

The Possible Harmful ‘Side-Effects’ of Psychotherapy¹

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Abstract:

This article developed out of a series of posts on ResearchGate and an attempt to explore this very important topic further. Some of the more seminal articles on the topic were examined, but also the thoughts of some of the 45+ posts over the last year from various participants in the ResearchGate listing have been included, along with the author’s own perception and experience. There are some suggestions as a conclusion.

Key Words: Client deterioration, harm, side-effects, psychotherapy, transference.

Introduction

The stimulus for an article comes from many different sources. I indifferently follow many internet discussions or ‘posts’ on Linked-In, Research-Gate, etc. What I like about these ‘posts’ is their spontaneity, their informal and international flavour, and the surprising depth of knowledge and information that can emerge from them.

This particular topic recently caught my attention, as I have been writing a lot recently about the Core Competencies of a European psychotherapist (www.psychotherapy-competency.eu) and, as a result, I am also thinking quite a lot about the other side of the coin, so to speak: ‘contra-indications’, ‘side effects’, ‘mistakes’, ‘incompetence’, etc.

The initial question or response that often arises, fairly immediately, fairly unfortunately and/or fairly defensively, when we consider the possible ‘side-effects of psychotherapy in any public face-to-face arena (like a conference) is, “What do you mean? There are side-effects from certain medications, but not really from psychotherapy: it’s just two people talking.” But this perspective is somewhat naïve and actually can be quite wrong.

Until quite recently, psychologists and psychotherapists have paid relatively little attention to the possible hazards of their treatments, but it is obviously an important subject, not just to protect clients, but also to protect our practice and integrity. However, further research is needed to bring greater understanding of the mechanisms of client deterioration in psychotherapy.

There is a completely understandable (to the therapist) process in psychotherapy whereby many clients go through a period of feeling worse as their old habits are replaced with new

¹ The status of this article is that currently (in March 2013), it is in a draft form. Other opinions and contributions are welcome, especially via the ResearchGate post.

strategies and ways of thinking: “Old habits die hard!” This process can temporarily heighten anxiety and insecurity, increase the number of negative thoughts, feelings of confusion or even helplessness and hopelessness, as well as more negative emotions before the client’s process stabilizes or integrates around the newer patterns of behaviour, positive experiences, etc. “Things seem worse before they get better!” However, the clients don’t always realise this, understand this or want this. They may have to be ‘nursed’ through this process.

‘Harm’ can and actually does happen in psychotherapy

Apparently, what research that there is shows that up to about 10% of clients become worse following psychotherapy. (Lilienfeld, 2011) and this is about where any general consensus (about potentially harmful effects in psychotherapy) stops.

Lilienfeld lists several multi-dimensional forms of harm, including “symptom worsening, the appearance of new symptoms, heightened concern regarding extant symptoms, excessive dependency on therapists, reluctance to seek further treatment, and even physical harm, and he also includes harm to relatives and friends of clients (including false abuse allegations). This brings into question the whole issue of how we assess ‘harm’; and the need to consider any value judgments concerning appropriate goals in psychotherapy; the issue of short-term ‘harm’ v. long-term benefits (and he mentions examples like increased anxiety over the confrontation of previously avoided conflicts); and the improper administration of otherwise effective ‘treatments’. He also addresses the question of premature client termination (drop-outs).

A Netscape recording from Wolfgang Fleischhacker (2012), from the Medical University of Innsbruck, Austria, lists a series of adverse elements, “These may include undue stress and potential overstimulation. Both of these issues may contribute to the potential for symptom exacerbation. In addition, there have been increased reports of family conflicts, with aggressive or suicidal behavior in people undergoing various psychotherapeutic interventions.”

One ResearchGate ² correspondent, Dale Pietrzak, suggested that the risk of, or concern about, client dependence, in part, drove the development of the brief therapies movement, though I am not so sure about this as I use a form of brief therapy (average 6 – 8 sessions) but I spread it out, with sessions at 2 – 3 week intervals, as being the most effective way of giving therapy within the limited resources of the NHS. I am quite proactive within this structure, and give handouts and ‘homework’: most clients seem quite happy with this relatively empowering form of psychotherapy or counselling.

