What Harm? A Case for Increasing Focus on Negative Effects of Counselling and Psychotherapy in Counsellor Training Programmes

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Abstract

There has been a welcome increased emphasis on providing evidence based practice in the field of counselling and psychotherapy. As a result, there is also an impetus to build a robust body of empirical evidence, showing the effectiveness of psychotherapy as a whole. However, until recently, little attention has been paid to the negative effects of counselling and psychotherapy. Up to 10% of clients are worse off as a result of therapy and research has shown that therapists underestimate the frequency of negative outcomes. Counselling and psychotherapy is often viewed as an innocuous undertaking, but this is not always the case. Training programmes are often geared around bolstering the belief, albeit true in most instances, that therapy has positive outcomes for clients. Practitioners have an ethical responsibility to avoid harming clients. Students must be made aware of the risks of harmful and negative effects involved, and, offered a framework to help identify and measure negative outcomes, while at all times respecting client autonomy.

Table of Contents

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Introduction

The field of counselling and psychotherapy has repeatedly been shown to be effective in helping people who are experiencing emotional and psychological distress (Rozental, Kottorp, Boettcher, Andersson & Carlbring, 2016). In recent years, there has been an increase in the demand for evidence based practice. More than ever, practitioners' work practices must be based on current research and as a result counsellor training programmes are evolving to meet this demand (Cooper, 2010). There appears to be a belief that talking therapies carry little risk (Berk & Parker, 2009), yet evidence to the contrary exists. The body of evidence demonstrating the efficacy of counselling and psychotherapy is expanding and we now know that up to 10% of people deteriorate because of therapy (Boisvert & Faust, 2003). Despite therapists having an ethical responsibility to do no harm, research into the potentially harmful effects of this potent intervention is lacking. The chief objective of this essay is to make the case for a heightened focus on the negative effects of counselling and psychotherapy in undergraduate counsellor training programmes. Chapter one will examine some of the existing research on the efficacy of counselling and psychotherapy. It will show that some practitioners are unable to detect when their clients are deteriorating. Obstacles to gathering empirical evidence on the negative effects of therapy will be discussed and attempts by researchers on how to define harm will be explored. Chapter one will also show why it is important to pay attention to the harmful effects of therapy. It will briefly review Lilienfeld's seminal research into potentially harmful therapies and outline those therapies that have been shown to have negative outcomes. Chapter two will discuss some of the tools that are already available to practitioners to measure the harmful effects of therapy. It will show that providing therapists with feedback on client progress can reduce the likelihood of harm. The case will be made that exposure to such outcome measures in training has the potential to make therapists less hesitant to use them in practice. It is outside the scope of this essay to design a complete training programme, however,

chapter three will outline guidelines for training programmes to assist them in educating trainee therapists on the potentially harmful effects of counselling and psychotherapy. Finally, the author will show that whilst the field of counselling and psychotherapy has a responsibility to do no harm, it is also critical to uphold client autonomy and personal responsibility in the therapeutic encounter.

Chapter One

Existing research findings

The efficacy of counselling and psychotherapy has long been established (Dimidjian & Hollon, 2010; Berk & Parker, 2009). With the recent shift towards evidence-based practice in the field, there is an abundance of research demonstrating the effectiveness of psychotherapy. After conducting extensive analysis of existing research, Cooper (2008) found that people, on average (eight out of ten), benefit from therapy as opposed to not having therapy at all. There was no statistically significant difference in outcomes between the main therapeutic orientations; cognitive behaviour therapy, psychodynamic therapy and humanistic/existential therapies. Justifiably, researchers are trying to identify the elements that make therapy effective, with a view to enhancing therapeutic outcomes. For example, Cooper (2008) noted that client motivation and the therapeutic alliance are two of the main contributors to positive outcomes. Much of the existing research is focused on trying to determine what makes therapy successful, yet "little is known about the occurrence and characteristics of possible negative effects, reflecting a major shortcoming in clinical research" (Bystedt, Rozental, Andersson, Boettcher & Carlbring, 2014, p. 319). Bystedt et al (2014) argue that most of the emphasis on negative effects has been on fringe therapies, such as rebirthing and recovered memory techniques, with less attention given to "negative effects that might be associated with evidence-based care" (p. 314). There is also some evidence to suggest that clinicians have a propensity to underestimate the negative effects of psychotherapy (Castonguay, Boswell, Constantino, Goldfried & Hill, 2010; Leitner, Märtens, Koschier, Gerlich, Liegl, Hinterwallner & Schnyder, 2012; Slade, Lambert, Harmon, Smart & Bailey, 2008). Furthermore, some practitioners are not able to predict when clients will deteriorate. For example, in a 2005 study by Hannan, Lambert, Harmon, Nielsen, Smart and Shimokawa, only 20% of the 48 therapists involved, noticed that their clients were deteriorating. Lambert (2010, as cited in Leitner et al

2012) found that just half of the therapists surveyed reported deterioration in their own clients. Whilst these studies have relatively small sample sizes, to the author, a worrying trend is emerging.

