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Expectations and experiences of psychological therapy from the client perspective: a qualitative study

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ABSTRACT

Clients' subjective expectations and experiences of psychological therapy are likely to influence engagement and outcomes. A better understanding from the client perspective of how client therapy expectations compare to experiences of therapy may highlight client information needs and improve therapist sensitivity and attunement. In this study, we interviewed ten clients who had recently completed individual therapy about their expectations and experiences of therapy. Interview data were thematically analysed in the template style. Three themes are presented: (1) Undertaking the hard work of therapy and developing personal agency; (2) Abandoning expectations about 'roles' to develop a relationship between imperfect individuals; (3) Applying and owning learning from therapy. This study provides useful information about participants' experiences of psychological therapy from the client perspective, including how these experiences compared to their expectations of therapy, and how these expectations changed over time. These insights could inform the development of materials to ensure those referred to and awaiting therapy are well informed and prepared for the process of therapy, promoting improved client experiences of therapy and increased engagement with the therapy process.

Psychological therapists offer well-established interventions for a range of mental health difficulties. There is considerable research demonstrating positive effects of various psychological therapies for a broad array of common mental health difficulties (Lambert, 2013). However, clients do not always benefit from psychological therapy (Scott & Young, 2016), and it is known that a significant number of those entering therapy either fail to engage in therapy or terminate psychological therapy prematurely without significant improvement (e.g. Swift & Greenberg, 2012). In the United Kingdom (UK), most adult psychological therapies services are provided by the National Health Service (NHS) (National Audit of Psychological Therapies, 2013). In a national survey of people receiving psychological therapy from services across England and Wales, around one in 20 respondents reported negative effects of therapy (Crawford et al, 2016). Insufficient information about the nature of psychological therapy and limited understanding of the rationale for it were associated with negative experiences of therapy (Crawford et al, 2016).

Expectations have a strong influence on health outcomes and play an important role in determining treatment outcomes across a range of medical and psychological conditions and (psychopharmacological, surgical, psychological) interventions (Petrie & Rief, 2019; Rief & Glombiewski, 2017). Individual differences (state and trait factors), cognitive constructions, social influences (e.g. close others, perceived cultural norms), prior experiences of treatment and the current treatment setting all influence patients' expectations about treatment (Rief et al, 2015; Rief & Petrie, 2016). Expectations are a common and important factor in psychological therapies (e.g. Constantino, 2012). Expectations can change over time, and may relate to both outcome expectations (the extent to which the client believes therapy will be helpful) and treatment expectations (expectations about what will happen during therapy, including client and therapist roles and therapy duration) (Constantino, 2012; Constantino et al, 2012). Although it has long been well known that clients themselves contribute

importantly and significantly to psychological therapy (e.g. Wampold, 2001, estimated 87% of variance in therapy outcomes to be due to clients), research in this area has been previously criticised for neglecting the client perspective (Levitt et al, 2016; Gordon, 2012; Bohart & Tallman, 2010). Qualitative research approaches allow for exploration of the subjective experience of psychological therapy from the perspective of clients, repositioning the client as central in research (Levitt et al, 2016). Levitt et al's (2016) comprehensive meta-analysis of qualitative research on clients' experiences within therapy calls for better integration of qualitative evidence into research.

The current qualitative study focused on the experiences of clients who had recently accessed a NHS adult psychological therapies service. Although expectations are recognised as an important factor in psychological therapy, there has been relatively little published research examining expectations of therapy (and how these expectations compare with experiences of therapy) from a client perspective. We wanted to explore with participants both their expectations and experiences of therapy, and to understand how these compared. Better understanding of these experiences should inform ways of preparing clients for therapy and managing expectations in a way that enhances positive therapeutic processes, as well as deepening clinicians' understanding of the client experience in therapy.

METHOD

Methodology and design

A qualitative design incorporating semi-structured individual interviews was used to collect rich data focusing on personal expectations and experiences of psychological therapy. Template Analysis (e.g. Brooks et al, 2015), a form of thematic analysis, was used to interpret data and to generate themes representing recurring features across participants' accounts. Our work was undertaken from what Brooks and King (2017) have described as a 'limited realist' position. We wanted (whilst acknowledging our own role in the research process as researchers and clinicians) to understand participant experience. Whilst recognising (and welcoming) participant accounts as individual and subjective, we understand these accounts (and our findings) as having potential applied relevance beyond the research process and setting, with relevance and possible implications beyond this particular study setting.