² ResearchGate post: “What are the side effects of psychotherapy of whatever modality?” (started May 28, 2012): www.researchgate.net/post/What_are_the_side_effects_of_Psychotherapy_of_whatever_modality?

Barlow (2010) gives a couple of examples where psychotherapy seems to have negative effects (one with “critical incident stress debriefing” where he recommends a closer examination of the data; and another example with negative effects in the use of techniques to combat panic disorder when used in different situations) concludes that, “the study of negative effects – whether due to techniques, client variables, therapist variables, or some combination of these – has not been accorded the same degree of attention”: some of these effects are actually quite difficult to find (summarized by Grohol, 2010). There is also a possible negative publication bias, in that reports of negative effects are often less readily acceptable for publication.

Ghraiba (2006) differentiates between “adverse effects” or “side effects” and “iatrogenic disorders” on the other, where the side-effects don’t disappear, emphasizing their chronicity, if not their permanence. He also lightly explores issues of natural dependency (as when seeking help); false memories; worsening symptoms and regression; indoctrination; superficial insight; acquiring new symptoms and/or dysfunctional behaviors; dissociative identity disorders and iatrogenic malingering, all as negative side-effects.

Linden (2012) describes 'unwanted events', 'treatment-emergent reactions', 'adverse treatment reactions', 'malpractice reactions', 'treatment non-response', 'deterioration of illness', 'therapeutic risks' and 'contraindications' and proposes a checklist, the ‘unwanted event to adverse treatment reaction’ (UE-ATR). Castonguay et al. (2010) encourages trainees to examine carefully the potentially harmful treatments of psychotherapy.

What we might mean by ‘harm’ or, more specifically, ‘side-effects’ are unintended, (possibly) adverse reactions, and – as we have seen – there are plenty of those. They also fill much of the content of our supervision sessions.

If psychotherapy is reasonably effective, and there are intended successful outcomes (relief of symptoms, increased well-being, greater sense of autonomy, improved self-esteem, better relationships with family and friends, improved attitudes to, or relationships at, work, etc.) then – de facto – psychotherapy will also have some unintended reactions or adverse (or even harmful) effects for some people as well.

And it is here where opinions start to differ widely and also opinions differ from theory or research to practice. If there are potential harmful side-effects, are we not obligated, as professional practitioners, to point this out to people prior to or at the onset of psychotherapy. From a slightly contradictory perspective, there is the old paradigm, “No gain without pain,” or as one correspondent in the recent discussion on ResearchGate writes: things have to get 'worse' symptomatically (or to become more dysregulated in Allan Schore's terms) before they get symptomatically 'better' (or more attuned and regulated). But – perhaps significantly – we don’t

tell the clients this. We might even assume that this is understood, in which case we are on very shaky ground. George Kalasz (Monash University) continues:

A clumsy comparison with surgery is the need for surgeons to cut into the healthy flesh to access the dysfunctional organ. The flesh was healthy enough but in the way, preventing the repair process necessary. So, crudely put, if we see psychological resistances and defences - and if we do not, then what are we doing in therapy - we should be very careful to advance lest the process harms more than it repairs. So, a side effect can be measured only against the intended outcome - it is not a symptomatic 'fact' in my experience. Ethically this is summed up in the principle to first do no harm, yet surgeons do inflict injury in a greater cause.

Again, perhaps unfortunately, here is another reference to the “medical model”, but not without some value. However, I think I would have to disagree with the point that a ‘side-effect’ can only be measured against an intended outcome.

Another correspondent (Henry Stein) alludes to the point that significant beneficial changes in one’s personal and professional life can also be surprising – and potentially disruptive – not only to the person (in therapy), but to the people around him or her. Whilst Lilienfeld mentions (false) accusations of abuse as a harmful side-effect, substantive accusations are equally harmful to the family structure, though it may be very beneficial to the individual concerned. Some of these changes are not technically side-effects according to our definition (whereby the client is directly and adversely affected), but this point also relates to an early awareness that I had about psychotherapy, especially when the client is in a significant relationship.

