapist's emotional responses and specific countertransference factor were explored using several *t*-test for independent samples, applying the Bonferroni correction ($p < 0.005$). With respect to the therapist's gender and to the patient's diagnosis no significant differences emerged: the mean values do not differ significantly neither between male and female therapists nor between patients with Axis I or Axis II diagnosis. However, the imbalance between men and women requires to consider the results related to the gender of the therapist still provisional. On the contrary,

with respect to the patient's gender, a significant difference emerged for the Sexualized countertransference with the female group showing a lower average than the group of male patients [$t_{(26)} = 2.06$, $p = 0.000$]. For all other factors the mean values do not differ significantly.

Finally, the therapist's orientation differences by the emotional responses and specific countertransference factor were explored using an one-way ANOVA, applying the Bonferroni correction ($p < 0.005$). Findings show that the psychotherapeutic orientation has not a significant influence on any of the countertransference factors, that is there are not specific countertransference styles depending on the therapist's orientation.

Results of Textual Analysis of Transcripts With T-LAB

Compared to the variables examined for this analysis, the results of the group of therapists show among them 15 (5 males, 10 females) who did not carry out post-dropout supervision while 14 (2 males, 12 females) instead performed it. Regarding the Triangulation variable in 23 cases the presence was not detected, in six cases it was present. Compared to the Mode of Communication of the interruption of therapy, in 10 cases it was communicated by the patient *de visu*, in 8 cases, instead, it occurred by telephone with a message or a call. Furthermore, in three cases it was the therapist to report to the patient the interruption of the therapy and in eight there was no communication of the interruption by the patient.

Thematic Analysis of Elementary Contexts

The thematic analysis of elementary contexts with the use of the measure of the cosine through the bisecting method K-means (Savaresi and Booley, 2001), implemented on the whole corpus of the 29 interviews, produced a five thematic cluster solution (the distribution in the factorial space is shown in **Figure 1**).

- Cluster 1, labeled *Mother Figure*, aggregates 446 elemental contexts of the 1682 classified, which correspond to 25.52% of the variance (see **Table 2**).
- The presence of words like *she*, *mom*, *mother* evokes the reference to a mother figure; moreover, the terms *alone*, *search for*, *to imagine* connote this female figure with respect to experiences of absence or difficulty.
- Cluster 2, named *Diagnosis*, aggregates 303 elementary contexts of the 1682 classified, which correspond to 18.01% of the variance (see **Table 2**).
- In this cluster the recurrence of the terms *diagnosis*, *disorder*, *evaluation*, *axis*, and *origins* refer to a purely diagnostic theme linked therefore to the patient's pathology and to its evaluation. The recurrence with the word *Axis II*, *Personality Disorder* refers to a specific type of psychological distress.
- Cluster 3, named *Relationship Configuration*, aggregates 395 elemental contexts of the 1682 classified, which correspond to 23.48% of the variance (see **Table 2**).
- The presence of terms such as *to ask*, *to take*, *know*, *therapeutic alliance*, *relationship* refer to a relational dimension. In particular, can observe the recurrence of verbs that express different modalities and approaches with respect to the interactions and motivations that can connote an interpersonal relationship. The terms *time*, *to happen*, *hourly*, and *work* evoke the temporal dimension of the therapeutic relationship.
- Cluster 4, named *Awareness*, aggregates 262 elemental contexts of the 1682 classified, which correspond to 15.58% of the variance (see **Table 2**).
- For this cluster the recurrence of the words *to understand*, *sense*, *path*, evokes a procedural aspect of understanding what happened; the same adverb *probably* refers to a retrospective reasoning with respect to hypotheses and reflections. Even the terms such as *bound*, and *to tie* can refer to phrases that refer to the connection between events, precisely *linked* to each other and that can be put in relation.
- Cluster 5, named *Dropout*, aggregates 276 elemental contexts of the 1682 classified, which correspond to 16.41% of the variance (see **Table 2**).
- In this cluster the presence of terms such as *impasse*, *to end*, *before*, *last*, *session* specifically evokes the psychotherapeutic treatment and the relative stalemate with the consequent early interruption.

Distribution Analysis

We proceeded with the analysis of the distribution of the five clusters among the different levels of the following variables: Diagnosis, Orientation, Supervision, and Triangulation.

As for the Diagnosis variable, the Axis I diagnosis is explained for its 25.8% variance from cluster 1, 18.7% from cluster 2, 23.5% from cluster 3, 14.1% from cluster 4 and 17.8% from cluster 5. With reference to the diagnosis on Axis II the variance is explained at 28.2% from cluster 1, 17.3% from cluster 2, 22.2 from cluster 3, 18.4% from cluster 4 and 14% from cluster 5.

Compared to the Orientation variable, the cognitive-behavioral orientation sees its variance explained to 20.7% by cluster 1, to 19.2% by cluster 2, to 22.1% by cluster 3, to 20.7% by cluster 4 and to 17.3% by cluster 5; for the psychodynamic orientation cluster 1 explains to 29.2% of the variance, 15.7% the cluster 2, the 22.3% from the cluster 3, 14.7% the cluster 4 and 18.1% from the cluster 5. The variance for the other psychotherapeutic orientations is the following: 30.1% the cluster 1, 19.3% the cluster 2%, 26.4% the cluster 3, the 10.8% the cluster 4 and the 13.5% the cluster 5.

Compared to the Supervision variable, for cluster of therapists who performed it, cluster 1 explains 36.3% of variance, 15.2% cluster 2, 22.1% from cluster 3, 12.6% cluster 4 and 13.9% from cluster 5. The variance for the group that did not perform post dropout supervision is explained with these results: 19.1% cluster 1, 20.2% cluster 2, 24.6% cluster 3, 17.9% cluster 4 and 18.3% cluster 5.

Compared to the Triangulation variable, for the group of cases in which the presence of this variable did not occur, cluster 1

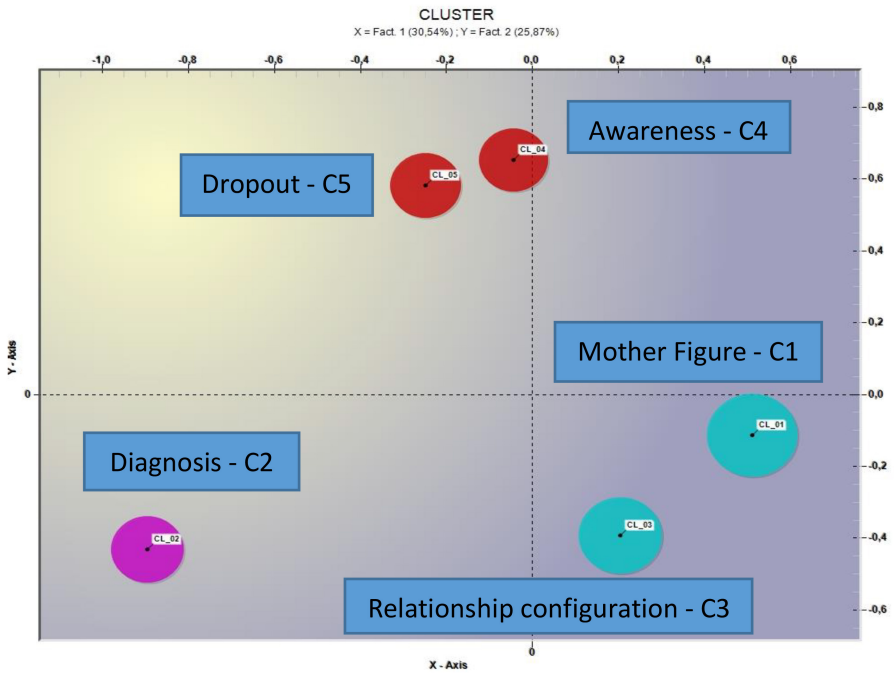

FIGURE 1 | Representation of the spatial distribution of the five thematic clusters.

TABLE 2 | Thematic analysis of elementary contexts.

Cluster 1		Cluster 2		Cluster 3		Cluster 4		Cluster 5	
Lemma	χ^2	**Lemma**	χ^2	**Lemma**	χ^2	**Lemma**	χ^2	**Lemma**	χ^2
She	562.22	Years	252.47	To ask	199.30	To understand	142.33	Impasse	106.62
Receive	36.85	Diagnosis	84.01	To take	126.03	Probably	95.03	Before	64.64
Alone	36.85	Disorder	71.54	Appearance	68.40	To tie	88.13	To end	60.16
Search for	34.46	Rating	68.88	Work	52.66	Bound	72.67	Last	58.49
To write	31.50	Anxiety	59.46	Time	46.71	Path	55.17	Of course	51.65
To imagine	29.67	Way	58.66	To happen	43.04	Happen	53.74	You	43.24
Mom	26.17	I remember	58.06	Much more	39.90	_interv_27	42.78	Sitting	37.77
To resume	25.82	Recent	44.64	Boy	37.19	Respect	40.29	Thing	35.09
Series	25.21	To dream	41.03	Therapeutic_alliance	36.07	Sense	37.45	May	31.20
Reality	24.58	Axis	35.75	Ok	33.57	_interv_6	35.57	Coping	30.75
Mother	23.00	Origins	35.75	Decision	30.34	Persistent	32.93	Best wishes	30.12
_interv_19	22.80	Personality_disorder	34.82	Report	26.02	Usual	32.69	Guide	30.12
Answer	21.68	Novo	34.82	Good	24.10	Aloof	27.44	To shift	29.67
Return	21.68	Anxious	34.57	Know	23.83	Bag	26.54	Go out	28.88
_supervis_yes	21.55	Meetings	32.07	Schedule	22.91	Past	26.32	To consider	26.94

explains to 25.8% of the variance, 17.5% the cluster 2, 24.8% from the cluster 3, 15% the cluster 4 and 17% from cluster 5. The variance for the group in which there was a triangulation is explained with these results: 29% cluster 1, 19.8% cluster 2, 19.1% cluster 3, 17.6% cluster 4, and 14.5% cluster 5.

Correspondence Analysis

The correspondence analysis, aimed at comparing different segments of the corpus, was performed for the Orientation, Diagnosis and Communication variables (test threshold value for significance ±1.96).

Orientation

The correspondence analysis for the Orientation variable (see **Figure 2**) showed two factors explaining, respectively, 53.38% and 46.62% of the data variance.

With respect to the first factor (i.e., horizontal axis) the negative factorial polarity shows a test value for the Cognitive-behavioral orientation of −46.12, for the positive factorial

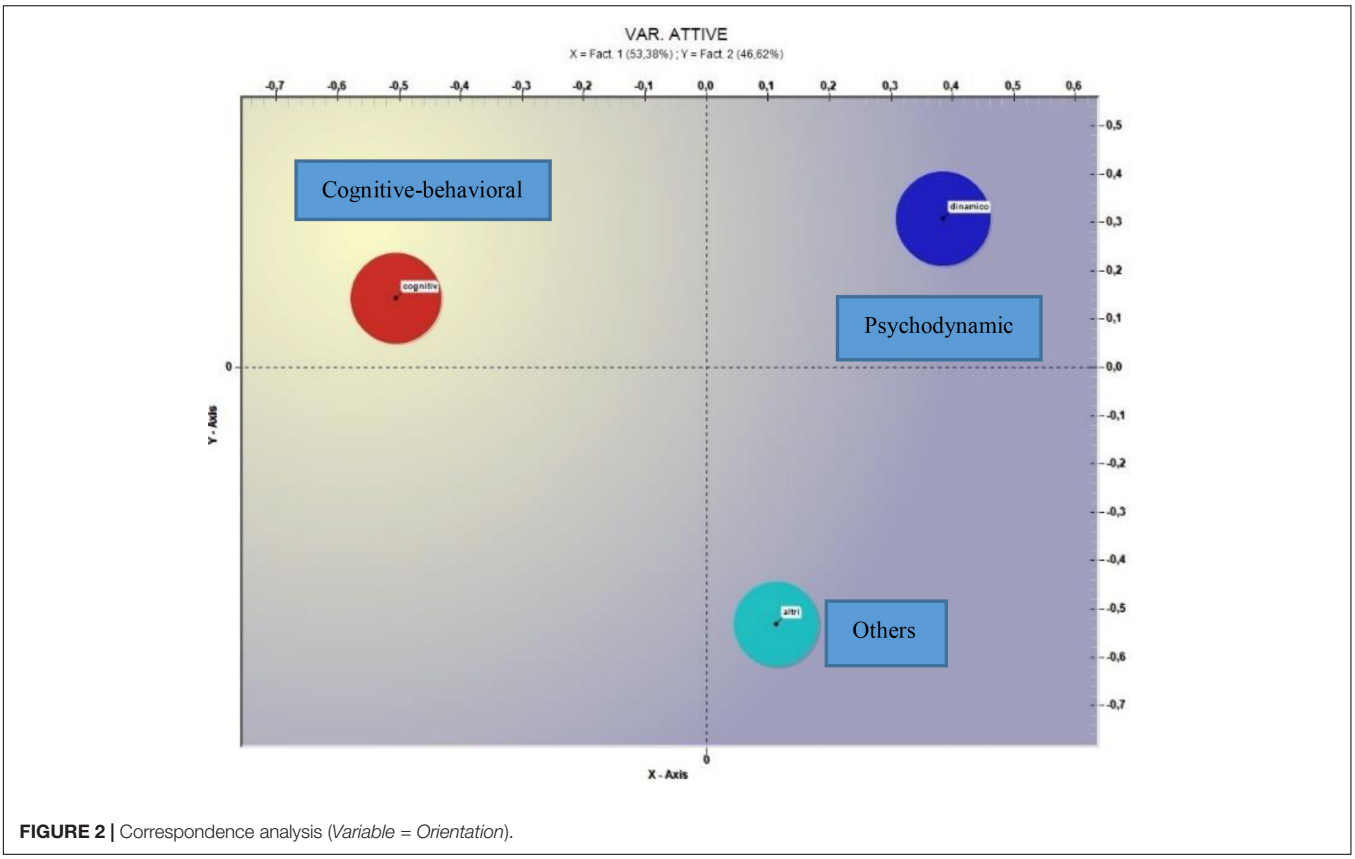

FIGURE 2 | Correspondence analysis (*Variable = Orientation*).

TABLE 3 | Correspondence analysis – therapeutic orientation.

Horizontal axis				Vertical axis			
Negative polarity		Positive polarity		Negative polarity		Positive polarity	
Lemma	Test value	Lemma	Test value	Lemma	Test value	Lemma	Test value
Cogn-behavior	−46.12	Psychodynamic	36.57	Others	−44.16	Psychodynamic	29.32
Sensation	−4.13	Others	9.40	Speech	−5.15	Cogn-behavior	13.03
Uncle	−4.15	Stuff	4.36	She	−5.53	Parent	4.16
Own	−4.27	Sons	4.06	Problem	−5.66	Comes	3.63
You	−4.73	Skip	3.57	To lose	−4.59	Sons	3.48
Probably	−4.85	Become	3.55	Receive	−4.68	Search for	3.11
Father in law	−4.98	Happen	3.43	Return	−4.74	Supervisor	3.04
Exit	−3.19	Partner	3.37	Work	−4.37	To start	3.00
To determine	−3.26	Separation	3.36	Ache	−3.27	Separation	2.88
Emotion	−3.26	Times	3.21	For me	−3.12	Little boy	2.88
Phobic	−3.26	Shoe	3.21	Method	−3.14	Work	2.87

polarity the value of the test for the Psychodynamic orientation is 36.57 and for the Other orientations of 9.40; in **Table 3** the most significant terms and the respective test values can be found.

The correspondence analysis with respect to the vertical axis shows a test value for the others mode of −44.16 for the negative factorial polarity; the test value for the Psychodynamic orientation is 29.32 and the Cognitive-behavioral of 13.03 for the positive factorial polarity. In **Table 3** the most significant terms and the respective test values.

Diagnosis

The correspondence analysis for the Diagnosis variable (see **Figure 3**) showed two factors explaining, respectively, 54.95 and 45.05% of the data variance.

With respect to the horizontal axis the negative factorial polarity shows a text value of Axis I – 45.53; the value of the test of Axis II is 45.70 for the positive farm polarity. With respect to the vertical axis it produces a test value for the mode No diagnosis of −42.15 for the negative polarity; the test value for Axis I is 8.80

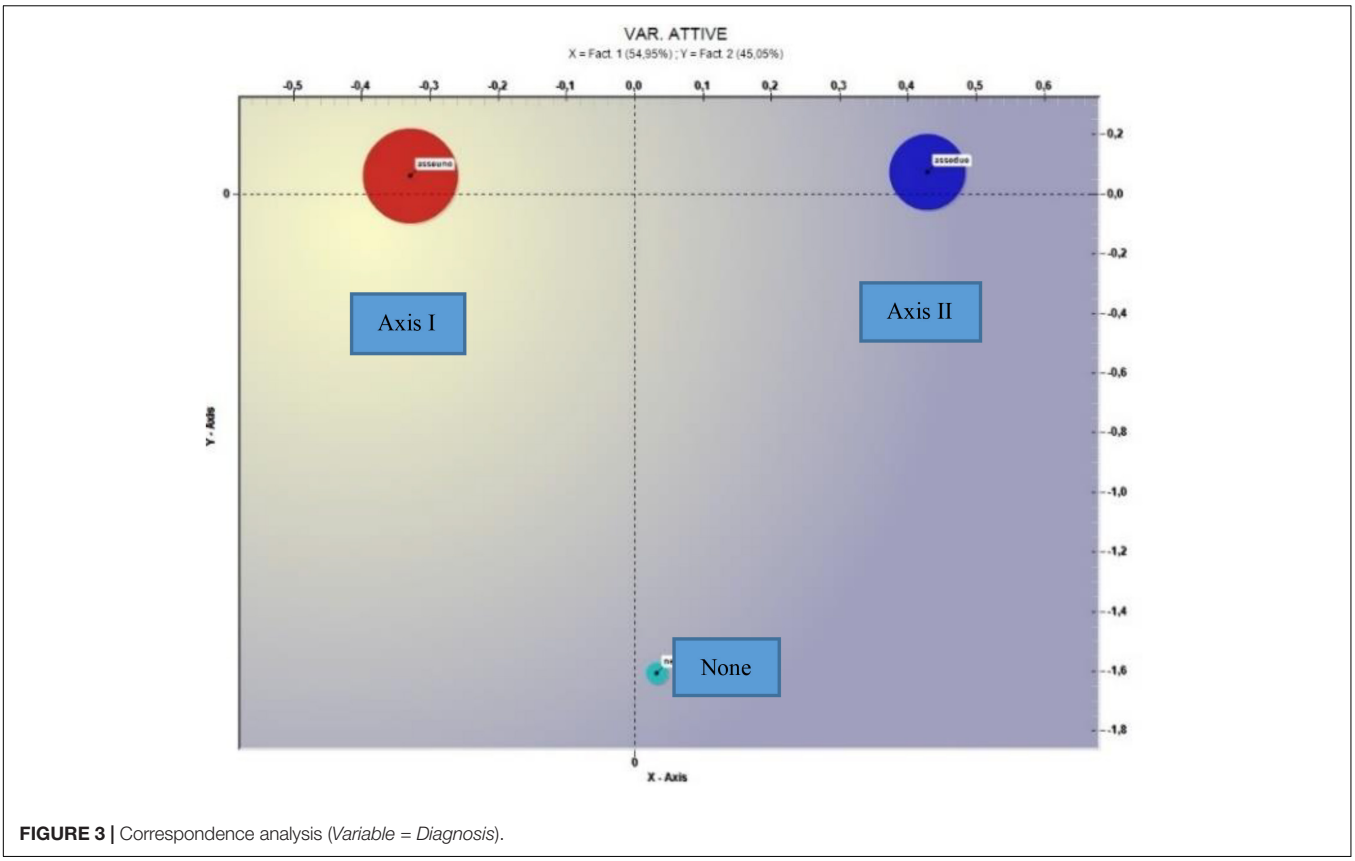

FIGURE 3 | Correspondence analysis (*Variable = Diagnosis*).

TABLE 4 | Correspondence analysis – diagnosis.

