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Chapter 11 Adverse Effects of Psychological Therapies

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Although there has been some recognition of the adverse effects of psychological therapies for over 40 years (Barlow, 2010), they have tended to be overlooked in the research literature. Unlike research involving medical interventions, investigations into the effectiveness of psychological therapies have not routinely documented adverse effects (Duggan et al., 2014; Jonsson et al., 2014; Vaughan et al., 2014). Instead, the emphasis has been on developing the evidence base for psychological therapies and promoting the benefits to increase access to a wider population (e.g. the Improving Access to Psychological Therapies programme in England). Within this, there has been an implicit assumption that talking therapies do not carry a risk of harm. However, it is increasingly being recognised that adverse effects occur on a frequent basis (Crawford et al., 2016; Mohr, 1995) and that the benefits of therapy need to be considered alongside any negative effects (Parry et al., 2016). There are calls for a shift in mindset so that explicit recognition of adverse effects is seen as a key part of being a competent and ethical practitioner (Wolpert, 2016; Linden, 2013). This chapter will discuss how adverse effects can be defined, identified and understood. It will also consider the strategies that can be used to address adverse effects and the implications for professional and ethical practice.

Clinical Vignette 1

Kathyrn (a newly qualified therapist) was feeling upset and hopeless following her fourth session with Jess. She had found it hard to establish a good therapeutic relationship with Jess from the start. Jess had expressed a lot of anger and frustration at the length of time that she had been on the waiting list and seemed to expect Kathryn to 'fix' very complex and long-standing problems. In the session that had just ended, Jess had openly expressed her dissatisfaction with Kathryn and the lack of progress that had been made, resulting in her stating that she wanted to make a complaint. Kathryn knew that she should have discussed

the difficulties that she was experiencing in supervision, but there were always so many other things to discuss. She had been given a large caseload due to the pressures on the service and she had also wanted to make a good impression as a new member of the team.

How would you respond if Kathryn was a colleague and shared this information with you?

Definitional issues relating to adverse effects of therapy

Multiple terms have been used in the literature to describe adverse effects, including negative therapeutic reaction, clinical deterioration, treatment failure, side effects, harm, adverse events, negative effects and negative outcome (Parry et al., 2016; Duggan et al., 2014;). Some terms are very broad whereas others are more focused on either the outcome or experience of therapy. In some cases, the possible causes have been reflected in the definition with a distinction made between side effects that may result from therapy that has been competently provided and negative effects that may result from malpractice (Linden, 2013). However, there hasn't been consistent use of these terms and the plethora of terms, combined with a lack of agreed definitions, has presented some challenges when conducting reviews of the psychological literature.

It has recently been recommended that there should be greater standardisation of terminology and that the following three aspects of adverse effects need to be considered, recorded and reported in studies that are designed to evaluate psychological therapies (Parry et al., 2016).

1) Adverse events (e.g. mental health-related hospital admission, suicide) that occur during or shortly after therapy and are deemed to be related to or caused by therapy.

2) Clinically significant deterioration caused by therapy, which could also include the emergence of new difficulties. This may be observed by the practitioner or detected by completing standardised outcome measures.

3) Client-experienced harm, which may not be detected by just monitoring adverse events and using standardised outcome measures. This recognises that there are limitations to the other methods and that each client is an individual with their own potentially unique experiences of therapy, therefore it is also important to incorporate clients' own perspectives on any harmful aspects of therapy.

While the above recommendations provide a framework for considering different aspects of adverse effects and potential approaches to identifying them when conducting research, this is a hugely complex area and there are important questions for clinical practice that need to be considered. For example, there may be other factors (e.g. significant life events) that could explain an adverse event so how can we determine whether or not it might be related to or caused by the therapy? How can we distinguish increased levels of distress that might be temporary and an expected part of a therapeutic process from those that would be classified as harmful? What happens if a client and their therapist have very different perspectives on whether or not therapy has caused harm? Whose perspective is given greater priority? These questions will be returned to later in the chapter.