Obstacles to research

So why this reticence to exploring the shadow side of psychotherapy? Linden and Schermuly-Haupt (2014) offer several reasons. Firstly, they argue that because the therapist is the one who provides the treatment, they are responsible for all negative outcomes "which results in a perceptional bias towards positive rather than negative effects" (p. 306). Secondly, the range of negative effects is very broad because there is a focus on social behaviour of clients as well as symptoms. Thirdly, as yet, there is no agreement on what to call negative. For example, crying in therapy can be an unpleasant experience, but it may be positive therapeutically. Fourthly, there is no delineation between side effects, failure of therapy and deterioration of illness. Finally, they point out that there is no agreement on how to measure and assess negative effects or rules on how to plan scientific studies to monitor these. Another reason, according to Nutt and Sharpe (2008), is that many psychotherapy trials have not entertained the idea that therapy could cause harm. They suggest that psychotherapeutic researchers, and indeed the public, assume that because it is only talking it is innocuous. There is also stiff competition for much sought after funding to further the field of mental health. For example, the Improving Access to Psychological Therapies programme in the UK will only allocate funding to "those therapies for which there is clear evidence of effectiveness" (Cooper, 2008, p. 9) which incentivises researchers to provide evidence that therapy works.

How do we define harm?

The classification of harmful treatments has generated controversy, and there is no consensus on how to identify harm, or "what to do about it when it occurs" (Dimidjian & Hollon, 2010,

p. 21). From a methodological point of view, it can be difficult to differentiate between negative effects from therapy itself, normal life events and the progression of a mental illness (Bystedt et al, 2014). Traditionally, deterioration effects and negative effect sizes from meta-analyses of therapeutic outcomes have been used to assert that psychotherapy can be harmful (Lilienfeld, 2007). Deterioration can be described as "not only worsening symptoms, but lack of significant improvement when it is expected" (Lambert, Bergin & Collins, 1977, as cited in Berk & Parker, 2009). Dimidjian and Hollon (2010) argue that harmful outcomes of therapy are those that are more than simply unhelpful, but are those interventions that cause injury or damage. Mays and Franks (1980, as cited in Bystedt et al, 2014) coined the term 'negative outcome' when referring to negative effects of psychological treatments. This is when a person's functioning declines after beginning therapy, and continues to decline for a significant length of time (which is not specified) after termination. Linden and Schermuly-Haupt (2014) believe that similarly to pharmacotherapy, "a distinction must be made between side effects, unwanted events, adverse treatment reactions, treatment failure, malpractice effects, side effect profile, and contraindications" (p. 306).

Why is it important to pay attention to harmful effects?

Clearly there are many obstacles inhibiting effective research on the topic of negative effects of counselling and psychotherapy. Given that we already work in a profession described by Freud as "impossible" (1937, as cited in Barnett, 2007, p. 258), the existence of a multitude of hurdles is insufficient reason to neglect a critical aspect of this caring profession. Evidence shows that anywhere between 3 to 10% of clients deteriorate during therapy (Berk & Parker, 2009; Castonguay et al, 2010; Cooper, 2008; Slade et al, 2008). It is the author's view that ignoring this evidence could potentially and unnecessarily put some clients at risk, a sentiment echoed by Dimidjian and Hollon (2010) who believe that "failure to detect harm can have serious consequences" (p. 21). We also have an ethical responsibility to avoid harming our

clients. This is outlined in section 3.2 of the IACP code of ethics which states that practitioners must "take all reasonable steps to ensure that the client suffers neither physical nor psychological harm during the practitioner/client relationship" (IACP, 2017). Although it should be noted that a definition of what constitutes harm is not offered.

What do we already know is potentially harmful?