Participants

Participants were 10 clients who had recently completed a course of psychological therapy and been discharged from a NHS adult psychological therapies service. The service was a stand-alone secondary care service offering a range of therapeutic interventions to individuals experiencing moderate to severe enduring mental health concerns. Participant ages ranged from 28 to 68 years, and the male: female ratio was 2:8. All participants were of white British ethnicity.

Recruitment was undertaken by the seven therapists (qualified clinical psychologists [N=5] and counselling psychologists [N=2] with training in the specific interventions delivered to clients (see table 1) and working for the service with whom potential participants had had clinical contact. All therapists were female. Participant details, including number of sessions

attended and type of therapy employed are presented in Table 1. The number of sessions clients had attended varied from 9 to 39 (see Table 1). All participants had been discharged from the service and were considered by their therapist to have completed therapy.

INSERT TABLE 1 ABOUT HERE

Ethical approval

Research ethical approval for the study was obtained from NHS Research Ethics (15/NS/0063). Management approval from the relevant NHS Trust was also obtained.

Procedure

All seven therapists were asked to identify their last two clients who had recently (in the last six months) completed therapy and undergone planned discharge. Therapists excluded any clients who had terminated therapy without undergoing planned discharge or who would be unable to provide informed written consent. Invitation letters (including the researcher's contact details and a study information sheet) were posted to potential participants. Participants were invited to contact the researcher directly if they wished to take part. The letter and study information sheet stated that the purpose of the study was to better understand the experiences of those who had attended the service. It was made clear that the researcher (the first author) was a female university academic who was independent of the service, and that participation was voluntary. Upon contacting the researcher, participants were given the opportunity to ask any questions about the study prior to arranging an interview appointment.

10 clients responded and took part in interviews with the first author (an experienced qualitative researcher). Participants were interviewed at a location chosen by them following discussion with the researcher: eight participants were interviewed at their home and two in a private room in a local community building. Participants provided written informed consent at the start of the interview (including consent for the use of anonymised direct quotes in publications). Participants have been allocated pseudonyms and any identifying information removed to protect their anonymity.

An interview guide (designed by the first author in consultation with the other authors and with feedback from other therapists working in the service) covered four broad areas with each including further sub-areas to probe as appropriate, depending on and responsive to the context of each individual interview. The broad topic areas covered were:

- Background to referral into the service
- Expectations of the service
- How expectations of the service had compared with experience of therapy
- Information/ advice that would be useful to others attending the service in the future

Interviews lasted between 43 and 113 minutes (mean duration 61 minutes) and were audio-recorded and transcribed verbatim. The interviewer was explicit that she had no particular prior knowledge of the service and was undertaking the work from an exploratory perspective.

Analysis

Template Analysis (e.g. Brooks et al., 2015) was used to analyse data, and followed the stages described by King and Brooks (2017). Template Analysis is a form of thematic analysis in

which, qualitative data are hierarchically thematically coded through the iterative development of a coding template. Analysis was led undertaken by the first author with a focus on understanding how experience of therapy contrasted with expectations of therapy. Preliminary coding was initially undertaken on a subset of the data (four interview transcripts). This involved highlighting data of relevance and assigning these segments initial descriptive codes. Codes were then grouped into meaningful clusters, and the research team began to reflect on and define how emerging themes related to each other within and between clusters. Further coding was undertaken at this point on another three interviews and further emerging themes informed the continuing clustering process. At this point an initial template was constructed: this was then applied to the final three interviews. Necessary modifications to the coding template to ensure it adequately represented the data were undertaken and this final version of the template was applied to the full data set. Analysis was regularly discussed on multiple occasions at ongoing intervals with the research team (comprising another qualitative academic psychologist researcher, a clinical psychologist trained in cognitive therapy not working in the service and two therapists working in the service – one a counselling psychologist with further training in EMDR and CAT; one a clinical psychologist with further training in schema therapy and DBT) to reach agreement on thematic structure. NVivo was used to facilitate analysis and data management.