Prevalence of adverse effects

Although the problems with definitions and associated measurement need to be considered, there is some consistency in the research findings, which indicate that 5–10% of all clients experience adverse effects of therapy (Crawford et al., 2016; Lambert, 2013; Hatfield et al, 2010; Hannan et al., 2005). However, there can be considerable variability across therapists (Saxon et al., 2017; Mohr, 1995) and according to client characteristics (Saxon et al., 2017; Crawford et al., 2016; Mohr, 1995). Some of the therapist factors that have been associated with negative effects are lack of empathy, underestimation of the severity of difficulties, lack of clarity about the focus of therapy, negative emotional reactions to clients and unethical behaviour (Hardy et al., 2019; Mohr, 1995). For client characteristics, both clinical and demographic variables have been highlighted. For example, a recent large-scale survey of people receiving psychological therapy for anxiety and depression in England and Wales (Crawford et al., 2016) found that people from ethnic and sexual minority groups were more likely to report that they had experienced adverse effects of psychological therapies. To help explain these findings, it is important to consider the potential causes of adverse effects.

Understanding the possible causes of adverse effects

Understanding the reasons for adverse effects is complex as a key aspect of the intervention is the relationship between the therapist and client. It is also an under-researched area so there is limited evidence for causal mechanisms. However, there are several potential explanations. It may be a result of the intervention itself with some therapies having been

listed as potentially harmful therapies (Lilienfeld, 2007). For example, critical incident stress debriefing has been listed as an intervention that has the potential to be harmful for at least some individuals following a traumatic event, perhaps because it interferes with natural coping and recovery. Another explanation for adverse effects is that there may be an inappropriate match between the intervention and the presenting difficulties (Duggan et al., 2014). There may be effective interventions indicated for the presenting difficulties, but a less effective or ineffective intervention has been selected. This may be due to several factors, including the therapist's preference for a particular way of working, gaps in knowledge in and of the evidence base, lack of fit with the service user's needs or preferences and service pressures. It is also important to acknowledge here that there are criticisms of evidence-based practice (see chapter 18 for a full discussion of these) and the findings from randomised controlled trials, which are seen as the 'gold standard' of evidence, may not easily translate to an individual in a particular context. A further possibility is that a potentially appropriate intervention has been selected, but it has been inappropriately delivered and the adverse effects are therefore a result of the attributes of the therapist and their level of competence rather than the therapeutic approach itself (Parry et al., 2016; Duggan et al., 2014). For example, there may be unresolved difficulties in the therapeutic alliance, which could be due to a lack of therapist skill in noticing and repairing ruptures. There may also be a poor fit between the therapist and client, perhaps due to the nature of the presenting difficulties and the personal resonance for the therapist or differences in world views (Parry et al., 2016). Alternatively, it may be that the intervention seems to be appropriate, but there are client variables that result in adverse effects even when it is competently provided. That is, an intervention might be effective in general, but harmful for a minority (Duggan et al., 2014). In addition, there may be organisational factors that help to explain negative effects (Hardy et al., 2019; Parry et al., 2016). For example, limited information or choice provided by the service or high caseloads and pressure to work beyond the therapist's level of competence.

A recent large-scale mixed-methods investigation of risk factors for negative experiences of therapy (Hardy et al., 2019), which involved conducting surveys and interviews with both therapists and clients, produced a model of the different potential factors and how they inter-relate. This model highlighted that there may be an initial 'lack of fit' that could be due to

service structures, therapist skills or patient needs. For example, there were frequent concerns about service and therapist inflexibility with some clients describing concerns about therapists' core clinical skills, a lack of understanding of their social context or being given very little information about the service, the therapy or their therapist. From the therapist perspective, there were also comments about service inflexibility and some accounts of working beyond their level of competence; sometimes only realising this later when reflecting on difficult experiences. Following on from any initial problems, there could be difficulties with safety and containment (e.g. a lack of structure or feeling ill equipped to deal with emotions or memories that had been brought to the surface) or difficulties with power and control (e.g. unable to raise important issues or being blamed for therapy not progressing). If left unresolved, these could lead to difficulties with trust, dreading sessions and pressure to perform with the ultimate consequences of feelings of failure, loss of confidence and loss of hope. These were frequently described from both therapist and client perspectives. Although this model has yet to be empirically tested, it provides a useful starting point for conceptualising different risk factors and indicates a range of ways of intervening to prevent or reduce the likelihood of adverse effects. Recommendations for identifying and addressing adverse effects will be discussed in the next part of the chapter, but it can be useful at this point to consider the following clinical vignette.