Lilienfeld (2007) believes that the emphasis on the gathering of evidence for the efficacy of empirically supported therapies is misplaced. Empirically supported therapies are those interventions that have been found in controlled trials to be effective for specific disorders, for example, major depressive disorder, obsessive-compulsive disorder and bulimia. He argues that because a practitioner's prime responsibility is to do no harm, identifying therapies that are potentially harmful should be afforded a higher priority than gathering evidence for the efficacy of empirically supported therapies. To that end, by examining current research findings, he created a provisional list of potentially harmful therapies (see Appendix A). Lilienfeld stresses that the list is not exhaustive, he expects it to be revised continuously and evolve over time. Among those therapies listed are recovered-memory techniques, critical incident stress debriefing, attachment therapies such as rebirthing, grief counselling for normal bereavement and expressive-experiential psychotherapies such as gestalt. It must be noted that he refers to these as 'potentially' harmful because the evidence suggesting they produce harmful effects is not definitive and they are not harmful for all individuals exposed to them. Lilienfeld (2007) believes that there is an attitude of complacency in the field towards the harmful effects of counselling and psychotherapy. He argues that exposure to research in this area should be an integral ingredient in the training of mental health professionals stating that "students in training also need to understand that even well-intentioned interventions can sometimes produce harm" (Lilienfeld, 2007, p. 66).

Chapter Two

Chapter one showed us that counsellors and psychotherapists frequently do not notice when clients are deteriorating during therapy. We cannot learn from our mistakes if we do not know we are making them. Sapyta, Riemer and Bickman (2005) posit that practitioners need to be aware of client outcomes if they are to learn from clinical experience. Providing clinicians with regular feedback on how clients are progressing has been shown to improve outcomes for clients predicted to leave therapy worse off (Harmon, Lambert, Smart, Hawkins, Nielsen, Slade, & Lutz, 2007). Slade et al (2008) point out that if clinicians can identify clients who are at risk of deterioration earlier in the therapeutic process, then they would be in a better position to prevent this. Despite the lack of consensus in relation to defining and measuring negative effects of therapy, there are instruments available that practitioners and researchers alike can use to monitor negative therapeutic outcomes. The following are a selection of some of the most prominent instruments that training programmes could introduce to students.

Inventory for the Assessment of Negative Effects of Psychotherapy (INEP)

Due to the lack of systematic studies into negative effects of psychotherapy, Ladwig, Rief and Nestoriuc (2014) devised the Inventory for the Assessment of Negative Effects of Psychotherapy (INEP). After surveying 195 participants, the researchers identified possible negative effects of psychotherapy across various areas of life such as intrapersonal change, relationships, friendships, family, malpractice and stigmatisation. Here, a negative effect was defined as any change "experienced as negative by the patient and that have direct or indirect harmful effects" (Ladwig et al, 2014, p. 2). Importantly, it must be the client who attributes the negative effect to the therapy, either during or after. The INEP is a self-assessment tool consisting of 21 potentially negative outcomes of therapy (see Appendix B). After the conclusion of therapy, clients are invited to rate whether certain items had a positive or negative effect on a Likert scale. They then indicate if that change can be attributed directly to therapy or to other circumstances in their life. Though it is a short questionnaire, this inventory can

give practitioners an indication of whether or not their client benefited from therapy. The creators of the instrument concede that it has limitations, primarily as it does not allow for therapist observations. Linden (2012) points out, clients' ratings of the quality of therapy are potentially misleading. For example, a client who is dependent may view a protracted period of therapy as beneficial when in fact it is exacerbating their dependency. With this in mind, he and his colleagues devised the Unwanted Events to Adverse Treatment Reactions (UE-ATR) checklist. He argues that this model can be used in research, clinical practice and the training of psychotherapists.

Unwanted Events to Adverse Treatment Reactions (UE – ATR) checklist

Linden (2012) believes there is a lack of theoretical conceptualisation on how to define and classify the negative effects of psychotherapy. He argued that side effects need to be differentiated from malpractice, non-response to treatment and deterioration of illness and so he constructed the UE-ATR checklist (see Appendix C). To begin assessing side effects of therapy, unwanted events (UEs) must be recorded. These are all events that are negative and occur in tandem with therapy. They include psychological and social symptoms. He offers the example of a divorce, which is not the goal of therapy, but which may be beneficial in the long run. An adverse treatment reaction (ATR) is any unwanted event caused by appropriate treatment. It is suggested that all UEs be recorded by the practitioner, even if initially they do not appear to be related to therapy. The checklist provides the therapist a list of 11 areas to check for unwanted events and it is suggested that it is used at fixed intervals. The areas to check include the development of new or the deterioration of existing symptoms, therapy dependency, changes in family or work areas and stigmatisation. Before it can be attributed to therapy, the therapist must determine if the UE is linked to the therapy using a five-point scale ranging from unrelated to related. The severity of the effect, from mild to extremely severe, is also evaluated. It must be highlighted that this is a tool designed to improve therapists' abilities

to identify negative effects and is not suitable for psychometric assessment of clients. In the author's view, a limitation of this tool is that it is based on therapist observation only, and does not include client feedback.