The final template focused on data relating to client experiences and expectations of therapy. It comprised three top-level themes which are reported here: (1) *'I didn't know what I was capable of':* Undertaking the hard work of therapy and developing personal agency; (2) '*It's 50% me, 50% her'*: Abandoning expectations about 'roles' to develop a relationship between imperfect individuals; (3) ***'****You take your stabilisers off and off you go'****:*** Applying and owning learning from therapy.

FINDINGS

[1] 'I didn't know what I was capable of': Undertaking the hard work of therapy and developing personal agency

This theme describes how participants experienced therapy as difficult work that was more demanding than they had anticipated. It captures ways in which participants experienced undertaking therapy as challenging work which they were required to take responsibility for, and ways in which this experience contrasted with their initial expectations. Participants described developing a sense of personal responsibility and playing an increasingly active role in their own therapy. They expressed surprise at what they had achieved and pride in their newly realised capabilities and their progress.

Participants had all spent (often considerable) time on waiting lists before their first appointment with a therapist. Accessing the therapy service had not been quick or straightforward, most accounts described referral and assessment as lengthy, challenging processes experienced as exhausting at a vulnerable time. The act of accessing the service was seemingly understood representing a place of refuge and safety – once reached, things would be 'ok' (Gina [EMDR for PTSD]: *'I'd got to that stage where I was reaching out for therapy and I were banging my head against walls so when it* [appointment letter] *came it were like thank god for that, maybe it'll be ok now'*).

This understanding of therapy as representing arrival at a 'safe space' shifted once participants began their therapy sessions. Participants reported that it became clear to them early on that the work of therapy was far more arduous than they had expected. Participants repeatedly described undertaking therapy as unexpectedly 'hard work' (Molly [Trauma focused CBT for PTSD and eating disorder]: '*I had no idea how difficult I was going to find*

it once I got into it and how much hard work it actually is to go through therapy'). This contrasted with the assumptions of some prior to undertaking therapy that the therapist or simply the act of attending therapy would 'make me better'. The work of therapy required full and active engagement and very often was described as going to unsafe places (Alice [EMDR and compassion focused CBT for emotion regulation and complex PTSD]: '*I didn't leave a stone unturned, we didn't leave that one stone at the very, very bottom that I used to protect and keep, no I can't tell anybody that, I can't ever say those words out loud')*. Therapy sessions were rather experienced as a supportive although not necessarily comfortable place in which to undertake challenging work (Tony [CAT for mixed depression and anxiety]: '*It was my safe zone, I cried and snotted all over the place… you can just, total release and just be totally honest, and that's the bit that helps*'). Participants contrasted this with initial expectations of undertaking therapy as a passive recipient in a regular, time-limited session. The work of therapy was described as all-encompassing, making significantly greater demands on participants than they had expected and not simply limited to therapy sessions (Julia [EMDR for Dysthymia and PTSD]: '*It is hard work and it's every single day. I didn't realise there was so much work involved, I didn't know I was capable of it'*). A number of participants described the process of therapy as akin to a journey (e.g. *'progressing on a very difficult journey',* Gina [EMDR for PTSD]), and several emphasised that improvement was not necessarily immediate or a linear process.

2. *'It's 50% me, 50% her'*: Abandoning expectations about 'roles' to develop a relationship between imperfect individuals

Whilst the therapeutic relationship was central for all participants, participants described their understanding of the role of the therapist and their experiences of this relationship in varied

ways. This theme captures the nuanced and sometimes changing understandings of the therapist and their role in therapy and highlights the therapeutic relationship as one between two necessarily imperfect human beings, that imperfection being what makes the relationship genuine and useful.