Horizontal axis				Vertical axis			
Negative polarity		Positive polarity		Negative polarity		Positive polarity	
Lemma	Test value	Lemma	Test value	Lemma	Test value	Lemma	Test value
Axis I	−45.53	Axis II	45.70	No diagnosis	−42.15	Axis I	8.80
Parent	−5.89	Own	9.40	Wife	−10.34	Axis II	8.07
Child	−5.04	Father in law	5.70	Emotion	−9.79	To success	2.43
Availability	−5.08	Obviously	4.36	To ask	−8.58	Years	2.12
To happen	−3.30	Return	3.78	You	−8.60	To understand	2.06
Appointment	−3.37	Boy	3.69	Way of doing	−7.15		
Know	−3.45	Stay	3.62	Shortly before	−7.15		
Play	−3.54	Not no	3.55	I remember	−7.65		
Clearly	−3.54	Borderline	3.50	Today	−6.41		
To find	−3.63	Front	3.47	To save	−6.54		
Life	−3.83	To leave	3.26	Ok	−5.08		

and for Axis II it is 8.07 for the positive polarity. In **Table 4** the most significant terms and the respective test values.

Communication

The correspondence analysis for the communication variable showed three factors; we considered the first two, explaining, respectively, 36.53 and 33.37% of the data variance (see **Figure 4**).

With respect to the horizontal axis the negative factorial polarity shows a test value for the therapist mode of −38.84 and −12.27 for the Mediated mode, for the positive factorial polarity it produces for the No communication mode a test value of 36.91. With respect to the vertical axis, the negative factorial polarity produces a test value of −34.79 for the Mediated mode and for the *de visu* mode of −14.05, for the positive factorial polarity it produces a test value for the Therapist mode of 27.38 and for the modality No communication of 25.32. In **Table 5** the most significant terms and the respective test values can be found.

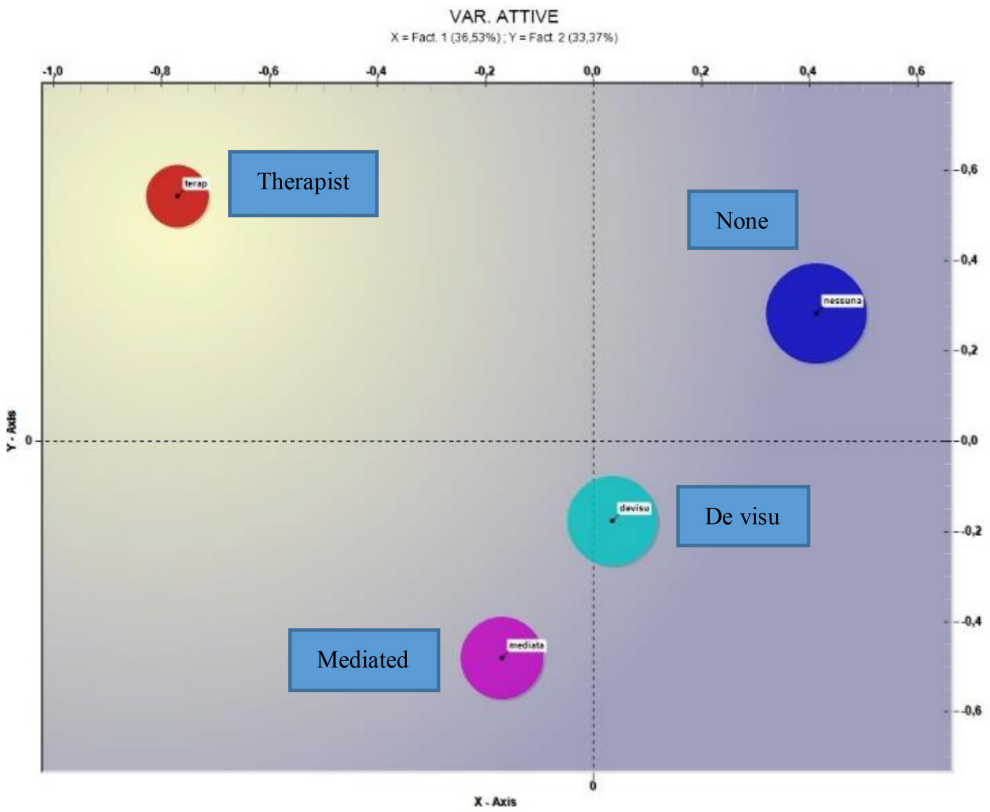

FIGURE 4 | Correspondence analysis (*Variable* = *Communication*).

Specificity Analysis

Finally, the specificity analysis on the Supervision and Triangulation variables was carried out. Below are the results that refer to the therapists who have carried out post-dropout supervision and to those who have not done so. **Table 6** shows the exclusive lexical units of Supervision or No supervision group comparing the whole corpus and their occurrence.

Table 7 shows the results, relative to the presence/absence mode of post dropout Supervision, compared to the typical lexical units; chi-square (threshold value $\chi^2 = 3.84$, $df = 1$, $p = 0.05$).

The results of the analysis of the specificities comparing to the cases in which a triangulation was present between the variables associated with the impasse can be found below. In **Table 8** the exclusive lexical units and their occurrence are presented.

Table 9 shows the results, relative to the presence/absence mode of Triangulation, with respect to the typical lexical units; chi square (threshold value $\chi^2 = 3.84$; $df = 1$; $p = 0.05$).

DISCUSSION

There are four countertransference responses that are on average more stressed than the other 5; in order: Helpless/Inadequate, Parental/Protective, Positive/Satisfying, and Overwhelmed/Disorganized. The reaction and the most widespread feelings by the therapist in the dropout cases seem to be those of inadequacy, incompetence and anxiety; the awareness of being in a deadlock and the inability or impossibility to solve it could have led to this experience. The second most urged factor is the Parental/Protective: the therapist feels invested in a parental role and feels compelled to take care of the patient in ways that exceed what may be normal positive feelings toward the patient. This factor, moreover, as noted by Betan et al. (2005), is positively correlated with personality disorders of DSM-IV TR cluster C: avoidant, obsessive-compulsive, and dependent (Sanavio and Cornoldi, 2001). Therefore, it is hypothesized that the above-average presence of the group of this factor can be connected to the presence of incorrectly diagnosed cluster C personality disorders.

In this sense it is interesting to point out that the disorders of cluster C are the most widespread in the general population (Torgersen et al., 2001; Coid et al., 2006; Torgersen, 2014); with respect to the clinical population, the most widespread personality disorder is borderline ($M = 28.5\%$), the second is avoidant ($M = 24.6\%$), and the third is dependent ($M = 15\%$) (Torgersen, 2014). It is emphasized for the present discussion that the disorders of the Cluster C are characterized by a strong difficulty in the management of work and in establishing and maintaining intimate affective relationships. This seems congruent with the general background of the patients examined that are characterized by a past of difficulties

TABLE 5 | Correspondence analysis – communication.

Horizontal axis				Vertical axis			
Negative polarity		Positive polarity		Negative polarity		Positive polarity	
Lemma	Test value	Lemma	Test value	Lemma	Test value	Lemma	Test value
Therapist	−38.84	No communication	36.91	Mediated	−34.79	Therapist	27.38
Mediated	−12.27	Respect	5.59	*De visu*	−14.05	No communication	25.32
Error	−5.01	Stuff	4.30	Receive	−4.06	Fifteen	5.24
Borderline	−5.23	Appointment	4.27	Finance	−4.33	Uncle	4.79
Problem	−5.33	In mind	4.16	Pharmacological support	−3.05	You	4.39
Admitted	−4.05	Father in law	4.05	Confusion	−3.11	To escape	3.68
Money	−4.08	I remember	3.79	Record	−3.13	Community	3.66
Thirteen	−4.09	Dream	3.78	Employee	−3.17	Phobic	3.66
Graduate	−4.16	Sensation	3.76	Important	−3.20	Failure	3.49
To escape	−4.18	Little boy	3.75	Return	−3.26	Appointment	3.44
Be sorry	−4.23	Comes	3.72	Easy	−3.37	Similar	3.34
She	−4.28			of _this_type	−3.40	Punch	3.34

in interpersonal relationships. Furthermore, the presence of a personality disorder in this cluster is associated with worse outcomes in the treatment of Axis I disorders (Shea et al., 1990; Reich and Vasile, 1993). This could partly explain the dropouts even in cases where the patient has shown a psychopathological picture in the first instance afferent to Axis I disorders.

Comparing to the cases examined, the therapist seems to try, even more than the average of the other factors, feelings of satisfaction (Positive/Satisfying factor) and a conviction with respect to the good course the therapy; the patient himself could contribute to this countertransference response, with the formal adhesion to the therapeutic path and with a compliant attitude and acquiescent behaviors toward the therapist. It could indeed be only a phase of treatment: the reference is to that positive period of progress that often precedes a stalemate, but which is actually fueled by the patient's transference toward the therapist and not by a real change and transformation of the patient (Freud, 1915–1917).

This would be an impasse of "withdrawal," that according to Safran et al. (2014) occurs when the patient shows excessive compliance or fails to express his difficulties. Another aspect to be taken into account is that the Positive/Satisfying countertransference activation could be linked to the often incorrect assumptions with respect to the degree of satisfaction (Norcross, 2005). Therefore, the feeling that there is a good therapeutic alliance could actually conceal a misalignment with respect to objectives and strategies. Another explanation of the activation of this factor above the group average could be linked to the positive re-evaluation of the impasse event, possibly influenced also from the time passed between the completion of the questionnaire and the dropout case described.

Finally, the fourth emotional response of the most stressed therapist refers to the Disorganized/Overwhelmed factor and shows how the therapist experiences strong feelings of repulsion and resentment toward the patient and wishes to escape from it. On one hand, this could be influenced by the stressful situation to which the therapist is subjected and on the other could be linked to one of the patterns that the patient unconsciously evokes in the therapist (Betan et al., 2005), prompted in this case to confirm possible expectations of rejection by the patient (Ogden, 1982; Gabbard, 2001).

The analyses on the presence of differences among therapist's countertransference responses according to some structural variables confirm only partially the hypotheses. Indeed, there were not significant differences related to the therapist (gender and orientation) variables as well as to the patient's diagnosis. On the contrary, a significant difference emerged for the patient's gender with female patients eliciting less sexual feelings in the therapist than the group of male patients. However, this finding could be explained by the gender imbalance in the sample of therapists consisting of 21 women and only 7 men and it requires further investigation.

Although only a significant difference between male and female patients emerged for sexualized countertransference, overall the relevance of transference in dropout situations is underlined by the present research, as already demonstrated by other studies (Weiner, 1974; Atwood et al., 1989; Elkind, 1992; Nathanson, 1992; Pulver, 1992; Hill et al., 1996). Indeed, therapists in stalemate situations report having difficulty in managing and containing what are the patient's negative affects, as can be closely linked to the failure to overcome past situations or to opposing and provocative behavior even with a difficult management of the setting. This last aspect is one of the characteristics of the Special/Overinvolved countertransference, which presents in the whole group of therapists values below the general average. Some themes related to countertransference seem to play a role; the therapists recognize elements that can be traced back to their personal history and to past experiences reactivated by treatment with the patient; there is an excessive desire to achieve good intervention and good clinical performance. This therapist's personal expectation may have affected the moment they put the centrality of the patient and the therapy in the background. This aspect would seem to be

TABLE 6 | Exclusive specificity analysis – no supervision group vs. supervision group.

No supervision		Supervision	
Lemma	**Occurrence**	**Lemma**	**Occurrence**
Father in law	14	Serious	13
Uncle	13	Return	10
Thing	11	Structure	9
To avoid	9	Dog	7
Own	9	Machine	7
Request	9	Ugly	6
April	8	Community	6
Mate	8	dark_Queen	6
Component	8	To exist	6
Guide	8	Pregnancy	6
Improvement	8	Abandonment	5
Avoidance	7	Hospitality	5
In discussion	7	Activated	5
Schedule	7	Included	5
To escape	7	Depressed	5
Alternative	6	Distraction	5
Borders	6	Paranoid_disorder	5
Emotion	6	Letter	5
Phobic	6	Improve	5
Frankly	6	Permit	5

TABLE 7 | Typical specificity analysis – no supervision group vs. supervision group.

No supervision		Supervision	
Lemma	χ^2	**Lemma**	χ^2
She	37.91	To ask	16.07
Mom	22.65	Comes	13.24
I think	22.19	Speech	13.24
Supervision	18.18	Path	12.32
Anger	17.99	Stuff	11.36
Receive	16.47	Clearly	10.19
Own	16.40	In mind	9.89
Jump	15.73	To find	9.55
Sitting	13.38	Sensation	8.78
Psychiatrist	11.82	Latest	8.75
Patient	11.81	Appointment	7.74
Little boy	10.62	Positive	7.60
Drug	9.44	Wife	7.56
Obviously	9.43	Idea	7.49
Live	8.72	Different	7.36
Difficult	8.40	Real	7.28
Pharmacological support	8.30	Era	7.28
Confusion	8.23	Place	7.28
Scare	8.23	Previous one	7.28
Report	7.79	Today	7.04

TABLE 8 | Exclusive specificity analysis – triangulation group vs. no triangulation group.

Triangulation		No triangulation	
Lemma	**Occurrence**	**Lemma**	**Occurrence**
Father in law	14	Error	24
Little boy	12	Brother	20
Shoe	10	To pay	20
Eighteen	7	To introduce	17
Borders	6	Place	13
Reconnect	6	Expectation	12
Constitute	5	Panic attacks	12
Distraction	5	Staff	12
Cannabis	4	To disappear	12
Setting up	4	Approach	11
Maturity	4	Position	11
At the same time	4	Space	11
Neuroscience	4	Confusion	10
nutritionist	4	Trust	10
potere_AMB	4	Return	10
Shame	4	Sorry	10
		Excuse	10
		Money	10
		Anxious	9
		Elaborate on	9

TABLE 9 | Typical specificity analysis – triangulation group vs. no triangulation group.

Triangulation		No triangulation	
Lemma	χ^2	**Lemma**	χ^2
Parent	66.16	I	25.87
Speech	35.82	You	20.89
Child	22.83	For me	12.05
Sensation	22.07	We	8.81
Involve	20.73	To ask	8.74
Of this type	20.65	Time	8.69
Therapy	19.91	Ok	8.50
Mate	18.23	Stuff	8.22
Of course	16.85	Person	7.73
Indoor	15.45	Fear	6.83

linked to what is detected and defined in the research by Hill et al. (1996) as a fixation on the so-called role of the savior, in which the therapist feels he must "save" his patient and take care of it at all costs. These stresses are attributed to personal motivations by a therapist who has influenced the choice of a helping profession.

On this theme Miller (1996) maintains that there is a common past for those who choose the profession of psychotherapist; in his opinion, those who practice this discipline have developed "a special sensitivity for the unconscious signals of the needs of others" because they have been the object of satisfying of the parents' emotional needs during childhood. For Miller, in the past of those who practice the profession is "always present a deeply insecure mother on the emotional level, which for her own emotional balance depended on a certain behavior or way of being of the child" (ibid., P.15). With time, the child to ensure

his parents' love refines his ability to respond and be supportive (Miller, 1996).

From the analysis carried out with T-LAB, the five thematic clusters that emerged offer interesting food for thought. As it also emerges on a graphical level, the thematic nuclei produced could be grouped into three large thematic areas, given the spatial contiguity between them.

(1) Cluster 1 – *Mother figure* and cluster 3 – *Relationship configuration* could constitute a *first area* that probably evokes a transference or countertransference theme linked in a salient way to a female figure.
(2) A *second thematic area* is the one related to cluster 2 – *Diagnosis* linked specifically to the pathology and its severity. This aspect plays an important role in the light of clinical studies in which it has been seen that patients with severe symptoms tend to activate negative emotional responses in the psychotherapist, as well as a considerable difficulty in the construction of the therapeutic alliance (Bender, 2005; Røssberg et al., 2010; Dahl et al., 2012, 2014; Lingiardi and McWilliams, 2015; Tanzilli et al., 2016).
(3) The *third area*, which sees the cluster contiguous – 4 *Awareness* and the cluster 5 – *Dropout*, could refer to the procedural aspects and the involution of the impasse situation; in this sense, therapists could highlight the difficulty in managing the stalemate or in the ability to identify precursory signals or events that can signal the impasse in time. In this sense, as underlined by Safran et al. (2011), the training of therapists in the ability to identify the impasse and to treat them in a constructive way has a positive impact on the outcomes of the therapy.

The analysis of the correspondences with respect to orientation shows with the bi-polarity on the *X*-axis that therapists with a cognitive-behavioral orientation use a language that is significantly different from psychodynamic therapists and other orientations. The terms *sensation*, *emotion* and *exit* used by the first evoke, compared to situations of impasse, a more instinctive or *belly* approach than the approach that can be inferred from the terms used by therapists with other guidelines. The latter, as a matter of fact, seem to have manifested a minor urgency and perhaps it seems to have a privilege, before a separation from the impasse, a request for support to face the stalled phase of the therapy (*search for*, *supervisor*, *to start*, *work*).

Compared to the *Y*-axis, therapists of other orientations seem to express greater emotional and relational involvement (*she*, *problem*, *to lose*, *receive*, *pain*) compared to cognitive-behavioral therapists and psychodynamic one, who seem to be more focused on the family context (*parent*, *children*, *little boy*). They could also represent different strategies to overcome the impasse; in the first case with the focus on the specific dynamics of the dyad and in the second one with an analysis of the influences on the treatment of the patient's family context.

As far as the diagnosis variable is concerned, from the bi-polarity on the *X*-axis it emerges that the language, compared to an axis I diagnosis, is significantly different from that in the presence of a patient diagnosed on axis II. In particular, it seems that in the presence of a diagnosis from axis I there is a more positive climate, as words like *availability*, *appointment*, *play*, *know*, *life* shown; in the second case the terms *to leave*, *front*, *borderline* seem to indicate a more negatively connoted climate.

With respect to the different modes of communication of the interruption, where this has occurred in a mediated or communicated way by the therapist, an atmosphere of urgency or gravity from the frequency of the lemmas (*error*, *Borderline*, *admitted*, *to escape*, *be sorry*) emerges. In the case in which there has not been the patient's communication, the theme of respect, which would have failed with this gesture of the patient toward the therapist and also the theme of the search for meaning of the patient's behavior, is emerged (*in_mind*, *remember*, *dream*).

There is also a significant difference between the Mediated and *de visu* modes on one side and the Therapist and No Communication on the other. In the first case it evokes a more positive and comprehensive context or situation (*receive*, *important*, *easy*, *return*), while in the second one it seems that the two modalities express a critical and urgent situation (*to escape*, *failure*, *punch*).

Finally, the verification of the relationships between the five clusters and the variables does not seem to detect significant data regarding the Diagnosis, Orientation and Triangulation variables. On the other hand, it seems interesting to point out that compared to the therapists who supervised the impasse, cluster 1 – *Mother Configurations* explains almost twice the variance compared to the group of those who did not use it. It seems then that the salience and intensity of this theme pushes the therapist to request help or advice post dropout. This behavior could suggest that the evoked female figure is therefore more referable to the therapist and therefore to more aspects of the countertransference. In favor of this hypothesis also the comparison of the typical lexical unit among the therapists who have used supervision, for which we highlight the most significant values for the words *she*, *mother*, *I think*, *supervision* and those who have not carried it out for which the most salient terms evoke more perhaps an intent than an urgency (*to ask*, *speech*, *path*) gives us some evidence.

Lastly, also for the variable Triangulation we highlight, in the comparison of the typical lexical unit with dropouts in which no intrusion was signaled by a third party, the presence of the words *parent*, *child*, *speech*, *involve* that can signal on one hand the importance of parental figures as variables associated with the impasse and on other hand also the need for a more participated and careful management of this third "external" to the therapeutic dyad. It is interesting to observe that the absence of triangulation is well evidenced by the typical occurrence of lexical units such as *I*, *you*, *us*; therefore, it seems that the intrusion of a person external to therapy may have a specific weight and importance in determining the impasse situation and the consequent drop out, as highlighted above also by the percentages found in the sample.

Limits and Future Developments

The *first limit* of this study is related to the number of the sample, which does not allow generalizations with respect to which are the most stressed countertransference in cases of dropout and the lack of a control group. The results of the present research should therefore be repeated on a sample with a higher number of subjects and should be compared with cases terminated with a positive result.

A *second limit* is linked to the possible memory bias of the therapists on the cases examined; as a matter of fact, the clinicians were invited to fill in the questionnaire on their emotional responses to remember how they had felt most of the time with the patient described in the interview. Lacking a homogeneity for the therapists with respect to the time between the compilation of the TRQ and the end of the treatment of the patient examined, it can be hypothesized that this has influenced both the quality of the evocation of the emotional aspects of the experience and the details of the same.

A *third limit* also reported in the research by Hill et al. (1996) is linked to the partial perspective with respect to the impasse examined. The point of view and the experience analyzed is only that of the therapist. What we know of the patient's experience is reported by the clinician and not by him in the first person. In this sense, it could be interesting to compare the experience of both components of the therapeutic dyad with respect to a dropout (Hill et al., 1996).