Negative Effects Questionnaire

In a bid to address the limitations of the aforementioned instruments, Rozental et al (2016) designed the Negative Effect Questionnaire (NEQ). It is a 32-item survey generated using "consensus among researchers, experiences by patients having undergone treatment, and a literature review" (Rozental et al, 2016, p. 12). The 32 items (see Appendix D) span six areas which are defined as: symptoms, quality of therapy, social stigma, dependence on therapist, hopelessness and failure. They aimed to design an instrument that was easy to administer by both researchers and therapists. It can be used throughout therapy to assist in the identification of clients who are at risk of a negative outcome so that alternative interventions can be offered. Whilst this tool can be used at regular intervals in the psychotherapeutic process, the authors of the study warn against repeatedly probing for negative effects as it may induce unwanted and adverse events. For example, it may make the client "more aware of certain incidents" (Rozental et al, 2016, p. 16). An unwanted event in therapy may be transient, and so the authors recommend using the NEQ in conjunction with other outcome measures.

Clinical Outcomes in Routine Evaluation (CORE) outcome measure

According to Mearns, Thorne and McLeod (2013), there are an increasing number of counselling services that require their staff to use brief surveys to collect client feedback. One such method that is popular in the UK is the CORE outcome measurement system. At the beginning of therapy, a 34-item questionnaire is given to clients to complete (see Appendix E for an example of this questionnaire) to help gauge the severity of issues clients may have. It covers issues such as life functioning, well-being, symptoms, and risk to self and others. It can

also be administered at intervals and at the end of therapy to measure change (Evans, Mellor-Clark, Margison, Barkham, Audin, Connell & McGrath, 2000). In addition, there are two forms the practitioner can fill out to give more context to the information provided by the client. The CORE outcome measure system is pan-theoretical, non-proprietary and freely available to practitioners. This is a screening tool and outcome measure only and cannot be used as a diagnostic tool (CORE System User Manual, n.d.). Evans et al (2000) argue that it can be used to help identify those clients who are not changing or are deteriorating. As it is a 'core' tool, it can be "supplemented with other measures as appropriate" (Evans et al, p. 253) such as Rosenberg self-esteem scale and the Beck Depression Inventory etc. Though it is standardised, this does not mean that it must be applied in a standardised way. Practitioners, with client consent, can decide how they would like to use this tool to keep track of developments throughout therapy.

As shown above, there are different tools available to practitioners to assist in the detection of potential negative outcomes in therapy. Hill, Roffman, Stahl, Friedman, Hummel and Wallace (2008), point out that having a credible framework to learn from and proficiency in specific skills can help trainees feel more confident in their abilities. The author believes that exposure to using instruments that assess harmful effects in a supportive learning environment would not only give invaluable feedback on their progression, but also help overcome reluctance to use such tools in professional practice.

Chapter Three

Chapter one showed that empirical research in the harmful effects of counselling and psychotherapy is lacking. It also offered evidence that suggests some practitioners seem to have difficulty identifying when clients get worse. To the author, it seems clear that there should be

a heightened focus on identifying potential harmful and negative effects in counsellor training. Her own training simply cautioned against doing harm, but did not offer any structured framework for defining negative effects, identifying harm or guidelines on what to do if negative effects are noticed. Castonguay et al (2010) assert that "one of the mandates of graduate training in clinical and counselling psychology should be to raise awareness of and to prevent, to the extent possible, predictable sources of harm in psychotherapy" (p. 35). Mearns, Throne and McLeod (2013) expect university graduates to be able to use instruments that evaluate the effectiveness of their work. Hill and Lent (2006) explain that experiential practices are the hallmark of helping skills training. Though not without their limitations, there are instruments available, such as those discussed in chapter two, that students can practice using throughout their training. The author will now discuss some training implications of Lilienfeld's research, as suggested by Castonguay et al (2010).