That person, the client, may have entered into that relationship many years ago, for a variety of reasons (to have children, because they were ‘in love’, or to work together, etc.). They then find – much later – that they have become unhappy, frustrated, miserable, stressed, etc. and so enter therapy. It is often the case that – rightly or wrongly – the other person in the relationship is blamed for their distress, and the ‘side-effect’ of the therapy is therefore that the relationship then starts to break down. In the best-case scenario, the client realizes that the relationship is now not fulfilling its original purpose, or that purpose has long since been filled, and that they have stayed (or have become ‘stuck’) in an increasingly dysfunctional relationship: that a “parting of the ways” is perhaps overdue, or the relationship can be re-structured somehow. Hopefully, the other partner can come to this realization as well, and the separation (or re-structuring) can be amicable, so that the “side-effects” – whilst significant, are not necessarily harmful.

I have had several clients where this scenario has been played out, in various ways, with varying degrees of ‘success’, pain, or, sometimes, fairly extreme reactions from the “third party” involved. In such a case, the psychotherapist must – of course – be very careful not to influence their client unduly, and supervision is nearly always appropriate. But, if the therapist is fairly clear

that this was not necessarily an ‘agenda item’ for the client on entry into therapy, but a development of the client’s realization – as they explored their deeper (and often hidden) feelings – and that the relationship was no longer a happy one for them, then the dissolution of the relationship is an unintended ‘result’ of their personal exploration and development – i.e. a ‘side-effect’.

In my experience, there have also been several clients, who have come – or been referred to therapy because of anxiety and/or depression, and who have realized, through the awareness and agency of the therapist, that their partner is (perhaps) ‘lacking’ in some way and thus the actual ‘cause’ of their distress. The continual reference to the other person and to what they have or haven’t done, and the lack of any obvious symptoms from within the client (other than a possible dependency, and a degree frustration or distress), can lead to a ‘diagnosis’ of a defect or personality disorder in their partner.

In such cases, I am very careful not to diagnose the partner (who I have never met), but perhaps it is appropriate to offer the client, when they are speaking about their partner, a set of anonymised ‘symptoms’ for (say) Narcissistic Personality Disorder, taken from DSM-IV or something similar, and say, “When you describe your partner, are you meaning something like this?” If the answer is affirmative, then this can complement the therapy in that the client can now see that – possibly – they are not the person with the problem, a fact that has been often denied in their interactions with their partner. Whether or not they decide to separate, or argue back (both possible side-effects), is relatively immaterial to the therapy, this sort-of ‘diagnosis’ of the Other has helped them to find themselves in that they have a clearer picture of themselves, or find a better ‘ground’ on which to stand. Exploring or exposing the relationship dynamic, of course, has risks. As a therapist, it is up to me to minimize these, hence the use of supervision and using standard authorities, rather than entering into a (false) position or collusion with the client.

Some therapies (gestalt, psychodrama, etc.) try to bring the ‘other’ person into the room (so to speak) so that some of the difficulties can be explored, and possible new ways of relating can be ‘acted out’ in relative safety. But this will also, inevitably change the actual relationship dynamic. At such choice points in therapy, when we are moving from the intra-personal dynamic to the interpersonal, I usually try to remember to mention this sort of ‘risk’, as a form of *caveat*, and also give the client the option of not ‘opening the box’ or the “can of worms”. They usually decide to continue, but I have, at least, taken the opportunity to check it out.

Another correspondent (Bob Rennebohm) comments that, “When we engage clients in a transformative, or a second order change process, we don't always know what is on the other side. It is pretty hard to list "side effects" or even all of the possible outcomes in order to create

optimum circumstances for informed consent.” Whilst this is very true, when entering into therapy – like with a major operation – we can sign a consent form, but we do not expect, nor should we expect, some of the possible outcomes (a drunk, tired or incompetent surgeon; a hospital infection; etc.). There is – and should be – a presumption of competence and thus a reasonable reduction in any possibly harmful side-effects. He continues in a later post:

I have worked with clients that have experienced pain within our work and would have been happy to think of this as a side-effect. As a very left-brain dominant, thought-organized therapist, in the early part of my career I might have been tempted to agree with them and, when searching for my own solutions, I was most pleased with concepts that de-emphasized the relational aspects of our work or of the discussion of "side-effects". Nothing we do as therapists can ever be sufficiently mechanical to treat the client's concern about side-effects as an inquiry that needs an information-based answer without an emotionally-based relational answer as well. And besides, how many clients can really grasp the statistical notions underlying the process of creation of side-effect lists sufficiently to not be concerned that such a discussion with a suggestible client might create a side-effects process?