Finally, for the present work a further implementation of the analysis of the corpus composed by the interviews seems interesting in terms of development. Through a more in-depth refinement of the text preparation procedures (such as greater disambiguation), we could found out other interesting elements that characterize the impasse situations and other variables associated with the deadlock situations.

In this sense, identifying other possible factors or evaluating the weight that everyone can have in terms of effects and how they interact in contributing to premature interruptions of psychotherapy seem important for future research. Finally, a greater diffusion of the results of the researches dealing with this topic is also hoped for; certainly useful in the prevention and identification of those events that precede the phenomenon of dropout, as pointed out by several authors.

ETHICS STATEMENT

This study was carried out in accordance with the recommendations of the Ethical Committee of the Catholic University of Sacred Heart of Milan. All subjects gave written informed consent in accordance with the Declaration of Helsinki.

AUTHOR CONTRIBUTIONS

SiM conceived and designed the study, collected and interpreted the data, and wrote the manuscript. SaM analyzed and interpreted the data, and reviewed the manuscript. OO developed the study design, contributed to the interpretation of the data, and wrote and reviewed the manuscript.

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frontiers in Psychology

CASE REPORT
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The Difficult Task of Assessing and Interpreting Treatment Deterioration: An Evidence-Based Case Study

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Objectives: Literature on outcome assessment suggests that 35–40% of patients in randomized control trials terminate treatment with unchanged or higher levels of symptomatology. The goal of the present study was to shed light on this phenomenon and the factors accounting for it using a single case study design that investigates the process and outcome of a treatment conducted within a non-randomized clinical trial comparing a cognitive behavioral and a brief relational treatment.

Method: The condition of L., a Caucasian man undergoing cognitive-behavioral therapy in a large metropolitan research program, was classified as deteriorating using the Reliable Change Index for the Inventory of Interpersonal Problems (IIP) and the Symptom Checklist-90 (SCL-90). Therapeutic process and outcome were examined using quantitative and qualitative methods rated by several sources.

Results: Analysis showed that the treatment was delivered skillfully, and that despite initial difficulties, a strong alliance eventually developed between the patient and the therapist whose perspectives on the outcome of therapy nevertheless diverged. The patient's satisfaction with treatment was high, and he believed his deterioration was caused by its termination.

Discussion: Results suggest that the deterioration was not caused by a negative process or a faulty delivery of the therapy. Several explanations were discussed in the context of the literature.

Keywords: deterioration, treatment failure, case study, outcome, process, patient satisfaction

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INTRODUCTION

In the last 40 years, psychotherapy outcome research has yielded many large-scale studies examining the process and outcome of various types of psychotherapy and demonstrating its efficacy and effectiveness for a variety of disorders. Treatment failure, including deterioration, defined by Lambert (2011) as a "subset of treatment failure" (p. 414) has yielded far less empirical literature and still remains under-researched. The goal of this study was to investigate this phenomenon at the single case level in order to shed some light on the factors that may be in play and potentially account for deterioration in psychotherapy.

The first impetus to study treatment failure may be traced to a seminal paper by Bergin (1963), in which he hypothesized that in certain cases psychotherapy may fail to facilitate improvement in patients' functioning, and even result in worsening. A series of studies by Lambert and his group subsequently determined that 35–40% of patients in randomized control trials do not improve over the course of therapy, and that among non-responders, 5–10% actually deteriorate, terminating treatment with higher levels of symptomatology (Hansen et al., 2002; Lambert, 2013). Lambert et al.' work further studied therapists' assessment of their patients' outcomes and suggested that therapists are less likely to identify the occurrence of treatment failure than their patients (Lambert et al., 2001; Whipple and Lambert, 2011). They also found that therapists are inclined to rate themselves as above-average clinicians and to underestimate the prevalence of deterioration among their patients (Walfish et al., 2012). Recent meta-analyses reported similar deterioration rates among patients enrolled in internet-based treatments for depression (Ebert et al., 2016; Rozental et al., 2017) as well as among participants in clinical trials for depression and anxiety disorders (Cuijpers et al., 2018).

While these recent studies have established the significant prevalence of deterioration in psychotherapy and called for caution when relying on therapists' viewpoints to assess treatment success, the causes for this phenomenon have not yet been fully determined. In this regard, some studies suggested that client characteristics, such as personality disorders and high levels of comorbidity (Brozovich and Heimberg, 2011), low education (Ebert et al., 2016), high level of interpersonal difficulties, poor motivation, and severity of problem are risk factors for deterioration (Lambert et al., 1977; Mohr, 1995). With regards to the relationship between diagnosis severity and deterioration, research has yielded contradictory findings (see for example Lambert and Bergin, 1994; Lunnen and Ogles, 1998), suggesting that the relationship between diagnosis and deterioration may be limited to pathologies requiring inpatient treatment. Therapist factors, such as lack of empathy, under-estimation of problem severity, negative counter-transference, poor technique, and disagreement with patient about the therapy process, also have been reported as related to deterioration (Mohr, 1995). In a comprehensive review on therapist factors impacting early treatment drop-out, Roos and Werbart (2013) highlighted therapists' skills and experience together with therapists' capacity to provide emotional support and concrete advice. Their work also pointed at the impact of the therapeutic alliance on early termination. Recent work on treatment failure among CBT for specific disorders suggested that some treatments may need to be refined so as to include research advances in areas such as memory and learning (Arch and Craske, 2011). It is reasonable to assert that patient, therapist, and dyadic-relational factors, as well as technical variables associated with the type of interventions chosen and their effective delivery, all combine to determine the treatment success or failure (Boswell et al., 2011).

In response to the scarce literature on treatment failure and deterioration, Dimidjian and Hollon (2010) stressed the importance of further investigating the field. They proposed a comprehensive taxonomy of treatment outcomes that departs from Lambert's conceptualization of deterioration as a sub-category of treatment failure. They noted that psychotherapy outcome cannot be reliably evaluated on the sole basis of symptomatology change, and rather needs to take into account the natural course of the disease a patient would have been expected to go through had they not attended treatment. Accordingly, a treatment may be successful at limiting the rate and the intensity of a naturally deteriorating disease and yet result in unchanged or even worsened symptomatology. In that case, the treatment should be considered successful, despite the patient's worsening. In a similar vein, if a disease is characterized by spontaneous remission, a treatment that would result in a partial remission should be considered unhelpful or even harmful, despite the apparent symptom improvement observed at termination. Dimidjian and Hollon (2011) called for further research on the mechanisms associated with treatment failure and deterioration and promoted the case study approach to investigate these topics. The special issue of Cognitive and Behavioral Practice they edited indeed included rigorous case studies that investigated specific cases of treatment failure and deterioration.

More recent work by Wampold and Imel (2015) further distinguished between treatment deterioration and harm and stated that deterioration can be said to occur when patients' functioning at the end of treatment is poorer than at its start. In contrast, treatment would be considered to have caused harm if the deterioration can be shown to be caused by the treatment itself rather than by factors such as "natural history" (referred to as "natural course of the disease" by Dimdjian and Hollon), life events, or error in measurement (Wampold and Imel, 2015).

An additional layer of complexity in the study of treatment outcome was generated by contradictory findings on the relationship between treatment outcome and patient satisfaction. According to past work (see for example Kazdin, 1977, 1993; Ihilevich and Gleser, 1979), patients with better outcome were found to report higher levels of satisfaction with treatment than patients with comparatively poorer outcomes. In contrast, more recent work suggested that patient satisfaction is not related to therapist- or patient-rated symptomatology change: patients classified as "deteriorators" according to Jacobson and Truax (1991) clinical significance criteria were found to be as likely to be satisfied with their therapy as patients who achieved symptom improvement or recovery (Pekarik and Wolff, 1996; Lunnen and Ogles, 1998). These findings suggest that symptom change may not provide a fully reliable estimate of treatment success, and that additional research is required to determine what constitutes a good or a bad treatment outcome (for further discussion of this question, see Hill et al., 2013; Bloch-Elkouby et al., 2015).

This review emphasized the scarcity of research examining treatment deterioration and the mechanisms that may induce it. This study's goal was to investigate the therapy ingredients potentially responsible for treatment deterioration as well as further clarify the fine line between deterioration and treatment harm. More specifically, this study aimed at assessing whether or not the factors discussed in the treatment failure literature and reviewed in this introduction could indeed be identified as

relevant in this case. To this end, we performed an evidence-based case study combining quantitative and qualitative analyses along McLeod's (2011) standards for in-depth single case study analyses.

METHOD

Participants

Patient

L. was a 60 year-old Caucasian patient and divorced father of two children. L. lived on his own and has been in a stable relationship with a woman for several years. L. recalled his childhood as having been tainted by a feeling of estrangement from his family as well as his teachers and peers, whom L. experienced as having high expectations he fell from meeting. L. was the son of immigrants from a lower economic status who struggled to provide their children with a better life than they had themselves. L.'s relationship with them was conflicted, as they resented his lack of interest in achievement and what they interpreted as a deficient motivation and effort on his part. In fact, L. did not thrive at school and "never adjusted" to its structure, rather dreaming of becoming a "bohemian artist." He described himself as a "moody" child, who was temperamental and not easily soothed. When he graduated from high school, L. pursued a college degree as well as some graduate studies that he never completed. L. reported a history of chronic depression and alcohol abuse since his young adulthood. These problems had a negative impact on his marriage and eventually led to the couple's divorce. L. reported that he failed to be an available and attentive father to his children, who grew resentful of his lack of involvement in their childhood. L. did not realize his dream of pursuing an artistic career. He changed jobs several times, struggling to sustain himself, until he finally settled as a computer technician, 16 years prior to starting therapy. L. felt unsuccessful at it his job, and was anxious that he may lose it. Although L. never let go of his old dream of being an artist, he did not undertake any action to accomplish it, either. His current partner was supportive of his artistic aspirations and believed in his ability to finally take action. However, L. felt paralyzed by his procrastination, had little motivation, and felt incapable of moving out of his inertia. L experienced elevated levels of shame and guilt, and constantly compared himself to others, resulting in a pervasive sense of being inferior and defeated. His proclivity toward self-blame alternated with resentment against others for their success and lack of support, resulting in high levels of interpersonal distress and unfulfilling relationships. L did not experience extreme levels of anxiety, but he struggled with constant ruminations about his past failures, with little faith in his capacity to ever change his life path. L. also felt anxious that he was inadequate at his current job and that he might lose it.

L. had been in therapy many times before attending the CBT treatment analyzed in this case study. Between the years 2006 and 2013 he attended therapy several times at the same research program and worked with several therapists in different modalities. At the time of the intake preceding the CBT process examined in this study, L. was in pharmacological treatment and stabilized on Fluoxetine (30 mg per day) and Buspirone (20 mg per day) (i.e., three months at the same dose before starting psychotherapy) to alleviate his depressive symptoms and his anxiety. He also had a prescription for Zolpidem that he used as needed to treat his recurrent insomnia, usually four times per week.

At the intake process, which involved the administration of the Structured Interview for DSM–IV Axis I & II (SCID; First et al., 1995) administered by trained research assistants, L. was not given any diagnosis on DSM-Axis I (American Psychiatric Association, 1994) and only met the criteria for Depressive Personality Disorder on Axis II. More specifically, L. met all the criteria of the Depressive Personality Disorder. He endorsed that his usual mood is "unhappy," that he sees himself as an "inadequate person," that he often "puts himself down," that he is a "worrier," that he is critical and judgmental toward others," that he is "pessimistic," and that "often feels guilty or remorseful" for things he did or did not do. L. did not qualify for alcohol abuse or substance use and reported occasional social drinking (less than once a month). On the target complaints form, L. reported three problems: (1) "I feel torn between being an artist and having a real job;" (2) "I have regrets about having been bad husband and father;" (3) "My present girlfriend feels I am too wrapped up in myself and worry more than I act."

Therapist

L.'s therapist was a Caucasian female therapist in training. L. was the first patient she treated at the research program. She held a Master's degree and was a doctoral student in clinical psychology with 2 years of prior clinical experience. Her training encompassed a psychodynamic and a cognitive-behavioral approach to therapy, but she personally identified with the psychodynamic orientation and had herself been through a psychodynamic psychotherapy. L.'s therapist lived by herself and was involved in a long-term romantic relationship. She did not see herself as affiliated with any religion.

L.'s Participation in the Research Program

L.'s case was conducted as part of a large psychotherapy research program at Mount Sinai Beth Israel Hospital. The research program involved a clinical trial that compared the process and outcome of a Cognitive Behavioral Treatment for personality disorders (CBT: Turner and Muran, 1992) and a Brief Relational Treatment (BRT; Muran and Safran, 2002). The former is a 30-session long, manualized CBT treatment for personality disorders (CBT: Turner and Muran, 1992) that involved a schema focus (Beck et al., 1990) and a case-formulation framework (Persons, 1989). The latter is a 30-session long treatment based on relational psychoanalysis, humanistic psychotherapy principles (Safran and Muran, 2000) as well as on Muran and Safran's empirical work on alliance ruptures and their resolution throughout treatment (1996). BRT aims at increasing patients' awareness of the relational themes and patterns they are embedded in so as to provide them with the opportunity to reflect on them and change them when desired.

Patients' inclusion criteria to the research program included: (a) 18–65 years old, inclusive; (b) Cluster C personality disorder or personality disorder not otherwise specified (PD NOS) on Axis II of *DSM-IV* (American Psychiatric Association, 1994); (c) willingness to be videotaped; (d) willingness to complete assessment parameters; and (e) English proficiency sufficient to communicate in therapy and complete the questionnaires. Exclusion criteria included: (a) evidence of organic brain syndrome or mental retardation; (b) evidence of psychosis or need for hospitalization; (c) diagnosis of severe major depression (these patients were referred to an outpatient psychiatry service for a combined treatment of CBT with antidepressant medication); (d) diagnosis of bipolar disorder; (e) evidence of active substance abuse; (f) evidence of active Axis III medical diagnosis; (g) history of violent behavior; (h) evidence of active suicidal behavior. Patients stabilized on an antidepressant/anxiolytic medication for 3 months prior to intake were eligible to join the program. After being assessed by trained research assistants, patients who met the inclusion criteria were randomly assigned to the CBT or the BRT condition. Patients committed to stay out of treatment for 6 months following treatment termination, after which they were allowed to apply for another round of therapy if they wished so. Patients who returned to the program underwent the same assessment as newcomers, at the end of which they were, again, assigned to a treatment condition. Patients who met the inclusion criteria but could not join the program immediately due to therapist unavailability were offered to be assigned to one of the conditions on a non-randomized basis. This was the case of L., who did not join the randomized control trial and was rather offered therapy based on therapist's availability.

Treatment

The treatment course examined in the present study was L's fourth therapy in the research program, and his first CBT after three utterances of BRT. This treatment was a 30-session long, manualized CBT treatment for personality disorders (CBT: Turner and Muran, 1992) that involved a schema focus (Beck et al., 1990) and a case-formulation framework (Persons, 1989). The treatment entailed two intervention phases: (a) Symptom Reduction, and (b) Schema Change, in which core beliefs were modified or restructured. Both phases included traditional cognitive–behavioral strategies, including self-monitoring, cognitive restructuring, behavioral exercises, and experimentation. The therapeutic relationship was founded on the principle of "collaborative empiricism" (Beck et al., 1979).

L.'s therapist underwent 16 h of didactic training in CBT provided by a licensed professional fellow at the Beck Institute and attended 90-min weekly group supervision. Supervision sessions made use of the videotaped case material and included case formulation, treatment planning, and change strategies. Therapists' adherence to the CBT manual was assessed using a 44-item Likert scale measure of treatment fidelity with demonstrated internal consistency, interrater reliability, and discriminant validity (Santangelo et al., 1994; Patton et al., 1998). L.'s therapist was found to be adherent to the treatment manual.

Case Selection and Informed Consent

L's case was selected from a dataset of 72 CBT cases that was originally extracted from the global archival data of the research program by the first author to conduct a pilot outcome study assessing the congruence between therapists and patients in the assessment of outcome (Bloch-Elkouby et al., 2015). The 72 cases were extracted according to the following criteria: (1) They completed treatment at the end of the 30-sessions protocol; (2) Their outcome data was complete and included all the patient and therapist-rated measures. Five of these 72 patients reliably deteriorated, as assessed by at least one outcome measure; L. was among the two out of these five who reliably deteriorated on two outcome measures. We chose L.'s case over the other "deteriorator" because more process and video data were available for him than for the other case. L. provided written informed consent for the future presentation and publication of de-identified personal information related to his treatment for research purposes, covering the present case study. The consent authorization form was approved by the Institutional Review Board of Mount Sinai Beth Israel Hospital that houses the research program. In this paper, L.'s identifying demographic information was modified and disguised in order to protect his confidentiality. The letter L does not reflect the patient's true initial and was assigned for ease of reading only.

Outcome Measures

The assessment battery employed by the study in which L. took part included multi-dimensional measures encompassing symptomatology, interpersonal functioning, chief complaints, and global functioning assessment. The following measures were used:

Symptom Checklist-90-Revised

The SCL-90-R (Derogatis, 1983) is a 90-item Likert scale questionnaire (ranging from 0 to 4) which measures nine symptom dimensions and provides three global indices of symptomatology. The Global Severity Index (GSI), used in this study, is obtained by averaging the scores obtained on the 90 items, and is often used as an overall indicator of symptomatology. The measure has shown good internal consistency, ranging from 0.77 to 0.90, and test-retest reliability of 0.84 over a 1-week period (Derogatis, 1983).

Inventory of Interpersonal Problems-32

The IIP-32 (Horowitz et al., 2000) is a 32-item Likert scale questionnaire (ranging from 0 to 5) measuring interpersonal functioning. It is composed of 32 items divided into eight scales that add up to a total score. When rated by patients, the measure has shown good internal consistency (Cronbach's alpha is 0.96), and good test-retest reliability of 0.78. Psychometric properties were not reported for the therapist-rated version of the IIP-32.

Global Assessment Scale

The GAS (Endicott et al., 1976) is a measure of overall functioning rated by therapists, which includes a 100-point scale divided into 10 equal ranges accompanied with examples of

TABLE 1 | Categories of change according to RCI scores.

Classification	Qualitative interpretation
RCI < −1.96	Reliable improvement
−1.96 < RCI < −0.5	Improvement
−0.5 < RCI < 0.5	No reliable change
0.5 < RCI < 1.96	Worsening
RCI > 1.96	Reliable deterioration

behavior characteristic of the range. No psychometric properties were reported for this measure in the literature.

The SCL-90-R and IIP-32 were completed by L. at intake and at termination. The IIP-32 and GAS were completed by the therapist after the third therapy session as well as at termination.

L.'s change across time was assessed using (Jacobson and Truax, 1991) Reliable Change Index (RCI). RCI was calculated using the test-retest coefficient of the SCL-90 and the IIP-32. Deterioration was operationalized as a reliable worsening exceeding 1.96 SD (Ogles et al., 1995).

Change Measurement

Reliable change index scores (RCI) were computed according to Jacobson' and Truax' (1991) formula: (Post-treatment scores–Pre-treatment scores)/Sdiff, with Sdiff = standard error of the difference between the two test scores (Sdiff = $\sqrt{2}\,(SE)\,2$, and SE = $S1\sqrt{(1 - test - retest}$, with S1= Standard deviation of the measure for the sample examined at intake, and test-retest = test retest reliability coefficient for the measure examined. The RCI scores were transformed into categorical scores following the example set by Jacobson and Truax (1991) and are presented in **Table 1**.

Process Measures

To understand different aspects of the therapeutic process in the present case, several quantitative and qualitative methods were selected to examine fluctuations in the quality of the therapeutic alliance, the impact of sessions, and the client's subjective experience of therapy over time. Additionally, patient-, therapist-, and observer-rated measures were used, so as to provide different perspectives about the therapeutic process and to correct for potential raters' biases.

Post-session Questionnaire

The PSQ (Post-Session Questionnaire) (PSQ: Muran et al., 2004) is comprised of several measures evaluating the therapeutic alliance and process by session. The Working Alliance Inventory (WAI; Tracey and Kokotovic, 1989) is a 12-item Likert scale measure assessing the patient-therapist bond and their agreement on tasks and goals, using three discrete subscales which can be combined to yield an average score. The Session Evaluation Questionnaire (SEQ; Stiles, 1980) is a 12-item Likert scale measure assessing the session impact. The measure includes two different subscales: session smoothness (SEQ/S) and session depth (SEQ/D. This study used the overall score yielded by the session's depth subscale as a measure of session impact.