Participants reflected on taking a conscious decision to fully engage with therapy. Metaphors used by participants ('*opening the can of worms'*; '*opening Pandora's box'*) reflect this sense of consciously choosing to 'take the leap' to engage in this challenging process. This was dependent on their establishing a trusting relationship with the therapist. Whilst for some this happened very quickly and early in the sessions (e.g. Molly [Trauma focused CBT for PTSD and eating disorder]:'*We gelled quite quickly and it was very, very easy from the word go*'), for most participants this was described as a more slow and cautious process. Developing this relationship was not described in terms of simply assessing the therapist in terms of their professional capabilities, although these were important. Participants understood the service as being staffed by highly qualified professionals with valued professional knowledge and expertise and several contrasted this with previous experiences of therapy from other sources (Tony [CAT for mixed depression and anxiety]: '*I'm going to use a football analogy of going to see a Conference team and going to see Manchester United*'). For some participants there was initially a sense of fault on their own part at the time taken to develop and build this working relationship (Gina [EMDR for PTSD]: '*The first sessions, I always felt that I wasted her time').* For others a reluctance to fully engage initially manifested itself in an somewhat aloof attitude, perhaps as a means of self-protection (Alice [EMDR and compassion focused CBT for emotion regulation and complex PTSD]: '*I think I had a little idea, 'I'm actually a lot cleverer than you, I'm too complicated, you could never understand me').* Prior to therapy, notions of 'the therapist' and their role had been varied (from archetypal notions of a healer who would 'make me better' to an authority figure to impress or gain the upper hand over).

As therapy progressed and a relationship was established, the therapist became more 'human' rather than a role (Alice [EMDR and compassion focused CBT for Emotion regulation and complex PTSD]: '*We're just two human beings in a room, we're not, you know, the counsellor and the troubled patient type thing').* The therapist was increasingly understood as someone there to support the client in their own therapy, a personal and effortful process requiring courage and commitment to achieve lasting, meaningful change (Wendy [CAT and CBT for eating disorder and PTSD]: '*It's 50% me and 50% her…She could help me and I don't mean take problems off me and deal with them for me. She can direct me in how I can help myself').*

Whilst the therapist then was understood as a highly skilled professional, participant accounts reflect the importance of the therapeutic relationship being experienced as truly personal and human. Where participants experienced therapy as less individual (adhering perhaps to the perceived imposition of a particular therapeutic model of therapy indiscriminately - e.g. Nadia [CBT and MBCT for low mood, anxiety and chronic pain]; '*It's all about this mindfulness, it doesn't matter who I go to because that's what's on the agenda … it actually doesn't matter what problem you've got, you're going to have to fit in somehow'*), then therapy was found to be less useful. Another participant recounted an ongoing focus in her sessions on a specific element of her experience (a diagnosis of cancer) which she did not believe was especially relevant to her distress. (Paula [Compassion focused CBT for anxiety and PTSD]: '*I would have liked to talk about that in my sessions but I felt that I couldn't because she wouldn't have understood it. She did want to help and you could tell that, it's just I don't think she had the experience to and I think she felt uncomfortable').* It was Paula's impression that the therapist was focusing on a non-collaborative case formulation which she (the client) did not accept because of (what she perceived as) the therapist's personal discomfort and level of experience. In the previous theme, the importance of developing a

sense of personal agency was emphasised – this cannot develop if the client's sense is that they are being 'done to', that therapy is progressing according to some guidelines or set protocols rather than in response to their individual and personal situation. Where experienced therapists were understood as flexibly applying psychological expertise to meet individual need, this enabled participants to develop and retain a sense of control and ownership over their own therapy (Molly [Trauma focused CBT for PTSD and eating disorder]: *'The different techniques and how she's able to tailor that to me rather than being a 'one size fits all' therapy…I was definitely given control of it, was a massive deal to me, it was reassuring to have that).*

Not having to fit into a 'one size fits all box' and experiencing the therapy relationship as one of unconditional regard from the therapist permitted participants to relinquish their own entrenched 'roles' (Wendy [CAT and CBT for eating disorder and PTSD]: '*She weren't judging me, she were accepting me for being a human being and not being a mum, not being a sister, not being a daughter. I felt listened to and cared about. Every single session, I felt I'd been heard').* Yet a truly 'human' relationship is between imperfect people (both client and therapist) and could ,on occasion, lead to a therapeutic rupture (Theresa [CBT for interpersonal difficulties, emotion regulation and anxiety]: '*At one point, I literally told her to fuck off for summat she said to me, she touched a nerve, I weren't for going back').* The process of working through a rupture was though described in positive terms (Theresa: *'But she wrote me a lovely letter, she actually wrote me a letter apologising and keeping it open…that were really special, that').* Understanding the therapist as human is to understand them as fallible. This contrasts with other participant accounts of feeling fearful of upsetting, burdening or 'offending' their therapist, (e.g. Nadia [CBT and MBCT for low mood, anxiety and chronic pain]: *To be honest, because she was nice, I used to kind of want to please her, I didn't want to let her down. So I'd end up saying 'Oh yeah, that kind of helped' when really it*