Clinical Vignette 2

Faisel is a builder who runs his own business. He lives with his wife and their three young children. He works long hours, but it is hard to make enough money to cover all of their bills due to the large debts that had built up in the past. Faisel frequently worries about their future and whether their house will be repossessed. These worries impact on his sleep and he has started to feel like a failure as a husband and a father. He initially presented to A &E with chest pains as he thought that he was having a heart attack, but he was told that there was no evidence of any problems with his heart. His GP then suggested that he try talking to a therapist. He was a bit sceptical of this idea but agreed to see if it might help. Although he tried to explain to the therapist the things that he was concerned about, she did not seem to understand his situation and said that she could not help with financial problems as it wasn't her role. He felt that he was just going around in circles talking about his problems and was starting to feel hopeless about the future.

Drawing on your knowledge and experience so far, how might you understand this scenario and what are your thoughts on an appropriate action to take?

Identifying adverse effects

As might be anticipated from the more limited attention to adverse effects of psychological therapies in the research literature, therapists may not have received specific training in identifying and responding to adverse effects (Bystedt et al., 2014; Castonguay et al., 2010). Furthermore, it has been found that therapists are very poor at identifying clients experiencing adverse effects, if they rely solely on their clinical judgment (Hatfield et al., 2010; Hannan et al., 2005). This is the case even when they are aware that adverse effects may occur. It has also been found that clients will often not spontaneously disclose negative effects (Hardy et al., 2019; Horigian et al., 2010). These findings indicate a need for therapists to be aware of the prevalence of adverse effects, to explicitly ask clients about potential adverse effects and to consider the use of additional methods to help identify them.

Routine outcome measurement completed on a session by session basis provides opportunities for therapists to closely monitor progress and become aware of when a client's presenting difficulties are getting worse rather than better. However, the outcome measures selected will determine the range of changes that can be detected, and this could be quite limited in scope. It is therefore important to also consider tools that have been specifically developed to assist with identifying and recording adverse effects (see Table. 1).

Table 1. Measures developed to identify and monitor adverse effects of psychological therapies

Measure	**Description**	**Rating**	**Reliability/validity**
Unwanted event to adverse treatment reaction (UE-ATR: Linden, 2013)	Clinician checklist, which includes a lack of progress, deterioration, emergence of new symptoms, difficulties in the therapeutic relationship and changes in the wider	Each unwanted event is given a rating for the context in which it developed, the likely relationship to treatment and its severity	No published information on reliability or validity

	social context (e.g. strains in family or work relationships)		
Experiences of Therapy Questionnaire (ETQ: Parker et al., 2013)	63-item scale with five factors: negative therapist, preoccupying therapy, beneficial therapy, idealisation of therapist and passive therapist	Each item is rated on a five-point Likert scale	The five factors have good internal consistency and high test-retest reliability. There is also some evidence of construct validity
Negative Effects Questionnaire (NEQ: Rozental et al., 2016)	32-item scale with six factors: symptoms, quality, dependency, stigma, hopelessness, failure	Each item has a 'yes/no' response, a severity rating and an indication of whether any negative experiences are likely to be related to therapy	Excellent internal consistency for the whole scale and acceptable to excellent internal consistency for the factors