The PSQ also includes three questions about whether a rupture occurred during the session (Rupture Presence), how upsetting it was (Rupture Intensity), and to what degree, if any, it was resolved (Rupture Resolution). Respondents also are invited to provide an open-ended narrative describing the problem (Rupture Description).

L. and his therapist were both required to complete a parallel version of the PSQ after each session. L. was informed that his therapist would not have access to the information he provided on the PSQ. To enforce the confidentiality of L.'s responses, he completed the PSQ in a private area and deposited it in a locked mailbox.

Rupture Resolution Rating System

The 3RS (Eubanks et al., 2015, 2019) is an observer-based measure of alliance ruptures and resolution strategies. The 3RS yields ratings for the frequency and significance of withdrawal and confrontation ruptures, as well as the therapist's use of strategies to resolve these ruptures. Ratings are made of 5-min segments, permitting the identification of ruptures and resolution strategies across the course of a session. Comparisons of the 3RS to other methods of identifying alliance ruptures have found that the 3RS is more sensitive (Eubanks et al., 2019). The 3RS also detects more ruptures than methods that identify declines in patient-rated WAI scores (Coutinho et al., 2014). The 3RS has a lso demonstrated predictive validity with respect to dropout (Eubanks et al., 2019). In this study, sessions 1, 5, 15, 25, and 29 (the video for session 30 was unavailable) were initially selected for coding in order to cover the span of the 30-session treatment. In an effort to increase the likelihood of coding a session containing an alliance rupture, the sessions with the lowest patient-rated alliances as measured by the WAI were identified. As the lowest patient-rated session, session 1, had already been selected for coding, the second-lowest session, session 3, was also coded. These six sessions were divided between two pairs of coders, comprised of one doctoral-level psychologist (the second author of this paper and the first author of the 3RS measure) and three graduate students whom the first coder had previously trained to reliability. For this study, coders first coded the sessions independently. Then, each pair of coders met and reached consensus on their ratings. The consensus ratings were used in the data analyses. Coders assigned scores for each type of withdrawal marker, confrontation marker, and resolution strategy: A score of 1 was given in a 5-min segment if the marker was observed; a score of 0.5 was assigned if a weak or somewhat unclear example of the marker was observed. The scores were summed for each session, and mean scores and standard deviations were calculated across the six sessions.

In addition, 21 sessions (70%) were randomly selected for viewing and descriptive analysis.

Patient Termination Relationship Interview

Information about the patient's global experience of and satisfaction with therapy and the relationship with the therapist was gathered using the patient termination relationship interview, a semi-structured interview administered by a

TABLE 2 | L.'s successive therapy outcomes at the research program.

Treatment modality	IIP rated by therapist	IIP rated by client	SCL-90
BRT	No change (RCI = 0.17)	No change (RCI = −0.03)	No change (RCI = −0.11)
BRT	Improved (RCI = −0.90)	Reliably improved (RCI = −2.09)	Worsened (RCI = 1.22)
BRT	Reliably improved (RCI = −2.81)	Worsened (RCI = 0.63)	No change (RCI = 0.22)
CBT	Improved (RCI = −0.82)	Reliably deteriorated (RCI = 2.81)	Reliably deteriorated (RCI = 2.31)
BRT	Reliably deteriorated RCI = 2.81	Reliably deteriorated (RCI = 4.26)	Missing data

BRT, Brief Relational Treatment (Muran and Safran, 2002).

research assistant at termination to assess the patient's subjective experience of the relationship and the treatment's impact.

RESULTS

Therapy Outcome

L. reliably deteriorated on the self-rated version of the IIP-32 and the SCL-90-R throughout the cognitive-behavioral treatment examined in the present study (**Table 2**). By contrast, and as can be seen in **Table 2**, the RCI obtained for the scores provided by his therapist about his interpersonal problems suggest some improvement, though not significant enough to be considered reliable. In a similar vein, L.'s therapist gave L. a GAS score of 70 at session 3, and 72 at termination, suggesting that the therapist did not see L. as severely ill at the beginning of treatment, and believed L.'s general functioning was minimally improved by the end of treatment. It is interesting to compare these results to those obtained at the end of the other treatments L. attended at the same research program (**Table 2**). First, it may be noted that the first time L. received treatment, both he and his therapist agreed that the therapy did not yield any reliable change. This was the only time the three outcome measures converged. Upon termination of the second treatment, however, L. reported reliable improvement in his interpersonal relationships, a conclusion somewhat corroborated by his therapist's report of some improvement, but he also described his symptoms as worsening. When L. ended his third round of therapy, his therapist believed L. had made reliable progress in interpersonal functioning but L. himself did not agree with this assessment. He was equally pessimistic about his symptoms, which he reported as unchanged. As mentioned above, during the CBT treatment examined in the present study, L. reliably deteriorated on the two self-report measures for the first time. Interestingly, his therapist did not concur with this evaluation, and endorsed that L. improved, though not reliably, in interpersonal functioning. Six months after the end of the therapy examined in the present study, L. repeated therapy one additional and last time at the research program. That time, both he and his therapist judged his interpersonal functioning as reliably deteriorated.

L.'s successive treatments outcome scores seem to indicate a general tendency toward a greater deterioration starting during the treatment examined in the present study (4th treatment at the research program). It may be necessary to mention that all the treatments received by L. at the research program, at the exclusion of the one presented in the present study, followed a relational orientation. In order to make sense of these findings, we will now turn to the therapy process which characterized L.'s treatment.

Therapy Process

Case Conceptualization

The therapist's case conceptualization of L.'s challenges followed Persons (1989), in which the patient's chief complaint is broken down into a list of problems, a proposed underlying mechanism, precipitants, and origins of the underlying mechanisms in the early life.

In L.'s case, the therapist did not document her case conceptualization in the patient file. Based on the video-recordings of her sessions with L., it seems like the therapist initially helped L. break down the chief complaints and therapy goals into more specific problems that could be targeted first. L. was able to follow her lead and focused on his difficulty feeling adequate at work, his fear of losing his job, his procrastination with art, and his tendency to ruminate over the past rather than take action.

L. and his therapist collaboratively explored the precipitants, and found that these problems typically emerged in situations that required L. to take initiative and perform tasks that did not include a clear course of action, or that belonged to areas in which L. was lacking skills. In these instances, he experienced automatic thoughts such as "I am inadequate," "I brought it on myself because of my bad choices in the past," "I'm not good at anything," "This is too hard" or "I am going to lose my job and will not have any money." These thoughts increased L.'s anxiety level and lowered his mood, which in turn reinforced the self-blame, thoughts of inadequacy, and catastrophic thoughts about his future. In these situations, L. typically resorted to avoiding the tasks he feared and engaged in increased rumination about the past.

Several assumptions typically triggered L.'s automatic thoughts when he faced challenging tasks: "If I don't know how to do this I am nothing," "If I can't even do this people are going to think I am a loser," or "If I had done better choices in the past I would know how to do this." These assumptions were fed by self-schemas characterized by a belief of inadequacy, lacking self-agency, incapacity to meet society's expectations, as well as by schemas of others as rejecting, teasing, disappointed, and incapable of loving or accepting him with his flaws.

L.'s schemas likely originated in his difficulty "fitting in" as a child, as well as in his impression that he was a disappointment for his family, teachers, and surrounding social circles. L. struggled academically and socially throughout his childhood, adolescence, and adulthood, making it reasonable to conjecture

that he may have had learning and executive functioning difficulties, and may have met the criteria for a developmental disorder. Feeling different, being incapable of succeeding since his childhood, and experiencing his environment as rejecting likely contributed to his core schemas and their activation anytime he was required to perform a task that he did not have mastery over, regardless of the actual difficulty involved in it.

Descriptive Analysis of the Therapy Process

A careful examination of the videotaped sessions suggests that during the initial phase of therapy, from session 1 to 5, L. and his therapist seemed to struggle with establishing a collaborative alliance. During these first sessions, L.'s therapist explained the principles of CBT and the dyad agreed that the treatment's goal would be to help L. identify and modify his maladaptive thoughts and beliefs that trigger his sense of inferiority and render it difficult for him to accomplish his projects. Despite their explicit agreement on tasks and goals and their collaborative work toward the identification of L.'s automatic thoughts, the dyad seemed to have difficulties making a connection and progressing. This difficulty seemed to stem from L.'s proclivity to be passive and distracted, coupled with his therapist's overly directional style. L.'s therapist was in fact a young, energetic, empathic, and hard-working therapist, who seemed to put forth a significant effort to provide a high quality therapy. She seemed to be competent and comfortable with the principles of CBT. By contrast, L. presented as a low-energy depressed patient with flat affect, who was prone to digressions and spent extended periods narrating stories from the past or the present with no clear purpose. L.'s therapist seemed to experience difficulty engaging L. and often redirected him to the task at hand. She also tended to fill in the gaps, and to offer multiple choice answers to L. rather than letting him answer her questions, as if trying to prevent him from getting distracted by his own thoughts. At times, her hard work seemed to impede her ability to be present in the moment and to remain attuned to L. For example, she continuously took notes, often at the expense of maintaining eye contact with L. The more structured the therapist became, the less engaged was L., who seemed to be disinterested in actively working with his therapist in a structured way. Accordingly, his responses became more avoidant, and he superficially complied with her requests. The following vignette illustrates the type of interaction which took place between L. and his therapist between sessions 1 and 5.

"L.: Reading it reinforced this feeling that I was a bad father and a bad husband.

Therapist: ok (pauses, looks at her notebook) and is there anything else as far as [coming to treatment]?

L.: Well I have a girlfriend and–

Therapist (interrupting): It's true!

L.: –and that's you know, that's going well right now–

Therapist: oh great!

L.: . . . and (pauses)

Therapist: Are you guys living together?

L.: Sorry?

Therapist: Are you guys living together?

L.: No, ehm no.

Therapist: How long have you been together?

L.: Ehm, well 12–13 years.

Therapist: Ok.

L.: And ehm (pauses to think)

Therapist: It's going well.

L.: Yeah yeah. She's, ehm. . .

Therapist: I read that she's feeling that you're wrapped up. You think, you worry more than you act."

An examination of the process after session 6, though, suggests some change. If L.'s therapist did not offer different types of interventions, she demonstrated greater flexibility and less directiveness, which seemed to allow for a more active participation on L.'s part. L. indeed became more dominant and contributed more to the sessions, even if he maintained an avoidant and digressive style. The following vignette from session 6 illustrates this change:

"Therapist: That's interesting, why do you think she would, why would she. . . (pauses). Well part of me wants to investigate and talk more about your girlfriend but she's just not here so it's weird, we can't really. . .

L.: Right.

Therapist: So I'm more interested in you and your thoughts and your behaviors and how, you know, we can work on that.

L.: Well, how would I want to?

Therapist: That's–

L.: How would I want to handle this?

Therapist: Yeah, how?

L.: I can neither get dragged down into her stuff nor can I just walk away from it.

Therapist: Hmm (pauses).

L.: So how do I want to handle it?

Therapist: Yes, what is the ideal, the best case scenario?"

As therapy progressed, L.'s therapist maintained this more flexible stance, even though she continued to adhere to CBT, its principles, and its structure. She also invited L. to provide feedback about the therapy, and to voice his disagreements and/or unmet expectations as he experienced them.

Descriptive Analysis of the Therapeutic Interventions

After L. and his therapist broke down L.'s chief complaints into specific problems, L.'s therapist work focused on helping L. gain awareness of the situations in which these problems emerged as well as the mechanisms potentially accounting for them. More specifically, L.'s therapist helped him increase his capacity to reflect on the negative automatic thoughts that emerged every time L. faced a new or bureaucratic task and uncertainty. Most often, these situations involved requests from L.'s employer to perform tasks L. did not know, administrative chores (such as making appointments or complete paperwork), and L.'s desire to promote his art. L.'s therapist also worked on increasing L.'s capacity to reflect on his subtle mood changes as they occurred, and to use them as indicators that some automatic thoughts had just been triggered by an internal or external stimulus. The therapist then proceeded to challenge the automatic thoughts to identify the assumptions and core beliefs underlying them, and to find more adaptive ones. L.'s therapist also engaged with him in problem-solving, as she typically examined with him life situations and encouraged him to seek alternative and more active behaviors to handle the challenging situations. In these

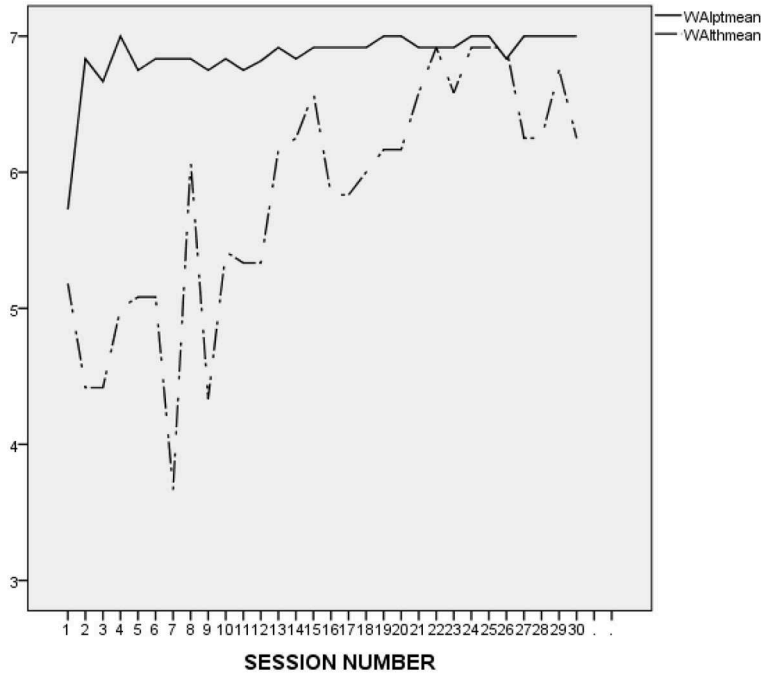

FIGURE 1 | L.'s and his therapist's ratings on the WAI-12 in the course of the treatment investigated in the present study (treatment 4). WAIptmean and WAIthmean respectively, represent the average score on the patient-rated and the therapist-rated Working Alliance Inventory (WAI; Tracey and Kokotovic, 1989) after each session.

instances, she helped L. break down the tasks that he avoided into smaller easier subtasks that were less anxiety provoking, and worked with him on adequate planning to reduce his procrastination. In the sessions, the cognitive work seemed to have a regulatory effect on L., in that it helped L. face his anxiety rather than avoid it and engage in digressive thinking which eventually increased his sense of being overwhelmed and his anxiety. In this context, the therapist's efforts seemed to contain L. and to alleviate his anxiety during the sessions. It seems, though, that L. did not acquire, throughout the treatment, the ability to structure his thinking in a similar vein. Rather, he typically brought to the sessions a lot of written material about the week's events and interactions, and relied on his therapist to organize it. If his compliance with the therapist's homework assignments speaks to his therapist's success in engaging him, the disorganized quality of the written material also show that L. did not actually learn to organize his thoughts. The same observation can be made with regard to L.'s problem-solving skills. L. was very cooperative with his therapist, and in fact, engaged in all the behaviors she prescribed outside of the sessions despite his well ingrained passivity and proclivity to procrastinate. Yet L. did not initiate problem-solving on his own and did not seem to develop a sense of self-worth and agency on the basis of his successes.

L.'s Increasing Anxiety at the End of Treatment

Toward the end of the therapy, starting at session 25, L. started to report increased levels of anxiety. His therapist carefully inquired about it and tried to help L. utilize the cognitive work they learnt throughout therapy. L. was indeed able to apply the cognitive principles during the sessions, but continued to report an increase in anxiety and depression. Per L.'s report, life circumstances triggered this worsening, as he faced changes at work, where he was required to change some of his working methods. For L., who always had difficulties with transitions, the change, together with his fear of losing his job, provoked anxiety and depression. Additionally, in the last therapy sessions L. started to express his anxiety that aging might render it more difficult for him to carry on in his job. The same thought, according to L., led his best friend to commit suicide, and therefore triggered increased levels of anxiety as well other feelings of sadness and mourning for L. This friend used to draw portraits in the street for his living and committed suicide when his physical condition deteriorated and prevented him from continuing this activity. Additionally, L. reported concerns about his girlfriend's health and was worried about the reemergence of a past illness. This increased his concerns about his own health as well as his and his girlfriend's finances.

WAI Ratings and Alliance Ruptures

In order to gain an additional perspective on L. and his therapist's dyadic interactional style, we examined L.'s and his therapist's ratings of the therapeutic alliance on the WAI, as well as their report of ruptures.

As presented in **Figure 1**, both L. and his therapist seemed to struggle to form an alliance at the beginning of the treatment. It is striking to notice, though, that after the first three sessions, L.'s ratings became flat and almost perfect, as opposed to those

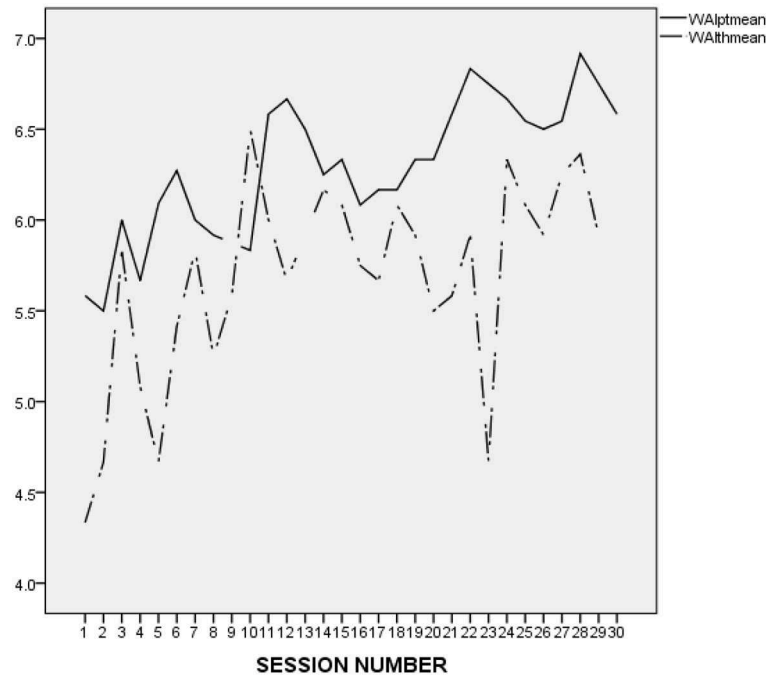

FIGURE 2 | L.'s and his therapist's ratings on the WAI-12 in the course of the 1st treatment at the research program. WAIptmean and WAIthmean respectively, represent the average score on the patient-rated and the therapist-rated Working Alliance Inventory (WAI; Tracey and Kokotovic, 1989) after each session.

of his therapist, which were less inflated and reflected some fluctuation, with a clear tendency toward improvement. In addition, it is worth noticing that L. did not report a single rupture throughout treatment, and that his therapist reported only 3 ruptures, at sessions 1, 2, and 3. L.'s therapist did not provide any narrative to specify the type of rupture that occurred at session 1. At session 2, however, she provided the following description: "patient went on tangents and I did not keep him on task," which seems to confirm that L.'s therapist experienced L.'s digressive and avoidant style as an obstacle to the establishment of a collaborative working alliance. At session 3, the rupture narrative stated: "patient often went off topic and had to be redirected toward agenda." The therapist also reported that the rupture was repaired using the following strategy: "I was direct with the patient about our goal for the session and at the same time empathetic to his needs. Suggested he does a thought record on his friend whom he continues to bring up." This description suggests that L.'s therapist's strategy to repair the rupture was to redirect L. rather than acknowledging the rupture and exploring the possible reasons behind it.

It is difficult to make an accurate interpretation of L.'s linear and perfect ratings. On the one hand, it seems that his ratings were inflated and possibly reflected his inclination to avoid acknowledging conflicts and painful feelings. However, it may be important to compare L.'s alliance ratings to those he provided in the context of the other treatments he attended at the research program. As presented in **Figure 2** (first treatment), **Figure 3** (second treatment), **Figure 4** (third treatment), and **Figure 5** (last treatment), these ratings were not as high, and included more fluctuations. This finding suggests that L. may have felt genuinely connected to his therapist throughout his treatment, and developed a stronger alliance with her than with his previous and subsequent therapists.