didn't; Henry [CBT for anxiety]*: I'm not going to upset her, I'm not going to rub her up the wrong way, I've got to be nice with her, I need her a lot more than she needs me).* Here, 'roles' are still being played out by participants, and a perceived power imbalance between therapist and client limits the extent to which an open and honest relationship (described as crucial for useful therapeutic work to take place) is possible. A 'good' therapist-client relationship is, it seems from our participants' accounts, not one without conflict; it is one in which (bi-directional) challenge is possible and an important therapeutic tool.

She challenged me and I challenged her. There were nothing that were hold barred, everything and anything were open for discussion, even if it did make me feel uncomfortable. And that's what I wanted, I liked it when she challenged me. Yeah, sometimes it were challenging, but it needed to be done… You need to let them see the real you, don't tell them what you think they want to hear, tell them what you want them to hear.

Wendy [CAT and CBT for eating disorder and PTSD]

[3] *'You take your stabilisers off and off you go':* Applying and owning learning from therapy

The final theme reflects on perceived therapy outcomes, and in particular conveys new learnings, ways in which participants understood therapy as facilitating change and the perceived extent and reach of such change. Learning included specific strategies and skills, as well as (for some) novel alternative views of the self and the world. These were not necessarily expected outcomes. Most participants reported positive and far-reaching therapy outcomes, but not all. This theme draws attention to particular aspects of therapy and the therapeutic process which participants reported as supporting fundamental change – as well

as aspects of therapy that were understood as contributing when therapy did not result in any significant perceived change for participants.

Therapy was frequently described by participants as providing a 'tool kit' of new strategies for coping and alternative ways of conceptualising their difficulties. When these strategies were understood as being selected from an existing array of possibilities but tailored by the expert therapist to individual need, therapy is congruent with the sense of personal agency and genuine relationship highlighted in the previous two themes. Available (and welcome) approaches and activities were not necessarily anticipated (Molly [Trauma focused CBT for PTSD and eating disorder]: '*Talking wasn't my forte at all, it became much more actually putting things down on paper or seeing things visually on boards and that was a really helpful thing. I didn't realise that was an option'*) – where participants recounted a sense of having worked together with the therapist to develop a personalised 'programme' for therapy, this was experienced as both encouraging and empowering. That choice was available to them was not something participants had expected prior to therapy. Offering an alternative lens through which to view difficulties was another key reported learning from therapy which had not been clearly envisaged (Theresa [CBT for interpersonal difficulties, emotion regulation and anxiety]: '*She made me look at stuff different').* Participants described continuing to apply strategies after therapy ended, with many reporting referring back to their therapy 'notes' for ongoing guidance. For some participants, undertaking new behaviours (e.g. implementing self-care for psychological well-being) represented a fundamental shift *(*Julia [CBT and MBCT for low mood, anxiety and chronic pain]: '*It was so unfamiliar to me to say to myself, come on, what do I need to do today to make myself feel better? And now I do that, whereas before it would have seemed bloody stupid and selfish').*

Client experiences and expectations of therapy

Whilst participants rarely reported expecting a specific outcome prior to therapy, at least some change was broadly anticipated. Where change was felt to be insignificant, shallow, limited or absent, there was some sense of let-down. Where tools and strategies presented in therapy were perceived as irrational or an ill fit, change is considered impossible (Paula [Compassion focused CBT for anxiety and PTSD]: '*All the time I was there, it was being driven to me that I had to think about myself only and no-one else. I had to do things how I wanted, regardless of how it hurt anyone else, which I found difficult. That's not how I've been brought up and it's not how I've brought my children up').* Perceived fundamental change depended on the extent to which participants had felt the new and the unfamiliar strategies and viewpoints introduced through therapy made sense to them, felt they were personally resonant and had developed a sense of ownership. If these changes and alternatives had become fully integrated, therapy was experienced as and described by participants as transformational (Gina [EMDR for PTSD]: *'has totally changed my life').* Experiences of the ending of therapy were important here and those who experienced this as non-negotiable or abrupt felt abandoned and alone (Theresa [CBT for interpersonal difficulties, emotion regulation and anxiety]: '*You wait too long and you get kicked out. The end, you feel like you've opened this can of worms, and now you've only got so many sessions, "Bye bye, deal with it on your own, off you go"'*). Where psychology services were experienced as a '*dead end service*' (Molly [Trauma focused CBT for PTSD and eating disorder]) and with no clear sense of what might be usefully available to them in the future, participants are left feeling isolated and without hope of change (Nadia [CBT and MBCT for low mood, anxiety and chronic pain]: '*I've sort of given up with mental health things. I've just sort of accepted that maybe I'm not going to get the help I need with my mental health';* Molly [Trauma focused CBT for PTSD and eating disorder]: '*Things aren't better, things aren't gone. It's still there and I'm kind of on my own to deal with it'*). In contrast,