The Unwanted Event to Adverse Treatment Reaction checklist (UE-ATR: Linden, 2013) was developed with the main aim of assisting therapists to identify adverse effects in routine clinical practice. This is not to say that skilled clinicians may not pick up on these anyway, but it provides one way of systematically monitoring these. Linden (2013) also proposed that the UE-ATR could be used for training, supervision and research purposes. However, the psychometric properties have yet to be investigated. A recently developed measure that has included consideration of psychometric properties is the Experiences of Therapy Questionnaire (Parker et al 2014; 2013). This is completed from a client perspective, but the focus has been on the use of this measure in clinical trials rather than routine clinical practice. Another recently developed measure completed from the client's perspective is the Negative Effects Questionnaire (NEQ: Rozental et al., 2016). Similar to the UE-ATR, it acknowledges that there may be other causes of adverse effects and considers the likely relationship to

therapy, but this is explicitly from the client's perspective. The questionnaire has demonstrated internal reliability, is currently free to use and available in eleven different languages. It is therefore a potentially useful additional tool. However, the development and evaluation of the measure predominantly involved participants who had sought help for anxiety and used internet recruitment to the study. More research is therefore needed to demonstrate the applicability of this measure to other populations.

Reducing the likelihood of adverse effects in clinical practice

Given the potential role of organisational factors in understanding adverse effects (Hardy et al., 2019; Crawford et al., 2016), it is important to think about the wider service context and ways of intervening at an early stage in the client's journey. In addition, there is a need to provide clear information in advance, ensuring choice and shared decision-making. Shared decision-making requires a good therapeutic relationship and sharing of information with a focus on eliciting client preferences and views so that they can be considered during the decision-making process. Clients who have preferences that have been met have been found to be more likely to report that therapy has helped them with their problems (Williams et al., 2016). It is also important to have explicit contracting at the start of therapy and agreement about the number of sessions, as well as how progress will be reviewed (Hardy et al, 2019). If we look at the following clinical vignette, we can see the importance of considering the context of the work, the expectations that Angelika had at the start of therapy, the initial information that her therapist provided, the strength of the therapeutic relationship, the extent to which there was shared decision-making, the way that the initial therapy sessions have been managed and any agreed plans for reviewing progress.

Clinical Vignette 3

Angelika is a young woman who has been experiencing problems with low mood and self-harm. She has attended three therapy sessions and is questioning whether it is worth continuing. Talking about events in the past has brought very distressing memories to the surface and she is increasingly on edge and finding it difficult to sleep at night. She has noticed herself being very short-tempered with her partner and distancing herself from friends. She is also self-harming on a more frequent basis. She thought that starting therapy would be a

positive step to take and it had taken a lot of courage to ask for help, but it just seems to be making things worse.

Providing sufficient information about therapy can address prior expectations and provide greater understanding of the therapy process. Clients who feel that they have been given sufficient information about therapy before it started have been found to be less likely to report adverse effects (Crawford et al., 2016). It is recommended that the information provided should make clear that there can be negative, as well as positive effects and that this needs to be considered when obtaining initial consent. This is in line with the British Psychological Society (BPS) (2017) Professional Practice Guidelines and the Royal College of Psychiatrists (2014) Code of Ethics, which both emphasise that the consent process needs to include clear, accessible information about the benefits and risks of any interventions being proposed, any alternative options and the potential risks of not engaging. The British Association for Counselling and Psychotherapy (BACP) (2018) Ethical Framework for the Counselling Professions also makes explicit reference to known risks and being willing to discuss them with clients. Being clear about potential harm may encourage open discussions, provide opportunities to resolve difficulties and reduce the likelihood of therapists and clients feeling hopeless and blamed. However, there still seems to be important empirical questions to be answered about how best to discuss potential adverse effects at the start of therapy and the ways that this might influence initial engagement (Wolpert, 2016). There are also questions about the extent to which it is even possible to know in advance what many of the risks might be, given the multitude of factors that might contribute to the experience of adverse effects after commencing therapy.

Working with adverse effects of therapy

In addition to any initial discussions, it is recommended that there is an agreed process for considering both negative and positive effects during therapy. There is some evidence that alerting therapists to situations where a client has not improved as expected or where there seems to be a significant deterioration, as indicated by scores on standardised outcome measures, can prevent a negative outcome (Lambert, 2007), however, the reasons for this effect are not well understood. Therapists have reported that they would take a range of actions once they become aware that a client's presenting difficulties have worsened since

starting therapy, including discussing the changes with the client, gathering more information, identifying precipitating events, consulting with peers, adapting the intervention, enhancing the therapeutic relationship and referring on to another clinician (Hatfield et al., 2010). Surprisingly, it has been noted that therapists may not use supervision to discuss lack of progress or deterioration (Hardy et al., 2019). This may be because of time constraints or lack of supervisor availability. However, it may also be because of the culture of the service and difficulties with openly discussing "failures".