Rupture Resolution Rating System

The most frequent rupture markers were examples of *avoidant storytelling/topic shift* ($M = 2.33$, $SD = 1.17$), which is a form of withdrawal in which the patient tells stories and/or shifts the topic in a manner that functions to avoid the work of therapy. Confrontation rupture markers were less common, but were still evident: the patient expressed some *complaints/concerns about the activities of therapy* ($M = 0.67$, $SD = 0.88$), and there were also instances of *patient defends self against therapist* ($M = 0.42$, $SD = 0.66$), in which the patient defended his thoughts, feelings, or behavior against what he perceived to be the therapist's criticism or judgment. The therapist responded to the ruptures primarily by utilizing the resolution strategy of *inviting the patient to discuss thoughts or feelings with respect to the therapist or the therapy* ($M = 0.92$, $SD = 0.66$), or by *changing the task of therapy* in an effort to re-engage the patient in the work of therapy ($M = 0.58$, $SD = 1.02$).

Session Impact

Figure 6 presents the evolution of L.'s and his therapist's ratings on the depth dimension of the SEQ, session after session. As we can see on the graph, L. provided flat and almost perfect scores after all the sessions. In contrast, his therapist's ratings were less inflated and show much more fluctuations. Their ratings were not correlated.

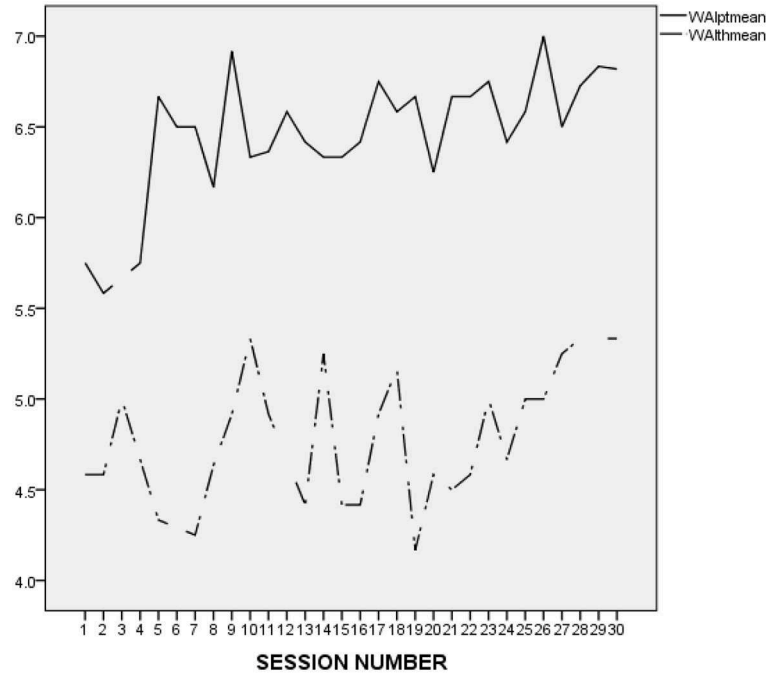

FIGURE 3 | L.'s and his therapist's ratings on the WAI-12 throughout the 2nd treatment at the research program. WAIptmean and WAIthmean respectively, represent the average score on the patient-rated and the therapist-rated Working Alliance Inventory (WAI; Tracey and Kokotovic, 1989) after each session.

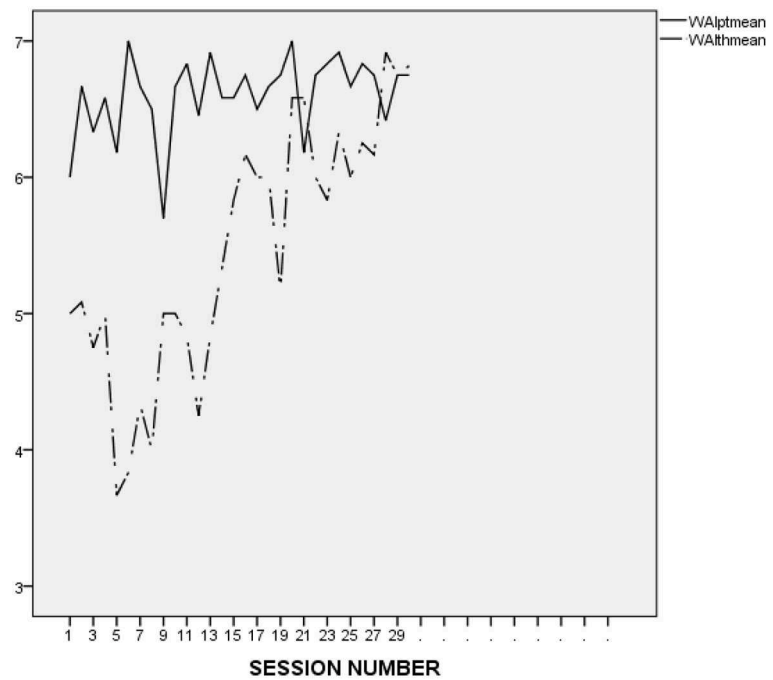

FIGURE 4 | L.'s and his therapist's ratings on the WAI-12 throughout the 3rd treatment at the research program. WAIptmean and WAIthmean respectively, represent the average score on the patient-rated and the therapist-rated Working Alliance Inventory (WAI; Tracey and Kokotovic, 1989) after each session.

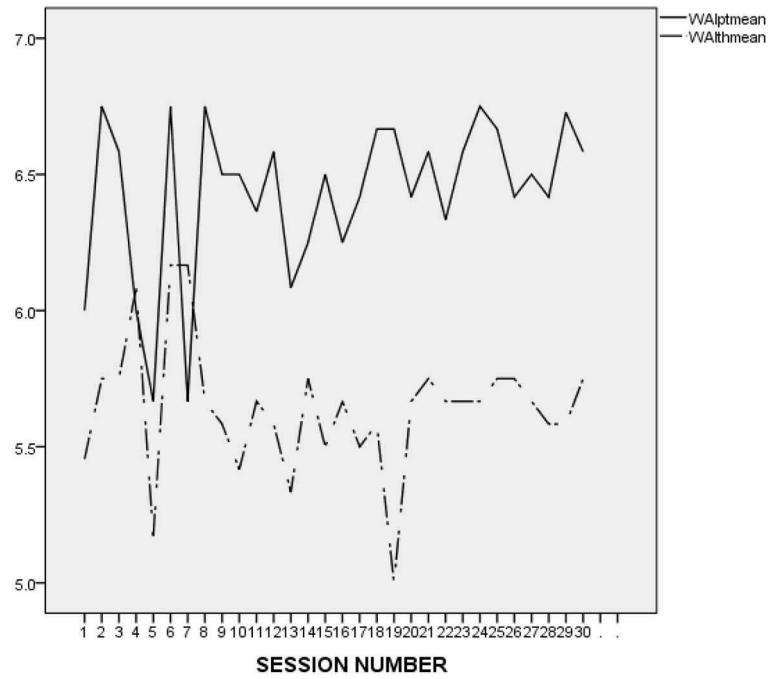

FIGURE 5 | L.'s and his therapist's ratings on the WAI-12 throughout the 5th and last treatment at the research program. WAIptmean and WAIthmean respectively, represent the average score on the patient-rated and the therapist-rated Working Alliance Inventory (WAI; Tracey and Kokotovic, 1989) after each session.

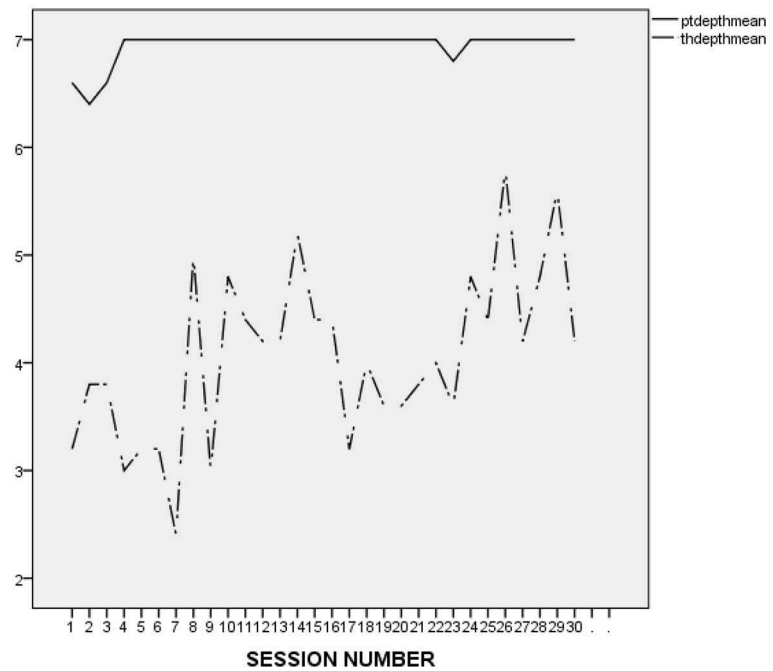

FIGURE 6 | L.'s and his therapist's ratings on the SEQ-Depth in the course of the treatment investigated in this study (4th treatment at the research program). WAIptmean and WAIthmean respectively, represent the average score on the patient-rated and the therapist-rated Working Alliance Inventory (WAI; Tracey and Kokotovic, 1989) after each session.

Patient Relationship Interview at Termination

It is very interesting to notice that when administered the termination relationship interview, L. reported being satisfied with therapy, and seemed quite realistic about the ability of a short-term therapy to promote change:

"Interviewer: Could you start by helping me to get oriented with your work with your therapist?

L.: Um well I um uh have had a lifelong problem with depression, I take medication I um, this was my fourth round of sessions with the [Name of the research program].

Interviewer: Oh, ok.

L.: And um well she was doing partly cognitive uh partly cognitive approach partly just relationship between patient and therapist and you know I really found it very helpful.

Interviewer: Mm-hm.

L.: It-it's not the answer to all my troubles but (pauses) I really found it to be helpful."

When L. was asked about his response to the treatment termination, he provided an interesting and insightful response, as follows:

"L.: Well sh—(pauses) uh (shrugs) (pauses) I didn't cry or anything. I just (laughs) (pauses) I went on my way and then um (pauses) I think the next day (pauses) I had started having serious problems at work—

Interviewer: Mm-hm

L.: –they started to come up right after I ended therapy

Interviewer: How did your therapist respond when it was the end of the sessions?

L.: Uh (pauses) y'know she didn't act any differently than she normally acts, she kinda just went, "Nice working with you." (pauses) She told me that if I wanted to ask her something ah y'know some sort of a—a longer term therapy—um that if I had any questions about that I could call her.

Interviewer: Are there any other separations that stand out in your mind?

L.: Well I've had a lot of separations. I separated with my wife, I uh I lost my parents, I um (pauses) …yeah I guess life is full of separations. (pauses) Um yeah (pauses) I had just um (pauses) well I when I (pauses) started um this guy I used to play with had recently committed suicide.

Interviewer: Mm.

L.: So I draw and uh this guy was an artist and he committed suicide and I had y'know strange feelings about that and (pauses) y'know that was a kind of separation. Uh, I don't I don't think that y'know, like she's the fourth therapist that I've had—I think that the last session is never really—quite easy.

Interviewer: Mm-hm

L.: I get too dependent on the therapists and um (pauses) I feel like I can't get along without help."

L. also compared his therapist to his previous therapists at the same research program and concluded: "My previous therapist in this program I thought there were things that she didn't quite get about me, but I didn't feel that with [therapist's name]."

L.'s positive responses seem to contradict McLeod (2011) claim that patients tend to be more critical about their therapy when interviewed about it than when asked to report their symptoms on standardized symptom measures.

DISCUSSION

The findings generated by the different methods throughout this study convey a complex and nuanced picture of L.'s outcome at termination, and support two main interpretative frameworks which are not mutually exclusive: (1) The treatment may have been beneficial for L., in that it slowed down his naturally occurring path toward deterioration in psychological functioning; (2) The treatment may have failed to develop L.'s sense of agency, therefore culminating in a sudden deterioration, toward the end of treatment, triggered by termination.

First and foremost, the descriptive analysis, and to a lesser extent the 3RS coding suggest that L. did not have a strong sense of self-worth and tended to engage in avoidance strategies, such as passivity and procrastination, rather than confront his feelings and difficulties. L. had attended three brief treatments before the cognitive-behavioral therapy addressed in the present study, and had achieved only mild and transient progress, suggesting that he was resistant to change. Additionally, L.'s thought process seemed to be characterized by digressive and ruminatory processes. All together, these elements seem to suggest that L.'s chances to change within the context of a short-term therapy may have been limited. L.'s choice to repeat brief treatments rather than seek for long-term therapies more adapted to his needs may also suggest some ambivalence toward therapy and change. Last, L. experienced a series of life circumstances, such as the death of his friend, the changes at his workplace, concerns about his girlfriend's health, and most importantly, his own aging. Together with his difficulty confronting the realization that he may not become the artist he dreamt to be, these stressors probably put him on a worsening trajectory. The fact that L. did not reliably deteriorate throughout treatments 1–3 at the research program, though deteriorated by the end of treatment 4 and 5 may support this hypothesis. In these circumstances, it is not possible to determine with certainty what would have been L.'s trajectory had he not attended treatment, rendering it challenging to formulate definite statements about the therapy success.

Several findings nevertheless seem to suggest that the treatment may well have been beneficial. First, L.'s therapist rated L. as improved (though not reliably improved) in interpersonal functioning. Additionally, L.'s self-reported increased anxiety and depressive mood toward the end of treatment may be indicative of L.'s improved capacity to report his symptoms accurately because of his expanding self-awareness and insight. This explanation aligns with McLeod (2001) claim according to which patients' understanding of self-report questionnaires changes throughout treatment as a consequence of increased insight, so that they do not rate themselves on the same constructs at intake and termination. Last, the process variables examined suggest that the therapist factors discussed in the treatment failure literature, i.e., negative countertransference, rejection of the patient, or critical stance, were not factors in the present case. On the contrary, L.'s therapist proved to be very empathic, attuned, non-judgmental, and accepting of L. She was also optimistic and kept trying to engage him despite his tendency to fall back on repetitive and idiosyncratic story-telling. Her efforts indeed yielded fruit, as attested by L.'s compliance with

homework. These findings seem to suggest that the treatment did not aggravate L.'s worsening trajectory and may in fact have minimized it.

On the other hand, the examination of the therapy process also suggests that the therapist's directive and pro-active style may have contributed to confine L. into a passive, avoidant and dependent position rather than encourage him to experience a more active and leading stance. The therapist's personal style was probably reinforced by the cognitive-behavioral orientation which guided her treatment and emphasized structured interventions, initiated by the therapist. Interventions aimed at fostering the development of L.'s own sense of agency and capacity for moment-to-moment self-awareness were not included in the therapist's repertoire. During his termination interview, L. indeed expressed his dependency toward his different therapists in the program, and his difficulty facing life challenges without their guidance. Accordingly, it is not unreasonable to hypothesize that L. may have experienced an actual, sudden worsening at the end of his treatment, caused by the termination, and different from a progressive deterioration occurring throughout treatment. In a similar vein, it is not unreasonable to postulate that therapy itself may have reinforced the maladaptive relational pattern that L. seems to have an inclination for. Namely, L.'s feelings of being safe and comfortable in his dependent and passive relationship with his therapist may have consolidated his core beliefs about his needs to be taken care of. Future research will need to gather outcome data session by session, rather than at intake and termination, in order to differentiate between deterioration throughout treatment and sudden deterioration possibly caused by termination anxiety.

Despite his deterioration on the symptom and interpersonal functioning measures, L. reported his satisfaction with therapy and the therapist, as well as his belief that the treatment was helpful. This finding is in line with the literature on patients' satisfaction with treatment, according to which patients' self-reported change is not correlated with satisfaction (Lunnen and Ogles, 1998). This finding, indisputably illustrated in L.s' case, may in fact suggest that the emotional experience provided by therapy, and its potential ability to increase one's feelings of acceptance and well-being probably need to be considered as outcome, beyond one's actual symptomatic and interpersonal change.

CONCLUSIONS AND FUTURE DIRECTIONS

This case-study illustrated Dimidjian and Hollon's taxonomy of outcome (2010) as well as Wampold and Imel's conceptualization of deterioration vs. harm. According to the former, patients' change in symptomatology is not indicative of treatment success when taken independently from patients' expected course of disease. Indeed, L.'s background, his personality style, and his successive treatment outcomes suggest that his symptoms may have deteriorated more severely had he not participated in treatment. For the later, deterioration in functioning throughout treatment can be caused by a variety of factors that are not related to the treatment *per se*. L.'s deterioration was indeed not induced by the treatment itself, so that his therapy cannot be qualified as harmful. Additionally, L.'s case emphasized that human functioning and its evolution throughout therapy are multi-faceted and difficult to assess in a comprehensive and fully reliable manner using quantitative methods only: L. indeed reliably deteriorated on two measures of outcome, and yet he felt satisfied with his therapy, improved his capacity for self-awareness, experienced a warm and productive relationship, and learned more adaptive ways of thinking and handling life challenges. Last, the present study suggests that the combination of client factors such as avoidance and lack of agency, therapist factors such as directiveness, and therapy factors such as brief treatment and high structure, may have played a role in L.'s sudden relapse and deterioration at termination. Future research may help clarify the extent to which this combination of factors indeed increases the likelihood of sudden deterioration at termination.

ETHICS STATEMENT

The study was performed with archival data collected at the Brief Psychotherapy Research Program, New York, approved by the Icahn school of Medicine at Mount Sinai IRB, application #048–88.

AUTHOR CONTRIBUTIONS

SB-E performed the analyses and completed the writing of the manuscript. CE performed the analyses related to the 3RS system and wrote the section on that topic. LK collaborated with the first author to interpret the findings and revise successive drafts of the manuscript. BG supervised the statistical analyses involving all the quantitative measures and revised the successive drafts of the manuscript. JM is the PI of the research program in which this study took place. He was responsible for the data collection and guided SB-E throughout all the steps leading to the completion of the manuscript.

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"We Just Did Not Get on". Young Adults' Experiences of Unsuccessful Psychodynamic Psychotherapy – A Lack of Meta-Communication and Mentalization?

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In order to avoid suboptimal psychotherapy, research needs to highlight and analyze obstacles in such treatments. This clinically oriented article brings together empirical material of unsuccessful psychotherapy with young adults; empirical material on the therapists' views of the same therapies; and theoretical perspectives on mentalization, therapeutic alliance, and young adulthood. Through a secondary qualitative analysis, it presents a tentative process model of how suboptimal psychotherapy with young adults develops, how it could be handled clinically, and possibly prevented. In three studies, experiences of young adult patients (aged 18–25; n = 27), in psychoanalytic therapy at an outpatient clinic, who did not improve from therapy (defined as no reliable and clinically significant symptom reduction) and/or were dissatisfied, and their therapists, were analyzed. Patients described experiences of not being understood and not understanding therapy, whereas therapists described patient non-commitment. These results were compared from the developmental perspective of mentalization in young adulthood. The primary grounded theory analyses and secondary analysis resulted in a tentative process model of the development of suboptimal psychotherapy with young adults. Suboptimal therapy is described as a vicious circle of therapist underestimation of patient problems, therapeutic interventions on an inadequate level, and diverging agendas between therapist and patient in terms of therapeutic alliance, resulting in pseudo-mentalizing and no development towards agency. A benign circle of successful therapy is characterized by correct estimation of patient problems, meta-communication, and the repair of alliance ruptures. One clinical implication is that therapists of young adult patients need to establish verbal and nonverbal meta-communication on therapy progress and therapeutic alliance. The importance of the patients' present mentalization capacity and adjusted interventions are demonstrated in an example. Research in the field should be process-oriented and investigate the effect of meta-communication and interventions targeted to foster therapeutic alliance based on this theoretical model, particularly for young adults.

Keywords: unsuccessful treatment, psychodynamic psychotherapy, young adults, grounded theory, secondary qualitative analysis, mentalization, meta-communication

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INTRODUCTION

Psychodynamic psychotherapy is helpful for adults, adolescents and children with various psychological problems (Barber et al., 2013; Lambert, 2013b) but does not help every individual. The awareness that certain subgroups and individuals might need different approaches in therapy is now leaving its mark on psychotherapy research, with in-depth studies on what works for whom (Zilcha-Mano, 2019). One conclusion is that a number of patients stay in treatment although it does not seem to be helping them (Lambert, 2013a), thus spending their own and their therapist's time and effort for very little benefit. It has been pointed out that non-responding possibly deprives the patient of the opportunity to have a successful treatment elsewhere (Dimidjian and Hollon, 2010). It could also be added that it deprives the therapist of the chance to offer other patients more successful therapy, since the same therapist often has both successful and less successful cases (Wampold and Brown, 2005).