Another posted comment (from Rein Heinsalu, Tallinn University) raises the point that:

Any therapy is a kind of tool in the personal development of client. Any tool when used unskillfully or inefficiently can have side-effects. So, a more precise question should be - what are the possible side-effects of tools [and] in which situation? It's a question of wisdom (and professionalism) [that comes] of using any methods. Like kung fu (meaning "skill" in Chinese), you should be very skillful to choose the methods, applications and [in] foreseeing possible side-effects. You can have harm from any application misused.

This takes us well beyond the ‘science’ and much towards the ‘craft’ concept of psychotherapy, which I have written about elsewhere (Young & Heller, 2000). This is also the area where the concept of competencies becomes quite relevant. But, I think that we need to go a bit further still.

We have, possibly all of us, experienced the situation of a client who comes for a couple of sessions and then drops out, never to be heard of again. Any follow-up contacts (letters or messages) are seemingly ignored. What might be going on here? It is possible to assume that the client might have got suddenly better, after just two sessions, and now does not want to waste their time with therapy any more; but this is an unlikely scenario. Much more likely is that the client didn't like your approach (best case), or that they actually felt worse after the sessions, and were perhaps too polite to mention this the first time, but decided not to waste any more of their money, time or energy after the second session, when they also felt worse.

One correspondent (Deirdre Price) commented that, “You tend not to find what you don't look for, or, looking for the unexpected is more difficult than looking for the expected.” But I think that the situation and the remedy should go deeper. Unless there is an effective form of client

feedback, possibly partially anonymised, or via a neutral body or patient association (or something), we will never know what has really been going on with these drop-outs (no offense meant): and, thus, not instituting some sort of regular follow-up study, can therefore be seen as a possible form of avoidance – an avoidance of the side-effects of ‘our’ therapy.

Many UK therapists (counsellors, clinical psychologists and psychotherapists) use something like CORE-IMS³, which does have some possibility for patient / client feed-back, but it is not specifically structured that way and it does not really permit the patient / client (herein after referred to as ‘client’) a ‘safe’ form of feed-back in that all the forms pass through and are submitted by the therapist. Some Employee Assistant Programmes (EAPs) offer a client feed-back form, with a stamped and addressed envelope to be posted direct to the EAP, i.e. so that the therapist doesn’t see it, and again, these forms may indicate some basic satisfaction or dissatisfaction, but they don’t always ask specifically about all (or any) possible ‘side-effects’. Until we ask, we won’t find out.

There are a number of issues about whether the ‘style’ of the therapy or counselling, or often the ‘modality’ concerned, is more or less effective. Research shows that consistently no one type of psychotherapy is more or less effective (the “Dodo Bird” verdict⁴), but within that there are numerous variations. Mike Jubb, a social worker in the NHS, commented that there is significance in the patient / clinician interaction that proceeds and diagnosis or treatment: “If clinicians really believed that the patient's behaviour is pathological, they might do well to review their own communication with patients and the psychology that lies behind that.”

I have had several clients comment voluntarily that they didn’t like a particular (different) form of psychotherapy or counselling, because ... and the various reasons chosen are interesting, but this is, of course, not scientific: however, I don’t think that I am alone in receiving such information. Sometimes, the clients have commented that they really liked my more proactive or interactive style (suitable for ‘brief’ counselling and psychotherapy in a GP practice) as they didn’t like it when the counsellor or psychotherapist just reflected back, or nodded and smiled but didn’t say much. Almost certainly, some other clients have left, after one or two sessions, without saying anything, because they didn’t like my proactive or interactive style; or my face, or the fact I was male and they felt more comfortable with a female therapist.

In the GP practices and the departments of Clinical Psychology in the Central Belt of Scotland that I have been working in for the last 8-9 years (and where I have been referred over

³ CORE-IMS: www.core-ims.co.uk

⁴ The **Dodo bird verdict** is a controversial phenomenon in psychology (viz: Rosenzweig, 1936; Luborsky et al, 1975; Lambert, 1992; Norcross, 1995; Wampold et al, 1997; Wampold et al, 2009), which states that all psychotherapies, regardless of their specific components, produce essentially equivalent outcomes, though some psychotherapies have produced evidence to show greater efficacy for some conditions.