Training recommendations

Sapyta et al (2005) state that "therapists are trained, are supervised, and practice in the absence of information about client treatment response from objective sources" (p. 147). In most training programmes, emphasis is on teaching results of studies where the evidence supports the efficacy of therapy. Less attention is given to the fact that not all outcomes are positive (Castonguay et al, 201.0). Castonguay et al (2010) make a number of recommendations for counsellor training programmes with particular regard to harmful effects associated with psychotherapy. Many of the recommendations already exist in most training programmes as they are theorised to contribute to positive therapeutic outcomes. However, Castonguay and colleagues underscore the importance of emphasising the avoidance of doing harm when training therapists. They clustered their recommendations into a set of overarching principles plus five general guidelines; (a) enhance therapeutic relationship, (b) skilful and appropriate use of technique, (c) preventing and repairing potentially toxic relational and technical

processes, (d) adjusting treatment to client characteristics and (e) recognising and addressing practitioner traits that may make them less effective.

Overarching principles

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

Enhance therapeutic relationship

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

Skilful and appropriate use of technique

Castonguay et al (2010) suggest that students be made aware of the potential negative impact of techniques employed, even if they are prescribed in an empirically supported treatment. They suggest that it is not necessarily the techniques in and of themselves that may be detrimental, but the strict adherence to their use in certain contexts. For example, when faced with resistance from a client, cognitive behaviour therapists often increase their adherence to an intervention which in turn leads to more opposition to the technique from the client. Additionally, frequent interpretations by psychodynamic therapists was associated with poor therapeutic outcomes (Castonguay et al, 2010). Boisvert and Faust (2003) also caution clinicians against insisting on using a particular technique, despite resistance from the client, as this may threaten the relationship.

Prevent and repair toxic relational and technical processes

According to Castonguay et al (2010), there is enough empirical evidence on the importance of relational factors such as the therapeutic alliance, to advocate for a clear focus on interpersonal skills in therapist training. Fostering self-awareness amongst trainees, and, increasing countertransference managements skills to build understanding of their own contribution to the alliance are important considerations for training programmes. Training programmes should also concentrate on technical processes by teaching methods to help therapists identify when their client is not responding to an intervention, and respond in a flexible way. Ackerman and Hilsenroth (2001) also argue that positive therapeutic outcomes rely heavily on the therapist's "capacity to recognize and effectively control negative process" (p. 171).

Adjusting treatment to client characteristics

Castonguay and his colleagues also stress the importance of ensuring that trainees are aware that different clients react differently to various interventions. For example, clients with

depression have a tendency to externalise their issues. These clients are often more responsive to cognitive-behavioural approaches than insight-oriented approaches such as gestalt. Again, the importance of adapting to client needs is emphasised by Castonguay et al (2010) when they suggest that psychotherapists need to be trained to integrate a variety of evidence based interventions in their work. It is also worth reminding trainees that even when following best practice guidelines, not all interventions work with all clients. If a client does not respond well to therapy, then it is not necessarily an indication of their incompetence.

Recognising practitioner traits that may be less effective

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

We are ethically obliged as practitioners to do everything within our control to avoid doing harm to our clients. Despite the numerous challenges in the field in relation to defining and researching negative therapeutic effects, there are tools and guidelines available to help overcome these hurdles. However, counselling and psychotherapy is not a solitary endeavour by the therapist. We must not forget that the client is just as much a part of the process as the therapist.

Client responsibility in therapeutic process

It can be tempting to conclude that therapists bear all responsibility for any negative outcome that occurs during the psychotherapeutic process. This was even suggested by Linden & Schermuly-Haupt (2014) in chapter one. However, by that rationale, does this mean that therapists can assume responsibility for positive outcomes? The author argues that by taking full responsibility for all results, we risk undermining client autonomy and subverting clients' capacity for personal responsibility. These are qualities we are supposed to help our clients cultivate (Kinsella, 2018; Mearns, Thorne & McLeod, 2013; Yalom, 2011). It must be stressed that "clients are not inert objects upon which techniques are administered" (Bergin & Garfield, 1994, as cited in Bohart & Tallman, 2010). As discussed above, it can be shown that practitioner interventions and characteristics can negatively impact a client. As professionals we must be responsible for our actions. We are responsible *to* our clients, but we cannot be responsible *for* them (Mearns, Thorne and McLeod, 2013). The significance of a client taking personal responsibility for their own therapy cannot be understated. According to Overholser (2005) "clients are more likely to benefit from treatment when they are willing to assume their share of responsibility for good and bad events" (p. 370). While we of course have an ethical responsibility to do no harm, we cannot accept all responsibility for how clients react to interventions, even those that are empirically supported. Yalom (2011) urges therapists to explain to clients the importance of being responsible for themselves, calling it an "essential first step in the therapeutic process" (p. 144). Kinsella (2018) states that "autonomy sits at the epicentre of counselling and psychotherapy" (p. 5). From the author's perspective, therapists need to be aware of therapies and common factors that have potential for harm. They must also be willing to reflect on, and manage, personal traits that may produce unwanted effects, such as their attachment style. Practitioners must be vigilant, on the look-out for any deleterious effects. However, it is critical that we collaborate with clients when unwanted effects occur, ultimately allowing them to decide for themselves what the best course of action is.