As a researcher and a clinical psychologist and psychotherapist, I am aware of the time and effort many clinicians spend in supervision trying to understand patients for whom treatment does not seem useful. It would be of great value to researchers and clinicians alike to know what makes patients stay in treatments that do not help them and how such therapies could be prevented, either by turning the deadlock in therapy into a productive process, or by singling out therapies which might not be helpful from an early stage.

To investigate unsuccessful psychotherapy in which patients stay for a substantial time (as opposed to dropping out), the first question is how non-improvement should be defined. The reliable change index (RCI; Jacobson and Truax, 1991) is often used for identifying cases without improvement, based on symptom levels before and after treatment. However, it needs to be taken into account that a high symptom level at the termination of therapy might not be due to therapy alone but other circumstances (Bowie et al., 2016), and that qualitative and quantitative measures do not always coincide in deciding whether psychotherapy was successful (von Below, 2017). Patients and therapists might have highly diverging views of the very same psychotherapy process and results (Dimidjian and Hollon, 2010; Gold and Stricker, 2011; Kächele and Schachter, 2014). Thus, the area is best investigated from different viewpoints and well defined in each study. To combine different measures is also an advantage, or have studies look at the same cases but with different methodological starting points (i.e., qualitative, quantitative, mixed method, meta-analyses, and secondary qualitative analysis) as it gives a fuller picture, e.g., when a patient shows deterioration in one measure and improvement in another.

However non-improvement is defined, we could expect a heterogeneous collection of factors contributing to it, including patient factors (Barber et al., 2013), circumstances outside of therapy (Bowie et al., 2016), and therapeutic alliance (Zilcha-Mano, 2017). Considering the diversity of factors that could be a part of unsuccessful psychotherapy, an explorative and inclusive approach is often needed, in which qualitative methods are useful (Barlow, 2010; Malterud 2001a).

Patients stress the importance of a good emotional bond as part of treatment (Midgley et al., 2014b; Levitt et al., 2016). This has spurred research into particular challenges to form an emotional bond to certain groups of patients, among them young adults (aged 18–25). Clinicians have expressed that they use a particular approach with young patients, in which the therapeutic alliance and in particular the emotional bond is central, but needs more focus than when treating older adults (e.g., Paulson and Everall, 2003; Bury et al., 2007; Cooper, 2009; Binder et al., 2011; Lynass et al., 2012; Henden Sagen et al., 2013; Midgley et al., 2014b; for an overview, see von Below, 2017). From a developmental perspective, young adulthood is for most individuals a period of insecure employment, sudden changes, identity exploration, and many possibilities (Arnett, 2014). Clinicians need to take into consideration the instable life situation as well as the life decisions in young adulthood, in order to form a good therapeutic alliance with young adults (von Below, 2017). Since a strong therapeutic alliance is associated with good outcome (Horvath et al., 2011), using therapeutic interventions for forming good alliance with young adults is of importance. Young people are an age group in which mental health is deteriorating in Sweden, particularly expressed in psychosomatic symptoms, anxiety and depression (Public Health Agency of Sweden, 2018), which further enhances the importance of treatments adjusted to the age group.

Patients' own explanations of why treatment was unsuccessful give researchers and clinical therapists hypotheses on how therapy can be better presented to patients, and how therapy progression can be followed, but is under-used as a source of information on how to improve therapeutic technique (Bohart and Wade, 2013; McLeod, 2013; Midgley et al., 2014a). In line with this, four empirical studies leading to this present study have focused on negative experiences among young adults in psychoanalytic psychotherapy and their therapists' view of the same therapies (von Below et al., 2010; von Below and Werbart, 2012; Werbart et al., 2015, 2018). One result was that patients experienced limitations in the therapeutic relationship, which made them restrained in therapy. Another was that therapists attributed the limited outcome in therapy to patients, whereas patients experienced a lack of therapist commitment as well as misdirected therapeutic actions important aspects of bad outcome. Their different perspectives could be understood in the light of limited therapeutic alliance (Bordin, 1979; Zilcha-Mano, 2019) by not sharing goals of therapy and an emotional bond that had severe limitations from the patients' view. The results were interesting in themselves, and other studies reporting patients' expectations and experiences of psychodynamic psychotherapy (Rennie, 2002; Midgley et al., 2014a), including meta-studies (Levitt et al., 2016) have come to similar conclusions on the importance of a positive therapeutic relationship and shared the goals of therapy. However, the clinical usefulness of the results can be further enhanced if the results are analyzed beyond the level of what patients say, by comparing patient statements to their therapists' reports of the same therapies, as well as placing the therapies in the context of the patients' present life situation and capacity and

exploring the implications of this for the therapeutic stance, which is the focus of this present study.

The aim of the present article is to draw theoretical and clinical conclusions on the process of suboptimal psychodynamic psychotherapy from the young adult patients' and therapists' view, leading to clinical advice, in order to avoid suboptimal outcome. In line with the grounded theory approach, the study is explorative and empirical in its starting point. It analyses (1) what leads to suboptimal outcome according to the patients and therapists; (2) what the combined picture of these two perspectives tell about the therapeutic process; and (3) how the therapeutic process can be understood theoretically in the light of the concept of young adulthood and mentalization. "Suboptimal" is defined in this article as psychotherapy which either does not reach the goals decided by patient and therapist or leaves the patient dissatisfied (see each study for details) regardless of whether goals were reached according to the RCI (Jacobson and Truax, 1991).

The conclusions are drawn from cases which were considered unsuccessful either by self-report measures (Werbart et al., 2015) or qualitative measures (von Below and Werbart, 2012) and their therapists' view of the same therapies (Werbart et al., 2018), which will be compared to cases with an average outcome (von Below et al., 2010) in a secondary qualitative analysis (Heaton, 2008). The tentative process model of the way to suboptimal outcome, as well as ways to break the negative spiral into suboptimal outcome has been published in my doctoral thesis (von Below, 2017), but is presented here along with a more extensive theoretical analysis and clinical conclusions. The secondary analysis adds a theoretical interpretation to the data, although the analysis in itself is not deductive or theory-driven.

MATERIALS AND METHODS

The present study is thus a secondary analysis (Heaton, 2008) of qualitative data from four studies with a focus on the hindering factors in psychodynamic psychotherapy. It should be seen as an additional qualitative interpretation. In two of the studies, the experiences of young adult patients in suboptimal psychodynamic psychotherapy were investigated (von Below and Werbart, 2012; Werbart et al., 2015), and in the third, focus was on the experiences of therapists of patients in suboptimal psychotherapy (Werbart et al., 2018). A fourth study investigated the experiences of young adult patients with depression diagnosis and average therapy outcome in the same larger study (von Below et al., 2010).

A secondary analysis of qualitative data can be used to aggregate or re-use data in order to answer questions not addressed in the primary studies (Heaton, 2008). The present secondary analysis re-uses data (interviews) as well as codes and categories from the grounded theory analyses in the primary analysis. By combining data from patient and therapist interviews in the primary analyses, discrepancies in their view of the therapeutic process were observed within the framework of each study. The conclusions and discussions in each study were limited to the focus of that particular study. When considering the conclusions from all four studies taken together, I observed that a re-analysis might contribute with new patterns and themes. The secondary analysis is thus a re-analysis and a synthesis of the primary studies with a particular focus on the theoretical understanding of the results (Heaton, 2008). The secondary analysis included further theoretical perspectives in line with the grounded theory approach in which the exploration of the empirical findings starts with a minimum of references to other research and theories but is added in the discussion section to present the process model grounded in data (Charmaz, 2014). The secondary analysis is thus still inductive but adds and stresses a theoretical framework as an interpretation.

Setting

The studies were conducted within the Young Adults Psychotherapy Project (YAPP), a longitudinal, naturalistic study of young adults (aged 18–25) in psychotherapy at the former Institute of Psychotherapy in Stockholm, Sweden. The patients in the project as a whole reported low self-esteem (97%), conflicts in close relationships (66%), depressed mood (66%), and anxiety (55%) (Wiman and Werbart, 2002). Moreover, about one-third of the patients had personality disorders according to the *DSM-IV and ICD-10 Personality Questionnaire* (DIP-Q; Ottosson et al., 1998). The therapies (mean duration 22.3 months, SD = 17.2) were aimed at improving the patients' ability to manage developmental strains and not manualized. Duration, frequency (once or twice weekly), and goals were jointly formulated by patient and therapist at the beginning of therapy. Treatment outcomes were studied at termination, after 1.5 years, and at a 3-year follow-up (Philips et al., 2006; Lindgren et al., 2010). Generally, there were large improvements on a group level in global functioning (Lindgren, et al., 2010).

The psychoanalytically trained therapists (n = 37) had backgrounds as psychologists, psychiatrists, and social workers before they started their employment as psychotherapists, supervisors, and teachers at the institute. They met weekly in clinical teams, where treatment problems were discussed, and had access to supervision. Adherence could not be measured.

Participants

From the Young Adult Psychotherapy Project, a subsample of participants was used in each primary study in accordance with the aim of that study. The subsamples are described below.

The secondary analysis comprised all of the participants from the primary studies. Due to an overlap of four patients, who took part in more than one of the primary studies, and one of them in all three, the total number of patients were 39 and therapists were 8.

Dissatisfied Psychotherapy Patients (n = 7)

The first study (von Below and Werbart, 2012) included all patients in the project thus far who were dissatisfied with individual psychotherapy, defined by the qualitative criterion that they expressed dissatisfaction with therapy in the termination interview. von Below read the 70 interviews available from

termination and 59 from follow-up, listing those predominantly dissatisfied with therapy, defined as expressing more dissatisfaction than satisfaction with therapy. Seven clear cases and three possible cases were found; all ten were discussed in the research team (Werbart and four other researchers) and seven patients (six women, one man) were labeled dissatisfied. Four of these had personality disorder diagnoses according to DSM-IV (American Psychiatric Association, 2000) and four had axis 1 diagnoses: acute stress syndrome, adjustment disorder with depressed mood, mood disorder due to medical condition, and major depressive disorder (recurrent). Therapy length was varying (2–48 months, M = 16.9).

Non-improved Psychotherapy Patients (n = 20)

The second study (Werbart et al., 2015) included all patients who did not improve significantly from individual therapy, i.e., who both belonged to the clinical range pre-treatment and showed deterioration or no symptom reduction at termination of psychotherapy. Of the 20 patients, 17 (85%) were women. The pre-treatment symptom level was measured by the Global Severity Index (GSI) of the Symptom Checklist-90-R (Derogatis, 1994). Change was measured using the RCI (Jacobson and Truax, 1991). For research design reasons, only nine had been diagnosed in accordance with the DSM-IV (American Psychiatric Association, 2000). Two patients had dysthymia and personality disorder not otherwise specified (NOS), one mood disorder due to medical condition, one obsessive-compulsive disorder, one acute stress disorder, one anxiety disorder NOS, and two personality disorder NOS.

Therapists of Non-Improved Patients (n = 8)

Study three included the therapists (Werbart et al., 2018) of the non-improved patients in study two. Due to research design, not every patient's therapist had been interviewed. The seven therapists included treated eight patients. Four therapists were female, three male; two were social workers, four psychologists and one psychiatrist. Six therapists were senior licensed psychotherapists with 6–14 years of experience and one had basic training in psychodynamic psychotherapy.

Patients With Depression (n = 17)

Study four (von Below et al., 2010) included all patients who were diagnosed with a depression diagnosis according to DSM-IV (American Psychiatric Association, 2000), at the beginning of therapy within the YAPP project. Nine of the patients were enrolled in individual psychotherapy with a mean duration of 27 months (range 14–48), eight in group therapy in three different groups, with mean duration 15.5 months (range 7–27 months).

Material

Interviews were conducted at therapy termination and at follow-ups at 18 and 36 months after termination. The interview protocol comprised the private theories interview (PTI; Werbart and Levander, 2005) and Object Relations Inventory (ORI; Blatt et al., 1979; Gruen and Blatt, 1990). The PTI is semi-structured and collects narratives on problem formulations, ideas of background, ideas of cure, descriptions of changes, and retrospective views of what could have been different. The ORI focuses on the participants' descriptions and views of significant others and themselves by asking participants to describe their closest relations and their therapists, followed by exploration of the answers. The interviews lasted 60 min and were recorded and transcribed verbatim. The interviewers were psychotherapists and researchers at the Institute of Psychotherapy trained in the PTI and ORI interview techniques.

Analysis

Primary Analysis

The qualitative method GT (Fassinger, 2005; Rennie, 2006; Charmaz, 2014) designed for analyzing interview material without preconceived categories was used in the primary studies. GT aims at generating tentative conceptual models grounded in empirical data and is often considered the method of choice when studying interactive, reciprocal processes and underexplored fields of knowledge. GT is especially useful for analyzing processes, or interrelations. We followed the steps outlined by Strauss and Corbin (1998) and developed by Charmaz (2014):

1. *Open coding*: the transcribed interviews were read line by line and all units of meaning were labeled with words or sentences capturing the participants own words. To reduce the risk of letting the researchers' preconceptions interfere with the initial codes, there was a *constant comparative analysis* against data and across coders. Codes were merged, defined and grouped together in preliminary categories, which were further defined.
2. *Axial coding*: the analysis moves from the descriptive to the theoretical. Focus shifts from individual codes to patterns (temporal, causal, and theoretical) in the relations between categories, leading to a number of categories and one or a few main categories, all connected by well-defined relations. Possibly, a core category that theoretically summarizes the material is formulated.
3. *Selective/theoretical coding*: the process model that was created in the axial coding created a need for further analysis of the empirical material or other patterns in data, which prompted a return to data.

Computer programs were an aid in the overview of codes, quotations, categories and patterns. We also used *memo-writing* to conceptualized material on an early stage (Charmaz, 2014).

Secondary Analysis

Codes and categories from the primary studies were revisited by the author of the present article. In some cases, interviews or excerpts from the interviews were re-read in order to define categories and codes with the new research question. No new data were collected. The process is best described as an *amplified supra analysis* of pre-existing data (Heaton, 2008), in which two or more existing datasets are combined or compared in order to explore a partly new research question that transcends the aim of the primary analysis. It could not be described as

a fully conducted qualitative meta-analysis, as the studies are part of the same project. However, the method in the secondary analysis is similar to that of a qualitative meta-analysis as it creates new themes and a further theoretical understanding by aggregating qualitative data (Heaton, 2008). In line with grounded theory, the aim of the amplified supra analysis was to present a tentative process model of suboptimal psychodynamic psychotherapy with hypotheses on how this could be prevented. The interpretation is grounded in data and to a certain degree hermeneutic as it is an interpretation of the process of suboptimal therapy with the intention of understanding it (Rennie, 2006). The aim is not to confirm causality but rather to explore the area to propose hypotheses for further research.

The analysis was carried out by the author and discussed with the co-writer of the primary studies, Andrzej Werbart, and research teams at Stockholm University.

Researcher Reflexivity

The researcher's preconceptions, background, theoretical preferences, and experiences inevitably affect the interpretation of data. No attempt to put one's knowledge and preconception into brackets will be complete. Thus, reflexivity is necessary for transparency. I joined the larger project of which this study is one part in 2006 as a newly graduated clinical psychodynamic psychologist with theoretical knowledge of psychotherapy, but little experience. With increasing clinical experience, doctoral studies, and as a lecturer of psychodynamic psychotherapy I have continued to combine clinical and theoretical knowledge on mentalization, attachment, and affect focused psychotherapy which has influenced my analysis in the present study, possibly by drawing my attention to aspects in data central to mentalization. It is both a limitation and a strength. The limitation is that other perspectives might play a lesser part. On the other hand, the project leader and co-researcher professor Andrzej Werbart has a psychoanalytic training which brought other perspectives into the discussion of the analyses. To have knowledge of mentalization theory and practice is also a strength, as it makes research clinically useful.

My own experiences of conducting successful and less successful therapies have possibly deepened my understanding for the research material. I have also experienced the importance of the therapeutic alliance in everyday work. However, I might also have lost some of the naivety that comes with being less acquainted with a field of research. In the beginning, I could not fill the gaps in the analyses with my own preconceptions of therapy. This might be the case in the later studies, no matter how hard I have tried to avoid this and to achieve triangulation and discussions with other researchers.

RESULTS

Here follows a summary of the primary results of each study, with a concluding comparison of the studies. The italicized words refer to categories in the process models presented in the original articles.

Dissatisfied Psychotherapy Patients

The dissatisfied patients described a vicious circle of dissatisfaction, summed up in the core category as *abandonment with their problems*: an experience of being abandoned with their problems in ways elaborated by the subcategories. Participants described *not being understood* when therapists were inattentive, uninterested, or not focusing on what participants considered important – *the therapist went her own way*. Participants generally described an *unsure, critical, powerless therapist* and experienced *lack of therapist response* and *lack of confidence*. One variant was *therapist absent or had problems of her own*, implying non-stability.

The core categories *insufficient flexibility and intensity* and *absent links to everyday life* summed up and interpreted how participants described *wanting advice, answers, and practical exercise* and *wanting direction* in therapy. Most patients expressed a wish for a therapist who structured the sessions better. The variant *feeling unable to reach or express own feelings* was the only category focusing on patients' own inability. Patients generally saw the therapy method and the therapist as the main obstacles to successful therapy.

Based on negative experiences, the participants generally concluded that *therapy ended too early*, *therapy did not help*, *needing some other kind of help* and as a variant, *therapy made things worse*. One patient expressed at termination: "Now I feel all shut up inside myself. It feels worse" (von Below and Werbart, 2012).

All participants mentioned some positive aspects. Typically, *therapy provided some acceptance and insight into oneself and one's problems* and *it felt good to talk*. *The therapist was gentle, sensitive, and stable* but this was vague and could not be exemplified.

Non-improved Psychotherapy Patients

The core category *spinning one's wheels* summed up the experience of continuing without getting anywhere. Six categories pointing toward the core category explained positive and negative experiences of therapy balancing each other. Positive experiences of some symptom reduction and being in therapy with a listening, professional and wise therapist, who sometimes confronted the patient and reflected about what was said in a helpful way, outweighed negative experiences of a distanced relationship, too much focus on understanding and unchanged core problems. One patient said in retrospect: "When I think back on the therapy, I get the feeling that I often sat and talked; sometimes something important came up, but often it felt like it was pretty much just spinning my wheels" (Werbart et al., 2015).

As time passed, outcomes of therapy became clear in four subcategories. Generally, instead of helpful therapy, participants described their *own helpful activity*, e.g., moving to a new place as bringing positive change, as well as *mending life conditions*, such as support from relatives or friends. As a variant, *negative impacts of life events* were neither caused by therapy, nor did therapeutic experience help resolve them.

Generally, *therapy generated some improvements* but *therapy was insufficient* and there were *remaining core problems*. Typically, participants described *impaired emotional life* for which therapy was not to blame, but also not helpful.

Therapists of Non-improved Patients

The conclusive experience of the therapists was summed up in the core category *having half of the patient in therapy*. Initially, the therapists experienced a *stimulating collaboration*, at the same time as a *distance in the therapeutic relationship*. However, the negative process developed and dominated at termination. The therapist experienced that the patient reacted with aversion to emotional, therapeutic closeness and the therapist experienced struggle and loss of control in therapy. The therapists described therapy outcome as favorable in the form of increased insight and mitigated problems, while core problems remained. This split picture was interpreted as a sign of a pseudo-process emerging when the therapist allied herself with the patient's capable and seemingly well-functioning parts. The therapists' experiences could be compared to the non-improved patients' "spinning one's wheels" in therapy. The therapists seemed not to have succeeded in adjusting their technique to their patients' core problems, despite attempts to meta-communicate.

One therapist summed up therapy at termination: "It reflects pretty much how her life is like. On the surface everything looks very competent and good. But you still have a sense that there is something going on under the surface. And I cannot get the hang of what's going on there" (Werbart et al., 2018).

Patients With a Former Depression Diagnosis

Participants with a depression diagnosis pre-treatment, who were in therapy with average outcome, described the process of finding themselves and a new identity as central, along with symptom relief. *Finding oneself* and *finding one's way of life* were changes and contributors to change as the participants reported *feeling better*. They felt proud and confident in studies or work. Relationships brought joy and satisfaction. Participants described a new attitude to life with humor, courage and acceptance, *viewing life differently – doing differently*. Increasing self-knowledge was a prerequisite for this, but also a result of it. New experiences and changes in therapy contributed to positive change, such as the typical *sharing what's inside oneself*. Talking and reflecting in a safe environment were experienced as helpful and as new abilities, as was the capacity to stand difficult feelings. *Gaining perspectives and understanding* through the therapist or therapy group members were helpful. *Therapy as a place and time for oneself* was important for many participants. *The march of time* and *other treatments* such as yoga were of help and so was anti-depressant medication.