1,000 clients), I have built up a considerable database of information. In one of the GP practices, where they can only afford one counsellor (me: a large, white, older, male), we try to overcome this bias by having other counsellors on placements, as a part of their training, and making sure that there are female counsellors (some of them younger and from different ethnic backgrounds), so as to offer the potential client some choice. This seems to produce reasonable satisfaction, but any substantive evidence isn't available.

Some clients ask, or are referred specifically, for Cognitive Behaviour Therapy (CBT). It is sometimes difficult to know whether this is because this is the only one they have heard of, or the one that has been recommended. Some report that CBT (if they have experienced it before) was too intellectual or cognitive or technical (“just filling in boxes”), and didn't address their underlying, and sometimes powerful, emotions. Others report that previously experienced psychodynamic or psychoanalytical work was too impersonal, or drawn out, or interpretive, or irrelevant, ... and so they have come 'here'. The experienced 'side-effects' of these other psychotherapies bring them into the here-and-now, with – perhaps – a greater commitment to whatever form of psychotherapy they will get in the present: but there are no guarantees, and about 12% disengage after 2 or less sessions, often with some cancellations or DNAs, so that it is difficult to tell whether the problem is their commitment, or the style of therapy on offer. Another correspondent on the ResearchGate post (Mary Cullen-Drill) writes:

I'd say when there is a mismatch between the theoretical approach used by the therapist and the specific personality and psychological needs of the patient the outcomes may be adverse. Also, another area that can lead to adverse outcomes is the counter-transference reactions of the therapist. If the CT reactions are not adequately acknowledged and processed the result can be "acting out" on the part of the therapist, which can have adverse effects on the treatment. Also, regardless of theoretical approach, a basic understanding of transference and CT is very important and, if this is lacking, the risk of adverse effects of the treatment increase.

However, this point of “mismatch” is countered by the next correspondent, Lucio Sabilia, who tellingly states that, “A deterioration or a worse outcome is more likely if not immediately acknowledged by a therapist, or attributed to unconscious factors, rather than used as a possible marker of a therapeutic mistake to correct.” So, negative 'side-effects' can possibly be corrected, if this is done quickly and appropriately: indeed, sometimes there can sometimes even be a beneficial outcome, if the acknowledgement creates better understanding, greater empathy or rapport, and further growth and development in either the client, the therapist or (hopefully) both.

Sometimes, after describing or 'talking about' a difficult (often very emotional) situation, which can often happen in the first one or two sessions as the client outlines their problems, but which sometimes happens before the therapeutic relationship is strong enough to 'contain' and

then help to ‘process’ these difficult feelings – so this form of ‘revisiting’ the problem can make the client feel worse, and headaches, anxiety, pain and anger, or another bout of crying and despair, or worse (self-harm, etc.) can follow the session: this ‘cycling’ in and out of difficult emotional (or life) problems actually can “make one feel worse” and thus the (often long-held) resistances and the repression of (negative) emotions can kick back in before any resolution can be achieved. This is a very difficult situation, particularly as it often occurs before the therapy has properly started. Psychotherapists may need to keep the client’s emotional content well-handled and contained in the initial stages of therapy.

However, effective therapy is often a therapy that focuses on helping the clients to experience and comprehend their emotional processes through, both the communication of an intellectual framework for understanding emotional, and the direct experience of (often long-repressed) emotions in the psychotherapy: “Recent research has shown that a common earlier view, that emotion is post cognitive, is inadequate. Emotion can and often does precede cognition, but, more importantly, it makes an integral contribution to information processing in its own right.” (Greenberg, 2004, p. 3-4: cited references omitted) It is therefore often necessary to help the client through this difficult phase.

Of course, the type of interactions, and not just the initial ones, between the therapist and client are crucial. Jaime Yasky comments on this point:

The problem is that the ‘side-effects of psychotherapy are specific to the psychopathological condition of the patient and to the specific fit between patient and therapist, so aside from issuing probabilistic warnings, I think the challenge in the assessment or initial stage of a treatment is to discern the expectations and psychological condition of the patient (defensive equilibrium, transference potential, pathological tendencies), discern our own disposition to the patient (counter-transference) and tailor a response in terms of potential benefits and risks of therapeutic process.

