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"HOW DO PSYCHOLOGICAL THERAPIES CAUSE HARM – AND WHAT SHOULD WE DO ABOUT IT?"

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There is no doubt that psychological therapies are generally effective in helping people with a range of mental health difficulties find relief from distress and improve their quality of life. Both from practice-based evidence and well-controlled clinical trials, we see that those who engage in a bona fide therapy with a qualified practitioner are, on average, better off than those who do not. The effect sizes are, compared with many medical interventions, quite impressive.

Yet that phrase 'on average' hides a genuine problem; some people who undertake therapy have a bad experience, feel worse afterwards than when they started, and may experience lasting bad effects. Even a cursory internet search will reveal many blogs, websites, books and articles from people who say they have been harmed. Psychotherapy research has a history of neglecting the subject, but is now starting to take this problem seriously. Recent developments include psychometric measures of negative effects of treatment, qualitative and survey investigations and meta-analysis of negative outcomes. Understanding therapeutic harm is vital in taking steps to prevent it, and I shall give an overview of some key issues in appraising the evidence of whether therapy is harmful, what makes it harmful and what can be done to reduce the risk of harm.

We know a good deal about how successful therapy works, in terms of therapist competence, therapist characteristics, client characteristics, trajectories of change, therapeutic alliance rupture and repair, specific techniques and 'non-specific' factors. We know less about bad therapy or harmful therapy. For a start, these are not necessarily the same things. There is an important distinction between process and outcome; bad experience and poor outcome. Bad therapy, therapy which does not meet minimum standards of competent practice, is not necessarily harmful, and well-conducted therapy can have unwanted negative effects.

Unwanted negative effects are sometimes termed 'side' effects, although I reject this terminology and shall explain why. Much psychological research in therapy uses a medical framework, characterised by terms such as matching treatment to diagnosis, dose-response, side effects, and treatment compliance and so on. Whilst this metaphor has utility, to address the potential for harm, I advocate a dialogic understanding of the *co-constructed* therapeutic frame; two subjectivities meeting in the consulting room, each with their own histories and patterns of managing self in relation to others. I find a cognitive analytic approach the most useful in this regard.

Most therapists are neither excellent nor harmful, but have a mix of outcomes. Only a minority are psychotoxic, with fake qualifications, lack of training, narcissism, psychopathy, sexual abuse,

financial abuse, emotional abuse, rigidity, lack of emotional intelligence or mentalisation capacity, and gross boundary violations.

However, I shall argue that the toxic few are not the main issue. I draw on evidence about clients' common experiences of harmful therapy, differences between therapists, therapist errors, inappropriate therapy choice, misdiagnosis, unresolved alliance ruptures, and what is known about the people most vulnerable to the risk of harm from therapy. From the therapist's perspective, I shall argue that there are clear limitations of therapist training and skill, and errors are inevitable. It is a natural defence to minimise and avoid discussion of our errors rather than accept them as a normal part of professional practice. A risk-averse, punitive system is not going to help, indeed it encourages defensive, secretive practice. Understanding the common causes of harm, creating a compassionate narrative and putting systems in place to mitigate risk is more useful. Therapy is undertaken within a systemic context – a private practice, a professional ethics framework, a public sector mental health service. These systems are powerful influences on the extent to which potentially harmful practice can be detected and prevented. I make five recommendations for safer practice at the individual, professional and organisational levels.

BIOGRAPHY

Glenys Parry is a clinical psychologist and Emeritus Professor at the University of Sheffield. She practises cognitive analytic therapy in a not-for-profit group practice in Sheffield.

She worked in the NHS from 1974 to 2011, where her roles included Consultant Psychologist and Psychotherapist, Director of Psychology Services, and Director of R&D. She has also been responsible for psychology and psychotherapy policy at the Department of Health (1992-1996) and has contributed to clinical guideline development at NICE. Professionally she is a Fellow of the British Psychological Society, MB Shapiro award holder, founder member of the Association for Cognitive Analytic Therapy and past Vice-President of the British Association for Counselling and Psychotherapy. As Professor of Psychological Therapies at the University of Sheffield (School of Health & Related Research 2002-2016), she conducted randomised trials, systematic reviews, qualitative research and service evaluations in a range of topics including the impact of life events and social support on depression, cognitive behaviour therapy for panic fear in asthma, health status of Gypsies and Travellers, therapist competence in cognitive analytic therapy, IAPT services, computerised CBT, care pathways in persistent depression and borderline personality disorder. Her project 'Understanding and Preventing Adverse Effects of Psychological Therapies' was funded by the UK NIHR Research for Patient Benefit programme.