Conclusion

With the increasing focus on evidence-based practice and empirically supported therapies, the field of counselling and psychotherapy is undergoing a paradigm shift. However, as shown in chapter one, not enough attention has been paid to negative outcomes. Lilienfeld's pioneering research has shown that there are a significant number of therapies and interventions that have the potential to cause harm. It has also been demonstrated that practitioners are not always aware when their clients are deteriorating. Obstacles to defining and researching harmful

effects of counselling and psychotherapy abound, but this does not relieve us of our duty to make advances in this overlooked area of research. Tools such as those outlined in chapter two exist to help practitioners monitor and identify potentially deleterious outcomes. It is the author's belief that if trainees were skilled in the use of such instruments early in their training, this would increase the likelihood of them using them in professional practice. Chapter three offered guidelines for the incorporation of research on negative effects into counsellor and psychotherapy programmes such as; exposure to and critiquing an evolving list of potentially harmful therapies, using techniques appropriately and in a flexible manner, teaching relationship building skills and self-awareness. Lastly, the author explored the client's responsibility in the therapeutic process, showing that it too has a central role in therapeutic outcomes. Like medical practitioners, counsellors and psychotherapists have an obligation to abide by the credo "*primum, non nocere"* (first, do no harm). The author believes that we can continue to fulfil this obligation by instilling the importance of paying attention to the shadow side of counselling and psychotherapy in trainee therapists.

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Appendix A

List of Potentially harmful therapies

Intervention	**Potential harm**	**Primary source of evidence**
	Level I (probably harmful for some individuals)	
Critical incident stress debriefing	Heightened risk for posttraumatic stress symptoms	Randomised controlled trials
Scared Straight interventions	Exacerbation of conduct problems	Randomised controlled trials
Facilitated communication	False accusations of child abuse against family members	Low base rate events in replicated case reports

Attachment therapies (e.g., rebirthing)	Death and serious injury to children	Low base rate events in replicated case reports
Recovered-memory techniques	Production of false memories of trauma	Low base rate events in replicated case reports
Dissociative identity disorder-oriented therapy	Induction of ‘‘alter’’ personalities	Low base rate events in replicated case reports
Grief counseling for individuals with normal bereavement reactions	Increases in depressive symptoms	Meta-analysis
Expressive-experiential therapies	Exacerbation of painful emotions	Randomised controlled trials
Boot-camp interventions for conduct disorder	Exacerbation of conduct problems	Meta-analysis
Drug Abuse Resistance Education programmes	Increased intake of alcohol and other substances (e.g., cigarettes) *Level II (possibly harmful for some individuals)*	Randomised controlled trials
Peer-group interventions for conduct disorder	Exacerbation of conduct problems	Quasi-experimental studies
Relaxation treatments for panic-prone patients	Induction of panic attacks	Replicated single-case designs

Source: Lilienfeld (2007)

Appendix B

List of items in Inventory for the Assessment of Negative Effects of Psychotherapy

ITEM	NEGATIVE EFFECT
1	Since completing my therapy, I feel better/worse.
2	Since completing my therapy, trusting others comes harder/easier.
3	Since completing my therapy, I am more/less troubled by my past.
4	My partner and I experience more/less conflict in our relationship.
5	My relationship with my family has improved/worsened.
6	My relationship with my friends has improved/worsened.
7	I am anxious that my colleagues or friends could find out about my psychotherapy.
8	I have troubles finding insurance or am anxious to apply for new insurance.