participants who reported lasting positive change described having some sense of control over the ending of therapy (e.g. Henry [CBT for anxiety]: '*We did slow down the frequency … so I was able to extend treatment under her which I was happy with because that's what I wanted'*). They additionally reported successfully testing out their own capabilities alongside newly acquired strategies as part of the process of drawing therapy to a close (e.g. Tony [CAT for mixed depression and anxiety]: '*I was ready, it was almost like you take your stabilisers off and off you go'*). Whilst all participants reported a sense of being 'on their own' after therapy, whether or not therapy felt 'finished' was important. Those who felt therapy had been successful did not suggest this 'success' was because they expected to no longer experience any difficulties, or indeed that their presenting problem had necessarily fully dissipated. Rather they described themselves as newly optimistic about their capabilities to manage based on a sense of having acquired and assimilated new approaches and skills that were understood as practical, transferable and credible.

DISCUSSION

Participants in this study had a range of experiences of psychological therapy, engaging with diverse therapeutic approaches and different therapists. Three core themes in relation to expectations of therapy and experiences of undertaking therapy have been presented. Participants described moving through a collaborative and supported therapy process, from a more passive position at therapy outset to one where they viewed themselves as the agent of change. Participants had not fully anticipated how challenging therapy would be, nor the extent to which the work of therapy would extend beyond therapy sessions. Active engagement and the development of a sense of agency and control were highlighted as essential processes. A therapeutic relationship perceived as warm, personal and genuine and

the extent to which therapy was perceived as individually tailored were key. The process of developing rapport and negotiating a shared understanding may not be straightforward, but disagreement and challenge were not unwelcome and could be useful. Participants described therapy as a collaborative process within which the therapist offered them an unexpectedly broad range of personally tailored coping strategies, rather than telling them what to do or what was needed. For participants who developed a sense of ownership over these coping strategies, therapy was described as transformational. Taken together, findings highlight the central importance of a sense of ownership, agency and control in therapy. Where participants experienced therapy as standardised and inflexible or perceive a particular hypothesis or approach as being imposed upon them (for example, when therapists were perceived as adhering rigidly to a particular therapeutic orientation or model of working; when service targets for therapy cessation were perceived as outweighing client needs), their experiences of therapy were recalled as less positive.

Our findings support and contribute further to existing work. In a recent meta-analysis of the perspectives of both clients and therapists on the development of a therapeutic alliance (Lavik et al, 2018), clients highlighted the crucial importance of a balance between their therapist's professionalism and personal warmth whilst therapists themselves similarly emphasised the need to appropriately balance technical interventions with interpersonal warmth, including humility. Expectations can change over time, and Petrie and Rief (2019) draw attention to aspects of the therapeutic interaction (empathy, shared decision making, perceived therapist competence) which can change patient expectations and are likely to lead to improved outcomes. Repairs of alliance ruptures are associated with positive outcomes (e.g. Safran et al., 2011), and Theresa's account of receiving a letter from her therapist is a specific example

of the therapist being able to name and negotiate a potential rupture in the therapeutic relationship in a way that enabled the client to return to therapy. The importance of the client experiencing their role in therapy as active and agentic is similarly in line with the findings of others (Levitt et al, 2016). The contribution of this study is to highlight that, whilst these aspects of client experience may be established in the literature and known to therapists, clients themselves coming into therapy may well not expect or be aware of these aspects of therapy. Inadequate information about therapy is associated with negative experiences of therapy (Crawford et al, 2016), so providing clients with information on these issues prior to therapy may support active engagement and better therapy experiences. Expectations are powerful predictors of outcome, and Rief and Glombiewski (2017) suggest that pre-treatment expectations about both positive and negative effects of interventions should play an important role in treatment planning.