It has been recommended that awareness and understanding of adverse effects is incorporated into core clinical training (Castonguay et al., 2010). Therapists need to be aware of the prevalence of adverse effects and that this is something that they need to attend to as part of their professional and ethical responsibilities. They also need to be aware that they are likely to have a positive bias when evaluating therapeutic progress such that adverse effects are not detected even when they may be aware that they could occur. Therapists therefore need to use specific tools to ensure that adverse effects are explicitly considered when reviewing progress and draw on their formulation skills to determine the appropriate action to take. In addition, it is important to make use of supervision to reflect on the factors that may have contributed to the adverse effects and the impact of identifying them.

Consideration of adverse effects in supervision

It is recommended that discussion of adverse effects is a regular part of supervision (Linden, 2013), which could help to embed it as a routine part of professional development and providing good quality care. However, supervisors will need to be sensitive to the fact that therapists may end up with feelings of hopelessness and failure. Attention needs to be given to the responsibilities of the supervisor in relation to the client and the supervisee, the quality of the supervisory relationship and the wider organisational culture. There needs to be an emphasis on promoting safe spaces for open discussions and a culture of learning rather than blame. This is in line with the statutory duty of candour that requires all health and social care providers to be open and transparent with people who use their services and to ensure that there is an organisational culture of openness, transparency and learning (Care Quality Commission, 2015).

Within supervision, it is important to have an awareness that there may be an accumulation of factors that need to be considered, including the wider social context. Close attention needs to be paid to the client's perspective, the quality of the therapeutic relationship and the ability of therapists to notice and repair ruptures in the therapeutic alliance. Identifying training and development needs in this area will require consideration of whether any difficulties in the therapeutic relationship occur across clients or whether they are more situation specific. This would help to determine whether there is a need to focus on the development of core clinical skills or whether it is about the fit between the therapy and the client or the therapist and the client. Consideration also needs to be given to the ways that difference and power are addressed in the therapeutic encounter. It is also important for supervisors to help their supervisees to recognise when cultural assumptions and biases may be impacting on the therapeutic relationship and to help identify ways of developing cultural competence (Bhui et al, 2015; Sue, 2009). Service factors, such as the options available and the pressure that therapists may feel to work beyond their level of competence, also need to be considered.

Conclusion

Adverse effects are sufficiently common that all therapists need to be aware of them and understand that there are a range of different strategies that can be used to address them in routine practice. These include providing sufficient information about therapy before it begins and ensuring that there are agreed systems for reviewing both positive and negative experiences of therapy, which take account of the wider social context. However, it is not just therapists' responsibility to attend to adverse effects. Adverse effects also need to be understood in an organisational context. Service and organisational factors will influence client experiences and the extent to which therapists are able to respond appropriately. Supervisors have a key role in ensuring that adverse effects are built into regular discussions in supervision and that there is consideration of the welfare of the client and supervisee training and support needs, as well as service developments that may be required. There also need to be developments in research to support clinical practice. Greater consideration of adverse effects in the evaluation of psychological therapies will help to inform discussions at the start of therapy and the formulation of adverse effects that may arise during therapy. Given the fact that a therapy may be effective overall, but harmful for a minority and that

some groups are more likely to report adverse effects, it is essential that future research also helps to develop greater understanding of when and how adverse effects occur, not just the frequency of their occurrence. In addition, the effectiveness of strategies that can be used to try to prevent or reduce the likelihood of negative effects need to be investigated.

Reflective questions

1. What information do you provide in advance of starting therapy with a new client? Does this include any information about potential adverse effects?
2. How do you monitor and review therapeutic progress?
3. Have you previously been aware of any clients that have been adversely affected by therapy? If so, how did you become aware and respond? Would you do anything differently having read this chapter?
4. In what ways can you take potential adverse effects into account within your practice? (List at least three)

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