9	I have more financial worries than before.
10	I feel addicted to my therapist.
11	I have troubles making important decisions without my therapist.
12	My partner is or has been jealous of my therapist.
13	Everybody has ups and downs. Since the end of my therapy, I have experienced more downs.
14	Since the end of my therapy, I have changed for the worse.
15	During treatment or since the end of my therapy, I suffered from suicidal thoughts or intentions for the first time ever.
16	I felt hurt by what the therapist told me.
17	I felt personally ridiculed by my therapist.
18	I felt sexually molested by my therapist.
19	My therapist attacked me physically.
20	My therapist forced me to do things I did not want to do (e.g., confrontations, role plays).
21	My therapist broke confidentiality.

Adapted from Ladwig et al (2014)

Appendix C

Unwanted Events to Adverse Treatment Reactions checklist

UE classes	Present	Context	Relation	Severity
Lack of clear treatment results				
Prolongation of treatment				
Non-compliance of the patient				
Emergence of new symptoms				
Deterioration of symptoms				
Negative well-being of the patient				
Strains in the patient–therapist relationship				
Very good patient–therapist relationship				
Strains in family relations				
Changes in family relations				
Strains in work relations				
Changes in the work situation				
Sick leave of the patient				
Problems in the extended social net				
Any change in the life circumstances of the patient				
Stigmatization				

Glossary of ratings		
Context of development	Relation to treatment	Severity
1. Diagnostic procedures	1. Unrelated	1. Mild, without consequences
2. Theoretical orientations	2. Probably unrelated	2. Moderate, distressing
3. Selection of the treatment focus	3. Possibly related	3. Severe, in need of countermeasures
4. Treatment procedures	4. Probably related	4. Very severe, lasting negative consequences
5. Sensitization processes	5. Related	5. Extremely severe, hospitalization required, or life threatening
6. Disinhibition processes		
7. Treatment effects		
8. Therapist–patient relationship		

Source: Linden (2012)

Appendix D

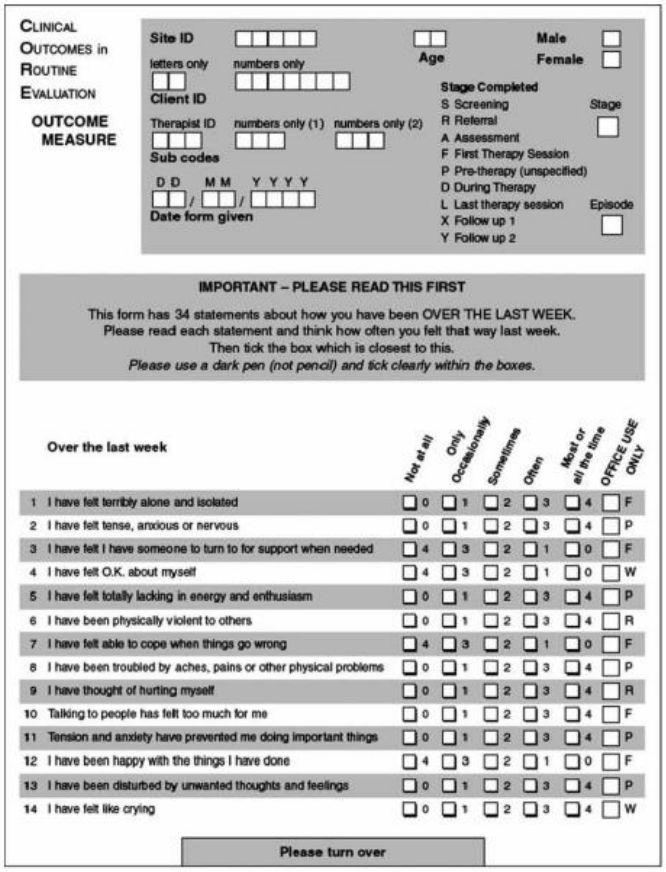
Items in the Negative Effects Questionnaire