Findings from this study highlight a number of ways in which experiences of therapy were surprising to our participants, and were not part of their pre-therapy expectations. These included: therapy being unexpectedly 'hard work', the likelihood that improvement may not be a linear process, the possibility of (useful) disagreement and challenge as part of the therapeutic relationship and the time it might take to establish this relationship, and the role of the client as the key agent of change (both in therapy and after therapy has ended). Issues around the necessarily time-limited nature of therapy available through NHS services (duration, ending) were also raised as worrying for clients from therapy outset. Providing information on these issues prior to therapy may be useful for clients and support active engagement in therapy. For services which may be moving towards the use of predetermined time-limited packages of therapy, it will be important to consider how such approaches can take into account and address client concerns around length of therapy and therapy being experienced as standardised and inflexible. Peer support is established as useful for people

experiencing symptoms for which they may seek support from mental health services (e.g. Naslund et al., 2014; Corstens et al., 2014), and incorporating a positive role model to demonstrate treatment effectiveness is a recommended approach to enhance patient expectations prior to treatment in other healthcare intervention settings (Petrie & Rief, 2019). Allowing learning from shared experience through appropriately anonymised previous client accounts might be useful for those about to attend psychological therapy, and was indeed suggested as a potentially useful approach by participants in this study. The efficacy of brief psychological interventions to optimise patient expectations and improve outcomes has been demonstrated in other (surgical) settings (Rief et al, 2017). Future work could usefully explore the potential use of this approach in psychological therapy settings.

An obvious limitation of the present study, in addition to all participants being of white British ethnicity, is its focus only on those who had completed therapy and undertaken planned discharge. Although we recognise the inherent difficulties in undertaking such work, future research needs to elicit the views of individuals who do not undertake or complete therapy, and to include participants from diverse backgrounds. This might assist in the identification of broader factors that impact on expectations as well as therapeutic engagement and outcomes, as previous research suggests social and economic inequalities are pertinent (e.g. Arnow et al, 2007; Bridges, 2015). A further study limitation is existing evidence that research participants are reluctant to criticise therapy or therapists, even when (as in this study) the researcher is independent of the therapy team (Holding et al, 2016). The valuable contribution that 'experts by experience' can make to applied psychology and psychotherapy training programmes has attracted increasing attention over recent years (e.g. Lea et al, 2016), and researchers could usefully think about ways to involve expert clients in

research and evaluation activities (for example, client-led interviews) to help elicit balanced accounts of the client perspective of psychological therapy.

References

Arnow, B.A., Blasey, C., Manber, R., Constantino, M.J., Markowitz, J.C., Klein, D.N., Thase, M.E., Kocsis, J.H., & Rush, A.J. (2007). Dropouts versus completers among chronically depressed outpatients. Journal of Affective Disorders, 97, 197-202.

Bridges, S. (2014). Mental health problems. In Health survey for England 2014. London: Health & Social Care Information Centre. Available at: http://healthsurvey.hscic.gov.uk/media/37739/HSE2014-Ch2-Mental-health-problems.pdf

Brooks, J. and King, N. (2017). Approaches to Qualitative Psychology. In J. Brooks and N.King (Eds), Applied Qualitative Research in Psychology (pp.14-32). London: Palgrave.

Brooks, J., McCluskey, S., Turley, E. and King, N. (2015). The utility of Template Analysis in qualitative psychology research. Qualitative Research in Psychology, 12(2), 202-222.

Bohart, A. C. and Tallman, K. (2010). Clients: The neglected common factor in psychotherapy. In B. L. Duncan, S. D. Miller, B. E. Wampold, and M. A. Hubble (Eds.), The heart and soul of change: Delivering what works in therapy (2nd ed., pp. 83–111). Washington, DC: American Psychological Association.

Constantino, M. J. (2012). Believing is seeing: An evolving research program on patients' psychotherapy expectations. Psychotherapy Research, 22, 127-138.