Participants reported *feeling uncomfortable in therapy* from time to time, often attributing these shortcomings to themselves. *Wanting treatment to be different*, a need for advice, active guidance or longer therapy was common. Participants also brought up *problems in therapy* such as long holiday breaks. There were negative experiences that could impede the experienced changes or be an obstacle, but these could be alleviated by positive outcomes, for instance *getting stuck in problems* and *feeling worse* through medication, therapy, and life circumstances. *Finding it difficult to do things differently* despite intellectual knowledge of how to do so was reported as hindering. To conclude, obstacles and dissatisfaction with some aspects of therapy were common but could generally be overcome with time and effort.

Summary of Results From the Primary Studies: A Comparison Between Dissatisfied Patients, Non-improved Patients, Their Therapists, and Patients With Average Outcome

Patients with an average outcome and an earlier depression diagnosis described their way to improvement as *finding oneself and one's way of life*. They described a new understanding of their own needs and responsibilities, which facilitated their decisions in life and gave them a sense of having command in their own lives. They established themselves as self-aware agents who could act, rather than be left to the circumstances. This new ability and experience gave their life direction and symptom relief. They appreciated the warmth expressed by the therapist and therapy group, understanding, honest feedback, active interventions and advice as part of development.

Correspondingly, participants in suboptimal therapies called for therapeutic actions similar to these: active interventions, focus on questions in their lives that matter to the participant. They wished for a therapist who offered advice and explanations, was interested, and intensified therapy by confrontation if needed. Thus, participants in suboptimal therapy had an intuitive knowledge of what was lacking in therapy and might have been helpful. With one exception, they did not bring this up with their therapist.

At termination, participants in suboptimal therapies described that important problems remained, most of all due to the lack of therapist engagement and understanding. Participants wanted the therapists' concern and guidance. Indeed, therapists in the study also felt interested and concerned about the patients. They wanted to, and tried to, help patients with their emotional suffering by offering a trusting therapeutic relationship, interventions, and confrontation, but perceived the patients as withdrawing or unwilling. Patients wanted confrontation and help to change from the therapists, still the therapists perceived the patients as unmotivated when offering exactly that, as expressed by therapists in the quote "*Having half of the patient in therapy*." The question of how therapist and patient could aim for the same goal, but not find the means to do so, is intriguing and will be further discussed in the following.

When reviewing the interviews of patients in suboptimal therapy, it became clear that the patients in suboptimal therapies expressed themselves in a way that differed from the patients in therapies with average outcome. Their wishes for advice, explanations of one's own behavior, and the attempts to understand the therapist were generally remarkably concrete and lacked the reflection interviews in a study of patients with average outcome showed. It was also reflected in their relatively high percentage of personality disorders. The concrete understanding of others' intentions and thoughts could indicate

that the participants were mostly in pre-mentalizing modes (that is teleological thinking, psychic equivalence, or pretend mode; Bateman and Fonagy, 2016) when trying to understand themselves and others, including their therapists.

SECONDARY ANALYSIS: PREVENTING SUBOPTIMAL PSYCHOTHERAPY WITH YOUNG ADULTS

The results and hypotheses from the second analysis are presented in the shape of a tentative process model (**Figure 1**). The model is an interpretation of the process of suboptimal psychoanalytic psychotherapy with young adult patients, understood from a developmental and relational perspective, based on the patients' experiences as expressed in the interviews and theories of psychological development.

The model should be followed from left to right. The first box depicts *young adulthood: developmental tasks*, which gives the context for psychotherapy with young adults. Patients in the primary studies described how practical matters such as housing, employment and changing relationships were central in their lives and their psychological suffering. Beginning with Erikson (1959), developmental psychologists have pointed out the life stage specific challenges young adults in general face: to create a meaningful life with capacity for intimate relationships and independence from parents. Young adult patients are in a life stage that demands rapid decisions on how to form one's life, decisions which will have future consequences. As pointed out by developmental psychologists (Arnett, 2014; Schwartz, 2016), such life decisions are both a part of becoming an adult and developing self-knowledge in order to create one's own identity. Patients in the primary studies did not feel their therapists met their wish to reflect on their life decisions and own will in therapy. Instead, they their therapists stressed other aspects of the patient's life, such as past relationship patterns to parents, which the patients did not see as important in the current situation. Thus, the means of therapy was not agreed on by the patient and therapist. The therapeutic alliance (Bordin, 1979; Zilcha-Mano, 2017) was impaired by this.

Relational history in the model refers to the patient's attachment pattern and interpersonal functioning, which influence the therapeutic relationship. Patients with a low capacity for reflection in general, and limited experiences of secure relationships, naturally present a greater challenge for therapists when establishing a therapeutic alliance (Bateman and Fonagy, 2016) as well as in treatment, as it is a factor that is associated with low outcome (Barber et al., 2013). Treating patients with these difficulties demands knowledge and suitable interventions from the therapists. Among such relational difficulties is insecure attachment with negative and insecure internal working models (Bowlby, 1988) or low capacity for mentalization (Bateman and Fonagy, 2016). Zilcha-Mano (2017) refers to the reasonably stable way of relating to others, including the therapist, as the "trait-like" aspect of emotional bond in the therapeutic alliance. In the present study, the high percentage of personality disorders according to DSM-IV (American Psychiatric Association, 2000)

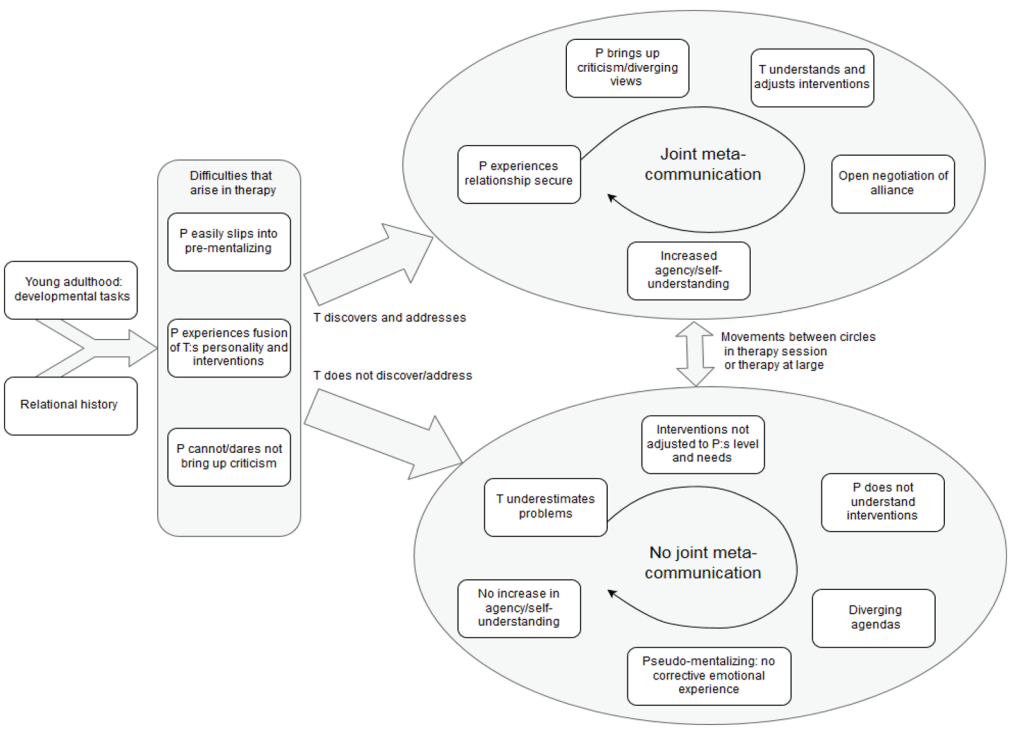

FIGURE 1 | A tentative process model of suboptimal therapy with young adults, with emergent principles and hypotheses on how to prevent it.

among patients in suboptimal psychotherapy indicates that had relational difficulties and would have needed interventions targeted at these difficulties, i.e., targeted at the "trait-like" aspects of the ruptures in the therapeutic alliance (Zilcha-Mano, 2017), for instance negative internal working models in attachment terms (Bowlby, 1988). This will be discussed below.

The rectangle containing three boxes depicts the process in therapy. Young adult patients with relational difficulties and insecure attachment history face difficulties in pressing choices about housing and employment, as they have a less clear sense of their own wishes and directions in life. Their stress resilience is lower, which means they risk slipping into concrete modes of thinking (pre-mentalization, discussed below; Bateman and Fonagy, 2016) more often than a patient with relational security or less stressful life circumstances. The capture *patient easily slips into pre-mentalizing* depicts the concrete understanding patients express in the interviews of the present study, when interpreting their therapists' actions in a concrete way, such as the change of hair color as a sign of the therapist's psychological imbalance (von Below and Werbart, 2012). A permanent or temporary low mentalization capacity needs attention from the therapist and interventions intended to reduce anxiety and improve reflective functioning in the present (Bateman and Fonagy, 2016).

I suggest that theory of mentalization is helpful in understanding the negative therapeutic relationship described by patients in the study and to inform therapists of ways to improve the therapeutic alliance and avoid suboptimal psychotherapy. The definition of mentalization is the ability to understand that (and how) mental states including feelings, intentions, wishes, values, and goals in oneself and others underlie our own and others' overt behavior (Allen et al., 2008; Bateman and Fonagy, 2016). The capacity develops gradually through childhood from a concrete understanding of others' actions to a reflective stance, if the circumstances are supportive. The child reaches early a teleological stance, in which there is a rudimentary understanding of the rationality behind a certain behavior, but only with regard to concrete reality. In the psychic equivalence mode, the young child equates the internal state with the outside world, not experiencing its own feelings and states as representations of the external world, but rather the external world itself. The pretend mode, on the other hand, is the extreme separation of the internal and external world – mental states are not anchored in the external reality and thus not a representation, but imagination. In a fully mentalized mode, the individual is capable of keeping multiple perspectives in mind, thus understanding that somebody else does not experience a situation in the same way as oneself. As repeatedly pointed out by mentalization theorists, these two stances of pre-mentalization are also common, temporarily or permanently, in adult patients with relational or personality difficulties (Fonagy et al., 2002; Bateman and Fonagy, 2016).

Based on the empirical data from patient interviews in the studies, I suggest in the model (**Figure 1**) that a patient with temporal or more long-lasting concrete or pre-mentalized thinking will have difficulties interpreting the therapist's interventions, which is expressed in *patient experiences fusion between therapist's personality and interventions*. Patients described their therapists by referring to their interventions and interpreted actions concretely, such as therapist silence as a sign that the therapist was "insecure" or "had problems of her own". In line with this, the *patient cannot/dares not bring up criticism*, as doing so would equal to criticizing the therapist as a person. Also, one often overlooked difficulty for young patients is the subordinate position they might experience in relation to the older psychotherapist (Gibson and Cartwright, 2013), which could have posed a problem for patients in the present study, particularly in a pre-mentalizing mode.

Possibly, therapists in suboptimal therapies did not observe their patients' sudden pre-mentalization, temporal or more permanent, or failed to address it in a fruitful way. Sudden shifts to pre-mentalization could be understood as the "state-like" part of the therapeutic alliance (Zilcha-Mano, 2017), i.e., a condition which changes (sometimes from moment to moment) over time. To observe and intervene would have helped the patient develop agency, a clearer self-understanding, reduce projection and lower anxiety over time (Allen, et al., 2008; Bateman and Fonagy, 2016). However, data from therapist interviews instead imply that therapists underestimated their patients' problems and thus did not notice their lack of self-understanding and mentalization. Early in therapy, therapists established an image of the patient as competent, but later experienced that "only parts of the patients' problems were brought into therapy". To overestimate the patients' functioning and underestimate their problems is generally correlated with lower outcome (Barber et al., 2013, p. 466). From this, it is reasonable to believe that better therapist ability to recognize sudden shifts in mentalization would help preventing suboptimal psychotherapy.

Patients with average outcome (study four) describe the development of *agency* during the course of therapy ("finding oneself and one's way of life"), in contrast to those in suboptimal psychotherapy. Agency signifies the experience of a lasting identity or a self that has the ability to understand oneself and others and thus act in adaptive ways and is closely linked to the capacity to reflect upon situations, experiences and oneself in relation to others (Fonagy et al., 2002; Allen et al., 2008; Bateman and Fonagy, 2016). This lack of agency is what patients in suboptimal psychotherapy in the studies describe and ask for help with from their therapists. However, therapy did not help them develop this capacity. The interpretation of the process that lead to this stalemate is summarized to the right in the process model. The arrows upward and downward to the left depict the pathways to suboptimal psychotherapy or more successful psychotherapy, depending on the therapist's actions.

The development toward suboptimal therapy with young adults is depicted by the arrow downward; *therapist does not discover/address* difficulties and pre-mentalization in the form of sudden changes of mentalization capacity or internal states, as described above. This leads to the circle of *no joint meta-communication*. The word meta-communication is used in this article to denote the explicit or implicit communication on the goals, tasks, and emotional bond in therapy (therapeutic alliance; Bordin, 1979), as well as communication on the

moment-to-moment emotions and thoughts in therapy and the state-like therapeutic relationship (Zilcha-Mano, 2017). It is both the conscious, explicit verbal communication on this, and the implicit, non-verbal negotiation of alliance in therapy. Thus, it also includes implicit or affective communication and mirroring to a certain extent. The therapist's role is to make room for this in the therapeutic collaboration by inviting the patient to share his/her impressions and views in therapy. It is the responsibility of the therapist to foster this and observe the patient's capacity for meta-communication and adjust interventions. In itself, meta-communication is a mentalizing process, as the patient deepens her/his understanding of the self in relation to others (the therapist and other important persons) not just intellectually, but also with regard to affect. Thus, it is a capacity that the patient could develop during therapy, and a method to foster therapeutic alliance. As a capacity, it is similar to reflective function in mentalization theory (Bateman and Fonagy, 2016). Indeed, patients with personality disorders and low capacity for mentalization have expressed their wish for therapists who communicate clearly in the therapeutic setting (Morken et al., 2019), indicating that patients in the present study would have benefitted from such an approach as opposed to the restrained version of the psychoanalytic stance they described their therapists applied. When not noticing the sudden shifts in mentalization capacity, the *therapist underestimates the patient's difficulties* which leads to *interventions not adjusted to patient's level and needs*. The *patient does not understand the interventions*, neither the goals nor how to make use of them.

An example could be interpretations of how earlier experiences influence the patient's current problems. If not rooted in present affects and emotional understanding in the here-and-now, such interpretations seem not to be useful for the patient according to this analysis. Patients in suboptimal therapies expressed that focus was too much on explanations from the past, which I understand as interpretations on a level the patient did not benefit from, although the therapists thought this to be useful. Focus on past experiences can be helpful if it is rooted in present emotions, which patients with better outcome in study four described. From the therapist's perspective an overestimation of the patient's capacity and functioning might contribute to the experience of "having only half of the patient in therapy," as expressed by therapists in the primary analysis.

The *diverging agendas* in suboptimal therapy appear when the patient does not understand the therapist's goals or interventions, and the therapist does not understand the patient's difficulties and goals. When the patient and therapist do not have same agenda, therapy continues to be *pseudo-mentalizing: no corrective emotional experience* and *no increase in agency/self-understanding* develops. On the surface, therapy is centered on important issues, and the therapist might consider therapy helpful for the patient, whereas the patient does not experience positive change. The therapeutic alliance, in terms of shared goals, a common understanding of the tasks, and a good emotional bond (Bordin, 1979; Zilcha-Mano, 2017), is thus weak, which in turn makes it even more difficult for the patient to bring up criticism and share their experiences with the therapist. It is probable that the patient's statement "spinning one's wheels" in therapy without improvements (Werbart et al., 2015) referred to a therapy that was ostensibly reflecting, pseudo-mentalizing, but without affective content. As described by participants, the therapist and patient discussed parts of the patient's life that might have been important, but the patient did not experience or feel that it made any difference, since it did indeed not make any affective difference. Patients in suboptimal therapy expressed better (intellectual) understanding but also that they did not feel any change. This could indicate a low integration of affect and thinking in the therapeutic process. Since mentalization is fostered in a secure relationship, this also implies the already suggested conclusion that the relationship to the therapist was not secure in attachment terms. An insecure relationship gave the patient less room for emotional exploration and corrective emotional experiences, since anxiety was easily awakened and difficult to regulate. As such exploration and activity in therapy was precisely what participants stressed as helpful, naturally therapies with low exploration would be less helpful.

In a rare study of patient experiences of non-improvement, Radcliffe et al. (2018) found that patients unfortunately had their negative self-image reinforced by the absent positive effects of therapy. The patients in their study started therapy with negative views of themselves and a fear of what psychotherapy might lead to (such as losing control), which might be understood as a fear of affects and a limited capacity to mentalize. Their therapists in the present studies did not become fully aware of this, indicating how difficult meta-communication is in practice.

The circle to the upper right depicts the positive process of joint meta-communication in a fruitful therapy, in particular when ruptures or stalemates appear. Even a very well-functioning therapy contains many instances of misunderstandings, difficult emotions the patient defends against, and disagreements, mainly referred to as ruptures (Barber et al., 2013). The repair of ruptures is seen as an important part of therapeutic change in relational psychotherapy (Safran and Muran, 2000) and mentalization-based interventions (Bateman and Fonagy, 2016), as it gives the patient a chance to take another person's perspective (the therapist's) and compare it to their own, thereby discovering own and others' misinterpretations and projections. A large part of the patients in suboptimal therapy in the present studies were diagnosed with personality disorder, despite their young age, which indicates they suffered from relational dysfunction and would have needed therapeutic interventions adjusted to their needs. As their mentalization capacity seems to have fluctuated, they might have benefitted from therapy in which the therapist took a more active part in focusing on and solving alliance ruptures, for two reasons. Firstly, to increase their understanding of themselves and others (i.e., mentalization). Secondly, to create a secure emotional bond as far as possible. Judging by the data, none of this happened, although we do not have verbatim recordings of sessions to confirm it.

If the therapist discovers ruptures, and fluctuations in mentalization as they occur, the model proposes the development

to a fruitful therapy is more likely. Participants in the studies described increased security when their unhelpful ways of thinking, as well as emotional difficulties, were addressed and confronted by the therapist. Meta-communication was then made possible, and patients gained increased self-knowledge and agency. As one patient expressed, the therapist "saw through" her and understood them on a deeper level, which was reassuring. Therapists in turn gained a clearer understanding of their patients' needs and capacities, and could adjust interventions accordingly, which in turn made meta-communication easier. This is illustrated by the capture *patient experiences the relationship as secure*. In a secure enough relationship to the therapist, the *patient brings up criticism/diverging views* and also feels secure enough to explore these. When the patient shares her/his experiences, the *therapist understands and adjusts interventions* to the patient's current level of functioning and mentalization. There is an *open negotiation of alliance* in terms of goals, tasks and the emotional bond, as well as implicit relational aspects of therapy. This leads to *increased agency/self-understanding*.

The model was developed to interpret the difference between a course of suboptimal therapy as a whole and a course of therapy with average outcome, based on the empirical data from the primary studies. However, a single course of therapy might also move back and forth between the circles on a micro-level, that is, in a single therapy session or in therapy at large. This is indicated in the model by the arrow between the two circles. An alliance rupture occurs for instance when the therapist does not understand the patient's current limited mentalization capacity and makes abstract interpretations that the patient does not understand. Or another patient with relational difficulties might easily and quickly slip into a feeling of threat in therapy and regard everything the therapist says in this light. If the therapist notices this immediately, the slip can be immensely useful in the therapeutic work as a starting point for the exploration of situations in which the patient feels threatened.

Alternative Interpretations

In the above interpretation, mentalization, and meta-communication play crucial roles, e.g., based on the patients' concrete ways of expressing themselves, which is interpreted as pre-mentalizing modes. The secondary analysis should be seen as one of a number of possible interpretations and theoretical frameworks that could make sense of the fact that these therapies did not reach their goals.

What if the patients' descriptions of the therapists and therapeutic processes should be taken at face value rather than analyzed. In other words, do the results describe an external reality of therapists who were inattentive during sessions, do they capture the patient's inner mental representations of the therapist and relationship, or both? If so, observers would perceive the therapists as clearly too passive.