The analytical perspective

In 1923, Freud, wrote about this topic and described the “negative therapeutic reaction”, which apparently often occurs after the psychoanalysis has brought some progress and there is then a somewhat paradoxical reaction. A good description of this occur in Horney (1936, 1999), where she states:

What Freud called the “negative therapeutic reaction” is not, indiscriminately, every deterioration of the patient’s condition; but the fact that the patient may show an increase in symptoms, become discouraged, or wish to break of treatment immediately following an encouragement or a real elucidation of some problem, at a time, that is to say, when might reasonably expect him to feel relief. In fact, the patient very often actually feels this relief distinctly, and then after a short while reacts as described.

Freud considers this reaction indicative of a bad prognosis in the particular case, and, as it is a frequent occurrence, a serious barrier to therapeutic endeavors in general. ... In principle, this sequence of reactions is invariably present: first, a definite relief, then a shrinking back from the prospect of improvement, discouragement, doubts, hopelessness, wishes to break off ... [sometimes] with intense hostility. (1999, p. 60-61)

Now, Freud linked this negative reaction (the attitude of spite and the impulse to show superiority to the therapist) to a superficial reaction (an example of what Frigenbaum calls a “by-product”) and the real unconscious dynamics are in a great tension between the superego and the ego resulting in a sense of guilt-iness and a need for punishment in order to protect the superego. He therefore considered it a resistance.

Horney considered it slightly differently, as an aspect of the masochistic character, and not just a resistance against a ‘good’ insight or partial solution of difficulties. She feels that – when experiencing the positive change, the patients “receive a good interpretation as a stimulus to compete, as if the analyst, by seeing something they had not seen, is proved more intelligent, clearer-sighted, or more articulate than the patient” (p. 62) – the patient then feels inferior to the analyst and expresses his (or her) resentment in a number of different ways. This can also be seen as “deterioration” within the psychodynamic psychotherapies,

This might be so – a resistance against change, wrapped up in some transference process. It is possible that the progress of the analysis leads to a new ‘nicer’ view of oneself; this sets up an internal conflict with the ‘old’ (nastier) view of the self. The internal conflict then rages and, as a result, we feel “worse”. But there are apparently lots of risks when interpreting transference and a marked deterioration in the therapeutic alliance is one of these (Bond, et al. 1998, quoted by Lemma, 2008).

But a lot of the discussion (immediately above) happens within the context of an on-going psychoanalysis. It is clear (as Mike Ware comments) “...that the recognition and management of counter-transference would be a critical factor in terms of outcome no matter what form of psychotherapy is involved.” His next comments however take us into a slightly different perspective:

Recent outcome research by Norcross 2003, determined that empathy was the single most important factor in relation to successful outcomes. I believe genuineness and collaboration followed as the second and third most important factors. Truly understanding, and communicating that understanding, of the client's co-determined experience of relational disruptions or disjunctions and relative identifications or conjunctions, (even those not consciously recognized) would certainly appear to be the critical factor in minimizing client side-effects.

I think it is likely that more structured approaches to therapy such as exposure and other directed activities would be disruptive if the client is not capable in terms of

reflective function of experiencing the interventions empathically. An untimely relived traumatic experience could be simply re-traumatizing: a direct challenge to one's perception might be painfully humiliating.

What I have found most striking ... [is] ... that research has not identified a single therapist who was effective in every clinical domain. If this finding stands up, none of us can think of ourselves as basically empathic for all clients. Every therapist studied was effective with certain clients and harmful to others. Interesting in light of the finding that most of us think we are above average therapists.

At the very least, the findings suggest that we must look even closer at our experience of each client, and each type of client, and our impact on a moment-to-moment and long-term basis.

Although I consider myself a relational psychoanalytic therapist, the other more generally known finding that all approaches are essentially equal in terms of outcome suggests not only the importance of the relationship/empathy but possibly the need for a meaningful integration of the contribution of each reputable approach in addition to the relationship component.

A Cambridge correspondent, Isabel Smith, provides a fundamentally telling point:

I think the possibility of both harm AND of benefit to a patient extends well beyond the prescription of 'medication' or 'therapy' per se. It exists within the framework of the consultation itself, regardless of whether that is medically or psychologically based. The ways in which people (client / patient / therapist / doctor) relate underpin this possibility. The attitudes, feelings and opinions of both parties in such a relationship (and the communication of these, both consciously and unconsciously) provide a backdrop, which is extremely powerful and cannot be neglected in any consideration of whether a certain treatment is helpful or harmful.