Constantino, M. J., Ametrano, R. M. and Greenberg, R. P. (2012). Clinician interventions and participant characteristics that foster adaptive patient expectations for psychotherapy and psychotherapeutic change. Psychotherapy, 49, 557-569.

Corstens, D., Longden, E., McCarthy-Jones, S., Waddingham, R. and Thomas, N. (2014). Emerging perspectives from the Hearing Voices movement: Implications for research and practice. Schizophrenia Bulletin, 40(suppl.4), S285-S294.

Crawford, M.J., Thana, L., Farquharson, L., Palmer, L., Hancock, E., Bassett, P., Clarke, J. and Parry, G.D. (2016). Patient experience of negative effects of psychological treatment: results of a national survey. The British Journal of Psychiatry, 208, 260–265

Gordon, R. (2012). Where oh where are the clients? The use of client factors in counselling psychology. Counselling Psychology Review, 27, 8–17.

Healthcare Quality Improvement Partnership/ College Centre for Quality Improvement (2013). Second Round of the National Audit of Psychological Therapies for Anxiety and Depression (NAPT) National Report November 2013. Retrieved from Royal College of Psychiatrists Website*:* http://www.rcpsych.ac.uk/pdf/NAPT second round National report website 28-11-13v2.pdf

Holding, J.C., Gregg, L. and Haddock, G. (2016). Individuals' experiences and opinions of psychological therapies for psychosis: A narrative review. Clinical Psychology Review, 43, 142-161.

King, N. and Brooks, J.M. (2017). Template Analysis for Business and Management Students. London: Sage.

Lavik, K.O., Froysa, H., Brattebo, K.F., McLeod, J. and Moltu, C. (2018). The first sessions of psychotherapy: a qualitative meta-analysis of alliance formation processes. Journal of Psychotherapy Integration, 28(3), 348-366.

Lea, L., Holttum, S., Cooke, A. and Riley, L. (2016). Aims for service user involvement in mental health training: staying human. Journal of Mental Health Training, Education and Practice, 11(4), 208-219.

Levitt, H.M., Pomerville, A. and Surace, F.I. (2016). A Qualitative Meta-Analysis Examining Clients' Experiences of Psychotherapy: A New Agenda. Psychological Bulletin, 142(8), 801–808.

Naslund, J.A., Grande, S.W, Aschbrenner, K.A. and Elwyn, G (2014). Naturally Occurring Peer Support through Social Media: The Experiences of Individuals with Severe Mental Illness Using YouTube. PlosONE, 9(10), e110171.

Safran, JD., Muran, J.C., and Eubanks-Carter, C. (2011). Repairing alliance ruptures. Psychotherapy, 48(1), 80-87.

Scott, J. and Young, A. H. (2016). Psychotherapies should be assessed for both benefit and harm. The British Journal of Psychiatry, 208, 208–209.

Swift, J.K. and Greenberg, R.P. (2012). Premature discontinuation in adult psychotherapy: A meta-analysis. Journal of Consulting and Clinical Psychology, 80(4), 547-559.

Wampold, B. E. (2001). The great psychotherapy debate: Models, methods, and findings. Mahwah, NJ: Erlbaum Publishers.

Table 1: Participant details

Participant number	Name	Age	Gender	Presenting problem	Type of therapy	Number of sessions
1	Molly	30	F	PTSD and eating disorder	Trauma focused CBT	37
2	Nadia	28	F	Low mood, anxiety and chronic pain	CBT and MBCT	20
3	Tony	46	M	Mixed depression and anxiety	CAT	16
4	Julia	61	F	Dysthymia and PTSD	EMDR	9
5	Theresa	54	F	Interpersonal difficulties, emotion regulation and anxiety	CBT	20
6	Henry	48	M	Anxiety	CBT	18
7	Alice	57	F	Emotion regulation and complex PTSD	EMDR and compassion focused CBT	29
8	Wendy	50	F	Eating disorder and PTSD	CAT and CBT	15
9	Gina	68	F	PTSD	EMDR	39
10	Paula	59	F	Anxiety and PTSD	Compassion focused CBT	20

Note: CBT = cognitive behavioural therapy; MBCT = mindfulness based cognitive therapy; CAT = cognitive analytic therapy; EMDR = eye movement desensitisation and reprocessing; PTSD = posttraumatic stress disorder