In psychotherapy research, the correlation between therapist warmth, engagement, agreeableness and flexibility in relation to good alliance and outcome has been stated (Barber et al., 2013). It is not surprising that participants in the studies described dissatisfaction when they experienced therapist passivity, ignorance, and powerlessness. One possible explanation for their descriptions would be that their therapies were indeed marked by high levels of criticism and negative comments from the therapists. Likewise, the patients' call for an active therapist could be rooted in the therapist's excessive silence, sleepiness, and an inflexible interest in childhood experiences, rather than relevant present emotions. Such an image would come close to the caricature of a psychoanalyst.

Although the primary studies were not designed to investigate therapist behavior, there are some points to be made. Even if an observer would conclude that therapists were negative and passive, the conclusion would not be sufficient from an interpersonal point of view. Passivity is not only a personal trait on one part, but also an interpretation of the therapist's action made by the patient. Obviously the patients found the therapist's lack of response hindering, and the therapist did either not perceive this or perceived it but did not change his or her approach. The question to be studied would then be how the interaction turned too silent and negative to be helpful for the patient and how the therapist could have found a way to handle this.

From an attachment perspective, the relationship between the patient and therapist can be viewed as an attachment relationship, and the therapist thus a potential attachment figure for the patient (Bowlby, 1988; Wallin, 2007; Slade, 2016). A secure attachment to the therapist would give the patient both a secure base and a safe haven, or, in other words, a balance between security and challenge in therapy. Individuals with an insecure attachment pattern more easily interpret others' actions, remarks, and expressions as hostile or critical (Wallin, 2007). This raises interesting questions of how therapist and patient attachment patterns influence the perception of the communication, and thus the transference and counter-transference. The participants in the present studies of suboptimal therapy seemed vigilant for therapist presence and availability, much like an individual with insecure attachment checking the availability of their attachment figure (Wallin, 2007). Slade (2016) concludes that individuals with preoccupied attachments need interventions or therapies targeted to their interpersonal problems. Generally, patients with secure attachment orientation at the start of therapy seem to have better outcome and more easily form a good working alliance (Slade, 2016). One possible conclusion is that patients in suboptimal psychotherapies in the studies had more easily accessed insecure inner working models than others and would have needed this to be addressed, and would have needed encouragement from the therapist to bring up criticism and discontent in therapy.

However, a conclusion based on patient attachment style heavily relies on the patient's part in the relationship. Therapists vary in their stance, skill and outcome (Baldwin and Imel, 2013). Thus, the question should be raised whether non-improvement and dissatisfaction were the result of a few therapists' lack of good results. To follow-up results of the secondary analysis the project data on outcome of the therapists in the two studies of suboptimal therapies were revisited. In all, 19 therapists conducted the 24 suboptimal therapies. The

majority of the therapists thus had only one patient who was dissatisfied or non-improved. The exceptions were one therapist with four non-improved patients, and two therapists with two patients each. However, these three therapists had a relatively large number of patients in the project at large compared to other therapists (six, five and seven, respectively), which means they also had patients who improved from their therapies. Thus, the suboptimal therapies were not solely the result of a few therapists' low general outcome. It could still be possible that the combination of a specific participant and therapist was unfortunate, e.g., due to their attachment styles and the therapist's inability to address this particular patient's needs or deficit skills to meet this particular patient (Wallin, 2007).

Another possible interpretation of participants' claim of therapist passivity is that the therapeutic interventions were not helpful, and thus experienced as therapist passivity. Gold and Stricker (2011) propose that psychodynamic psychotherapists should actively assess the patient's level of functioning and should not avoid active interventions, if they are to reduce the risk of treatment failures. Traditional therapists might find this difficult (Gold and Stricker, 2011), which could have been the case in the present study. As an example of activity, psychodynamic affect focused therapy (e.g., McCullough et al., 2003) targets defenses, avoided affects and anxiety in relation to the affects in order to create changes in the way the patient perceives, experiences and expresses affects, leading to personality changes. Although we do not have process data to study interventions in the studies in detail, the conclusion that the interventions did not challenge defenses and help the patient experience authentic emotions and impulses is not too far-fetched. Participants' descriptions of not feeling understood, or that therapy had the wrong focus, indicates that problematic emotions and defenses were not discovered or worked through in therapy. The participants' call for therapist activity and lead could thus mean therapeutic action that would have helped them reach beyond defenses to a new understanding of their inner life. The participants expressed a wish for this in the interviews, but it did not come about in the therapies.

One possibility is that the match between therapist expectations or needs in therapy did not match the therapist competence or psychoanalytic psychotherapy, and that patients needed some other form of treatment such as CBT or pharmacotherapy.

Apart from mentalization theory, there could be other theoretical perspectives that would improve our understanding of the lack of success in the therapies that were analyzed and the processes involved.

To summarize, a look into therapist factors shows that therapists of the suboptimal therapies also conducted other therapies in the project with better outcome. Thus, the patients' descriptions of therapist passivity and lack of response cannot only be explained by the general lack of skill of a few therapists in the project, although the therapists' might have been passive with these particular patients. From an attachment perspective, the participants in suboptimal therapies might have had insecure inner working models, due to their attachment history, which contributed to their experience of therapist passivity, criticism, and unreliability. In line with this interpretation, therapists probably did not discover, address or find ways to work with attachment insecurity enough to create a secure therapeutic attachment relationship.

Paradigmatic Example With Clinical Implications

As an illustration of the processes and theories involved in suboptimal psychotherapy presented in the tentative process model above, I present a fictive case. It is a combination of several cases from the suboptimal therapies in the empirical material, and is meant as a prototypical example without identifiable individual markers.

Amanda, 23, felt stressed out and "lost" when she sought therapy. She studied politics at a university but did not know whether to continue, took a term off and earned her living from time-limited employments. She moved between flats. The goals for therapy were mutually formulated: to be able to develop close relationships, feel secure in herself and know what she wanted. Therapy lasted 18 months and Amanda showed no improvement on the self-report measures of anxiety, relational functioning, and depression. Amanda expressed in the interview at termination that she experienced the therapist as uninterested in what Amanda tried to tell her, as the therapist was quiet and did not ask any questions of importance. Amanda tried her best to answer the few questions the therapist did ask, although she did not see the point. She thought the therapist knew best, as she was an experienced woman in her sixties. Amanda did not dare to bring up her dissatisfaction with therapy. Instead she blamed herself for not getting better. She could not reach her own feelings and did not feel comfortable with the therapist. However, the therapist was also kind, she expressed.

The therapist, a 62-year old female psychotherapist, teacher and supervisor with a background as social worker expressed in her interview how therapy with Amanda started well. They cooperated to find a common goal, and the relationship was good, but she sensed Amanda drawing back emotionally after a few months. The therapist asked questions she saw as important, but experienced Amanda as quiet or avoidant, which puzzled the therapist. Amanda often canceled late and the therapist was frustrated but found it hard to talk about, as Amanda avoided such questions. The therapist made an effort not to be obtrusive, since Amanda had described her mother as obtrusive, impulsive and temperamental, without respecting Amanda's integrity. Amanda's father, on the other hand, was described as unemotional and uncomfortable when Amanda tried to bring up anything important with him. The therapist saw emotional loneliness as part of Amanda's problem and thought a focus on this would help Amanda.

As the example shows, the therapist and patient did not share the same image of the process in therapy, although both would agree that there were problems. In following the process model above, one could conclude that the patient was pressed by life decisions in young adulthood that had to be made but could not be made unless she knew her direction in life though a certain degree of agency. Amanda's therapist thought she had difficult relations to her parents and an insecure attachment

pattern, which the therapist wanted to work on and tried to explore with Amanda. Amanda, however, "did not see the point" in these interventions but still answered the therapist's questions, possibly partly because of the age gap between the two which made Amanda think the therapist was a wise person. We cannot say with certainty that Amanda often reasoned concretely or in pre-mentalized modes, but it is obvious that she did not dare to express criticism, which then made the therapist unaware of her perception of the therapist. This led to a vicious circle of mutual misunderstanding. There seems to have been no meta-communication. Obviously, the therapist sensed some of the interpersonal difficulties Amanda had in relation to the parents, but did not discover or address her submissiveness in therapy. Neither did the therapist explore the areas Amanda considered most important, which were her direction in life in terms of education and employment. In a focus on those areas, Amanda could have had a good chance of developing agency.

From the perspective of the present model, it is possible that the therapist would have needed to be observant on the patient's present emotional state and capacity to mentalize in order to move from the suboptimal circle to the positive circle within a session with Amanda. One way is to bring up difficulties in the relationship in a responsive way, to meta-communicate and build a secure relationship with Amanda. Interventions for this are described within a number of therapeutic theoretical orientations. One is to continuously assess the patient's affects, not only at therapy intake, but during therapy, as it shifts from moment to moment, for instance through interventions developed in affect-focused psychotherapy (McCullough et al., 2003). By explicitly labeling the patient's emotional states or reactions (i.e., "I see you turn away your gaze when I ask you about this, I wonder what is going on inside you"), the chances for meta-communication would have increased. It would also have helped the patient become aware of her own reactions and possibly understand herself better. The point of such interventions is to draw the patient's attention to his or her emotions and explore them together with the therapist to develop the mentalized affectivity mentioned earlier (Bateman and Fonagy, 2016).

The therapist could have initiated meta-communication on the therapeutic bond in general and in the present moment (Bordin, 1979; Zilcha-Mano, 2017), for instance by asking what the patient thought about her experiences of therapy. In the case of Amanda, the therapist could have meta-communicated in by sharing her thought, saying "I sometimes wonder if you feel it helps to talk to me. I think it is sometimes helpful, but I also doubt it from time to time, especially when we talk about your relationship with your friend." Or, since patients still might hesitate to express criticism, feedback can be formalized as questionnaires on therapeutic alliance. The trait-like alliance (Zilcha-Mano, 2017) is similar to internal working models in attachment theory (Bowlby, 1988) and could be assessed formally or informally. Amanda's expectations might have been that closeness is often conditioned by the other person, and could be intrusive. State-like alliance is contextual and changes with the situation and therapeutic action, i.e., the therapist's understanding, or lack thereof. Amanda had repeated experiences of ruptures in the relationship and seems to have reacted by withdrawing. A responsive and careful focus on this pattern would most likely have been helpful meta-communication in her case and might have turned the non-improvement into fruitful therapy.

In line with this, openness to the patient's sudden changes in mentalization level might have been helpful, for instance when Amanda perceived the therapist as uninterested. Such interventions help the patient become aware of their own emotional state and thus also of possible projections onto the therapist of hostility or disinterest, which makes criticism easier to bring up in therapy. Since affect awareness and mentalization are under development for young adults, interventions with such a focus bear the potential not only for giving room for criticism from the patient, but for a healthy development of mentalization and self-reflection in itself.

A way for the therapist to develop therapeutic skills fostering meta-communication is to enhance his or her own ability to discover and address concrete pre-mentalized modes of thinking, e.g., by professional development and supervision on difficult cases. Therapists have their personal challenges or difficulties with certain patient cases or emotions. The awareness of this and the use of supervision when needed, possibly in a form targeted towards these particular difficulties, such as deliberate practice (Rousmanière, 2016), is one way to help oneself as a therapist.

To conclude, there are interventions that foster joint meta-communication and a secure therapeutic relationship with young adults. Such interventions generally include both assessment and meta-communication at the start of therapy, as well as during therapy. More detailed descriptions on developing skills to meet the challenges of young adult patients, and patients where developing a therapeutic alliance is difficult, need to be formulated within each therapy tradition or orientation.

Bridging the Gap Between Practice and Research

The results and discussion raised a number of clinically relevant questions. I summarize some of them here in the form of questions and answers. These clinical conclusions are meant to be easily accessible, based on results from the studies and previous research. By necessity they are held simplified, short and general. The present studies are based on psychoanalytic psychotherapies, and most of the research cited is either psychodynamic in orientation or generic. Thus, the conclusions might not be valid in other contexts.

What Do These Studies Tell us About Suboptimal Psychotherapies From the Patients' Perspective?

Even therapists with long experience and good results with other patients might have therapies in which patients do not improve or are dissatisfied. It might be difficult for therapists to discover non-improvement or dissatisfaction. In the studies, therapists of non-improved patients overestimated their patients' capacity and underestimated their difficulties.

How Come Patients Do Not Bring up Criticism With Their Therapist?

It is well-known that patients refrain from criticizing their therapists, or do so very reluctantly. Many psychotherapy patients, and probably in particular those in suboptimal therapies, see the therapist's interventions and personality as a whole. Criticizing lack of progress in therapy or the therapist's interventions thus amounts to criticizing the therapist personally.

How Could Therapists Encourage Patients to Bring up Criticism?

By making room for it in a way that suits the therapist, patient and therapy method. Meta-communication on the relationship between the therapist and patient, as well as the interventions in therapy, is one way. That is, the therapist routinely asks for the patient's views on how the two are getting along and reactions to interventions. Therapists could also routinely check therapy progress and address any deviations in therapy by using standardized measures for symptom relief and therapeutic alliance. They could also pay attention to the continuous assessment of the patient's emotional and relational functioning throughout the therapy, in order to discover ruptures. If the therapist senses that the relationship does not feel right, they could bring it up.

What Do Patients Usually Bring up When Researchers Ask Them What They Did Not Like in Their Therapies, and What Do We Learn From it?

There might be differences in criticism across therapy orientations. The studies in this article concerned psychoanalytic psychotherapy. Often, patients suggest that they and their therapist had different perspectives on the goals and tasks in therapy. That is, they did not agree on how to best use the time in therapy. This might not have been outspoken. In the therapies of these studies, goals, and methods were discussed, but patients still experienced focus was partly on the wrong things. Furthermore, they did not seem to be secure enough in the relationship to be able to criticize the therapist. Moreover, patients brought up that their therapists were not active enough, which could be interpreted as not enough initiative to target the most important issues. Therapists might need to observe more closely when the patient needs further pedagogical explanations of therapeutic method in the beginning of therapy.

What Is There to Do When the Relationship Between Therapist and Patient Does Not Feel Right or a Patient Does Not Seem to Get Better?

There will be ruptures often in therapy. There are interventions that focus particularly on ruptures in the therapeutic alliance, and difficulties in the relationship, in therapies of different theoretical orientation. The aim of such interventions is to create a secure atmosphere where criticism and difficulties can be brought up. It can then be used in therapy as a way of understanding and working with the patient's interpersonal difficulties. Since patients seem not to differentiate between technique and therapist personality when things go wrong, working with the relationship and the moment-to-moment interpersonal situations in therapy might be helpful. Sometimes a change of therapist might be considered, if the issues are hard to solve. Also, to bring up the question of improvement, to see whether patient and therapist agree that there is no expected improvement is of importance. In these studies, patients seemed to have an idea of what would help them, but in suboptimal therapies it was most likely not discussed with the therapist. If the therapist is able to help the patient make the idea of what would be helpful explicitly, and compare these to their own views of therapy, it will be easier to know when the therapist should recommend a change of therapy.

What Is Special About Young Adult Patients?

The results suggest one central issue is agency. This includes developing a sense of identity which is stable across many situations and an awareness of one's own will and feelings. Also, the therapist needs to practice responsiveness for the therapeutic alliance to be able to meet the patient. The therapist could remind herself that young adults have limited experience of themselves in different situations, since the capacity for mentalizing and reflection is still developing.

Final Conclusions on Research and Clinical Practice

As an example of how research results and clinical practice might influence each other, I present the intertwined clinical and theoretical conclusions that can be drawn from this study as I have come to use them. My professional development as a psychotherapist during the course of the project influenced and was influenced by the research results. While conducting psychotherapy with young adults, I experienced how difficult it is for a therapist to discover patient dissatisfaction or patient experiences of not being understood and how often I did not succeed. The research results have encouraged me to focus on the three parts of the therapeutic alliance (Bordin, 1979) when first meeting the patient. Few patients have a clear image of what means of therapy they wish for, but most have thought about the goals and all of them can express how the therapeutic relationship develops when asked. I try to explain as clearly as possible what goals I consider realistic and how I would understand these therapeutically. I invite patients to bring up doubts and negative aspects of the therapeutic relationship in order to work with their view of it, which is not the same as trying to change according to their wish, but rather a means to bring up transference and misunderstandings at an early stage.

I focus on alliance ruptures whenever I discover them. Sometimes they are resolved, sometimes not. I do not presuppose that my and my patient's view of the ruptures and therapeutic process in general coincide, but I ask patients regularly how they experience we are getting on.

Patients with severe personality difficulties typically need more support and treatment than a therapist in private practice can offer, which calls for good assessments at the beginning of therapy.

Lastly, in order to prevent patients from entering or continuing a therapy in which we would only be spinning our wheels, I have learnt to more often bring up the question of whether a therapist of another orientation would be better suited to help the patient in some cases.

Strengths, Limitations, and Future Directions

The naturalistic setting meant that therapies were studied as they were conducted at the Institute of Psychotherapy in Stockholm, which in general led to good external validity and translation to a clinical setting. The longitudinal design added further naturalistic value of the data. There were measure points before therapy, at termination of therapy, and at two follow-ups, 18 and 36 months after termination, which is a substantial time in psychotherapy research. Additionally, to adopt the double perspectives of the patient and therapist was a strength, as was the mixed method design (Elliott et al., 1999; Creswell, 2011; Teddlie and Tashakkori, 2011) that highlighted non-improvement and dissatisfaction from different angles. A mixed method approach is useful from pragmatic standpoints and can be applied by combining quantitative and qualitative data and analyses in different stages of the process (McLeod, 2013). The naturalistic setting had the disadvantage of non-manualized treatments. However, the aim was to study a natural setting, and non-manualized treatment or manualized treatment without adherence measures constitute the reality in many clinics. A major limitation was that no recordings of sessions could be done, which limits the conclusions of the process of the therapies as it could not be observed, but interpreted retrospectively. The design and data do not make room for any causal conclusions. The primary and the secondary analyses should rather be seen as an interpretation of the qualitative data in the light of mentalization with the aim to suggest hypotheses for further research and improvements in therapeutic practice.

The participants of the studies were generally from urban, well-educated middle class areas, which limits the transferability (Lincoln and Guba, 1985; Malterud, 2001b). Emerging adults in small towns might express different wishes for psychotherapy and also face different challenges in life in general. One limitation was the overlap of four patients, who took part in more than one of the primary studies (three were dissatisfied and non-improved, two non-improved with a depression diagnosis, one of was also dissatisfied). However, grounded theory aims to analyze themes on a group level, and the participant who occurred in all three studies thus had a limited influence on each model as a whole.

All studies aimed for credibility in qualitative terms (Elliott et al., 1999; Malterud, 2001b; Morrow, 2005). In all primary analyses the emerging categories and core concepts were discussed between the researchers involved in each study, which is a form of triangulation (Charmaz, 2014). The researchers in each study explored rivaling interpretations of data such as whether a subgroup of therapists had particularly low outcome, as well as alternative tentative models and categories throughout the analyses as a part of the constant comparative analysis (Charmaz, 2014). In the secondary analysis, the author discussed emerging categories and process models with one of the authors of the other articles (Andrzej Werbart) as well as research teams at the department. The process model was re-formulated several times. Concerning transferability, or the degree to which the results can be useful for other contexts than the one studied, the naturalistic design meant circumstances were similar to many psychoanalytic clinical contexts in terms of patient inclusion, formulation of goals in therapy and presenting problems among patients. Thus, results can be expected to be relevant for some contexts outside the research setting.

The interpretation in the shape of the tentative process model in a theoretical interpretation, and data could possibly also be interpreted by using other theoretical frameworks, in line with the hermeneutic strand of psychotherapy research (Rennie, 2006). However, the usefulness of mentalization theory in the present article shows its strength in describing the vicissitudes of the psychotherapeutic process that does not lead to the desired change.

The need for studies of patients' understanding of suboptimal psychotherapy needs to continue in order to prevent it. The study of ruptures on a micro-level is a growing field (Zilcha-Mano, 2017, 2019), but the research is often limited to adults or not does differentiate between young patients and adults. Young patients have a mentalization capacity still under development, and research focusing on how to let this knowledge inform psychotherapy interventions is needed.

DATA AVAILABILITY STATEMENT

The datasets generated for this study will not be made publicly available. Patients could be identified if the interviews (raw data in this article) are publicly available. Also, patients' consent did not include such public availability. The parts of data which can be anonymized are available from the corresponding author on request, after discussion.

ETHICS STATEMENT

The studies involving human participants were reviewed and approved by Regional Research Ethics Committee at Karolinska Institutet. The patients/participants provided their written informed consent to participate in this study.

AUTHOR CONTRIBUTIONS

The author confirms being the sole contributor of this work and has approved it for publication.

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