Another correspondent, David Johnson, makes a telling point when he considers a (hypothetical) real-life situation, similar to some that I have encountered in working with EAP programme (work-based counselling) clients. He says:

There are also side effects that might be perceived as positive, even intended by the therapist. Say, for example, a client is concerned about the client's performance at work, as evidenced by verbal abuse [from their] the boss. Understanding that the boss's behavior is inappropriate, and that the client's rights may have been violated, fundamentally alters the client's relationship with the boss and their job. While some might argue the change is for the client's benefit, I will remind them that the client is the person who decides that. Imposing the therapist's values on the client can be one of the most grievous forms of counter-transference. Therefore, it is critical that the therapist monitors the process to ensure that the client has informed consent about the risks of bringing the work relationships into therapy. Informed consent is an on-going process, requiring insight and vigilance by the therapist. It's also an important reason that therapists need on-going peer consultation.

We are now, in effect, beginning to move away from the identification of possible 'side-effects' towards considering some remedies for the situation. Jeremy Halstead, a well-known UK researcher in psychotherapy, picks up on this point (without the psychoanalytical content) and writes:

The implication is that, when we talk about "side-effects" of psychotherapy, we need to redefine side-effect for the new situation. I think broadly we could say that, in psychotherapy, we seek certain effects that fit in with our concepts of psychopathology and our ideas of what a particular psychotherapy is supposed to do. The "sought effects" are mainly likely to include a lessening of symptoms, but this would not always be the case. For example, a therapy that aimed to help someone by bringing painful memories into awareness might cause the person to become more distressed (show more symptoms). In this case, the effects are not really side-effects because they are part of the way that the therapy is supposed to work.

If, however, we looked at the same therapy from a more general perspective and asked the question, "Is this therapy making the person feel better?" the answer would be "No, at this point in time the therapy has made the person feel worse". Furthermore if the person left therapy at that point and continued to feel bad, we could say that this therapy with this person, produced an increase in symptoms, thus a side-effect. 'Side', in this context, means "other than intended" and so can include positive as well as negative unintended responses. Researching into psychotherapy that specifies intended responses and also systematically records unforeseen or unintended responses will be valuable for the theory and practice of psychotherapy, as well as a more thorough understanding of its effectiveness.

I use a small (1-page) information sheet about counselling in the GP surgery, which describes what counselling is, and what it is good for. and what conditions are not suitable (for which there are local specialist services). Dale Pietrzak (University of South Dakota) suggests that the 'risks' of psychotherapy should be mentioned in standard disclosure statements, common in systemic psychotherapies.

Conclusion

It seems that there are probably no ways of avoiding all harmful 'side-effects', but the negative effects of these can perhaps be ameliorated by awareness and on-going vigilance, by supervision and peer-consultation, and by giving out appropriate information to clients. There may also be opportunities to turn 'harmful' side-effects into more positive ones within the therapeutic relationship and the process of psychotherapy – if it can be maintained.

But, obviously, more research is needed, especially into how to get much more specific and detailed feedback from clients who 'drop-out' of therapy early or suddenly: we really need to know why, so as to improve our practice – and, as a profession, we need to find ways to get this information.

We may also need to (legally, ethically) inform our clients much better about the potential 'risks' of psychotherapy: to themselves, but also to those around them. This can be rather like the maxim "Know Thyself" that was supposedly carved above the entrance to the Delphic Oracle. Maybe there should be a form of warning – a plaque – on every psychotherapist's door, "Psychotherapy Might Change Your Life."

Author

Courtenay Young is a UK-based psychotherapist who works both in the NHS and privately in and around Edinburgh. He is already the author of a couple of articles on this topic, one about the risks inherent in Body Psychotherapy and one about the shadow aspects and taboos within various psychotherapy modalities (as yet unpublished). He is also the author of many articles and several books, as well as being the Editor of the International Journal of Psychotherapy. For the last 3 years he has been the lead writer in the Working Group on a project by the European Association of Psychotherapy to Establish the Professional Competencies of a European Psychotherapist (www.psychotherapy-competency.eu). His articles and books are available through his website: www.courtenay-young.com.

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