ITEM	Negative Effect
1.	I had more problems with my sleep.
2.	I felt like I was under more stress.
3.	I experienced more anxiety.
4.	I felt more worried.
5.	I felt more dejected.
6.	I experienced more hopelessness.
7.	I experienced lower self-esteem.
8.	I lost faith in myself.
9.	I felt sadder.
10.	I felt less competent.
11.	I experienced more unpleasant feelings
12.	I felt that the issue I was looking for help with got worse.
13.	Unpleasant memories resurfaced.
14.	I became afraid that other people would find out about my treatment.
15.	I got thoughts that it would be better if I did not exist anymore and that I should take my own life.
16.	I started feeling ashamed in front of other people because I was having treatment.
17.	I stopped thinking that things could get better.
18.	I started thinking that the issue I was seeking help for could not be made any better.
19.	I stopped thinking help was possible.
20.	I think that I have developed a dependency on my treatment.
21.	I think that I have developed a dependency on my therapist.
22.	I did not always understand my treatment.
23.	I did not always understand my therapist.
24.	I did not have confidence in my treatment.
25.	I did not have confidence in my therapist.
26.	I felt that the treatment did not produce any results.
27.	I felt that my expectations for the treatment were not fulfilled.
28.	I felt that my expectations for the therapist were not fulfilled.
29.	I felt that the quality of the treatment was poor.
30.	I felt that the treatment did not suit me.
31.	I felt that I did not form a closer relationship with my therapist.
32.	I felt that the treatment was not motivating.

Adapted from Rozental et al (2016)

Appendix E

Example of CORE OM questionnaire



CLINICAL OUTCOMES in ROUTINE EVALUATION

OUTCOME MEASURE

Site ID ☐☐☐☐☐ Age ☐☐ Male ☐ Female ☐

letters only ☐☐ numbers only ☐☐☐☐☐☐☐

Client ID

Therapist ID ☐☐☐ numbers only (1) ☐☐☐ numbers only (2) ☐☐☐

Sub codes

D D M M Y Y Y Y

☐☐ / ☐☐ / ☐☐☐☐

Date form given

Stage Completed

S Screening
R Referral
A Assessment
F First Therapy Session
P Pre-therapy (unspecified)
D During Therapy
L Last therapy session
X Follow up 1
Y Follow up 2

Stage ☐

Episode ☐

IMPORTANT – PLEASE READ THIS FIRST

This form has 34 statements about how you have been OVER THE LAST WEEK.
Please read each statement and think how often you felt that way last week.
Then tick the box which is closest to this.
Please use a dark pen (not pencil) and tick clearly within the boxes.

Over the last week	Not at all	Only Occasionally	Sometimes	Often	Most or all the time	OFFICE USE ONLY
1 I have felt terribly alone and isolated	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ F
2 I have felt tense, anxious or nervous	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ P
3 I have felt I have someone to turn to for support when needed	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0	☐ F
4 I have felt O.K. about myself	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0	☐ W
5 I have felt totally lacking in energy and enthusiasm	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ P
6 I have been physically violent to others	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ R
7 I have felt able to cope when things go wrong	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0	☐ F
8 I have been troubled by aches, pains or other physical problems	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ P
9 I have thought of hurting myself	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ R
10 Talking to people has felt too much for me	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ F
11 Tension and anxiety have prevented me doing important things	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ P
12 I have been happy with the things I have done	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0	☐ F
13 I have been disturbed by unwanted thoughts and feelings	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ P
14 I have felt like crying	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ W

Please turn over

Over the last week	Not at all	Only Occasionally	Sometimes	Often	Most or all the time	OFFICE USE ONLY
15 I have felt panic or terror	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ P
16 I made plans to end my life	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ R
17 I have felt overwhelmed by my problems	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ W
18 I have had difficulty getting to sleep or staying asleep	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ P
19 I have felt warmth or affection for someone	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0	☐ F
20 My problems have been impossible to put to one side	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ P
21 I have been able to do most things I needed to	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0	☐ F
22 I have threatened or intimidated another person	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ R
23 I have felt despairing or hopeless	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ P
24 I have thought it would be better if I were dead	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ R
25 I have felt criticised by other people	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ F
26 I have thought I have no friends	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ F
27 I have felt unhappy	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ P
28 Unwanted images or memories have been distressing me	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ P
29 I have been irritable when with other people	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ F
30 I have thought I am to blame for my problems and difficulties	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ P
31 I have felt optimistic about my future	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0	☐ W
32 I have achieved the things I wanted to	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0	☐ F
33 I have felt humiliated or shamed by other people	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ F
34 I have hurt myself physically or taken dangerous risks with my health	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ R

THANK YOU FOR YOUR TIME IN COMPLETING THIS QUESTIONNAIRE

	(W)	(P)	(F)	(R)	All Items	All minus R
Total Scores	☐	☐	☐	☐	☐	☐
Mean Scores (Total score for each dimension divided by number of items completed in that dimension)	☐	☐	☐	☐	☐	☐