When Cognitive Behavioural Therapy for Obsessive Compulsive Disorder Fails: Service User Perspectives

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Abstract

Background: Cognitive Behavioural Therapy (CBT) is an effective psychological treatment for Obsessive Compulsive Disorder (OCD), but not all service users' benefit from treatment. The factors involved in non-optimal response have been largely examined from the perspective of therapists. The current study explored the reasons for treatment failure from the perspective of service users.

Method: Twelve participants were recruited, six with OCD and six with Panic Disorder (PD), with the latter being included as a comparison group. All participants had undertaken ≥ 2 unsuccessful courses of CBT. The Treatment History Questionnaire (THQ) was used to determine the adequacy of participants' previous treatment. Qualitative interviews were conducted, and reflexive thematic analysis was used to analyse interview data.

Results: The THQ indicated that most participants had undertaken a technically adequate previous course of CBT, meaning that inadequate therapy was unlikely to be the sole reason for treatment failure in the study sample. The qualitative findings indicated three overarching themes capturing participants' experiences of treatment and its failure: 1) Invalidating and Disempowering Experiences; 2) Factors Relevant to Formulation and Socialisation; and 3) Wider Barriers to Recovery. The first two themes were shared by both OCD and PD participants and the third was specific to OCD.

Conclusion: The majority of factors underpinning therapy failure related to the therapeutic interaction and were pertinent to both participants with OCD and PD. In addition, OCD participants described a wider set of socio-contextual obstacles to their benefitting from treatment. Clinical implications are discussed.

Key words: Obsessive Compulsive Disorder, OCD, Cognitive Behavioural Therapy, CBT, Exposure and Response Prevention, ERP, Treatment failure.

Introduction

Cognitive Behavioural Therapy (CBT) that includes Exposure and Response Prevention (ERP) is the psychological treatment of choice for Obsessive Compulsive Disorder (OCD) (Katzman et al., 2014; Koran & Simpson, 2013; NICE, 2005, 2018). It has a robust evidence-base and has been shown to be efficacious in both randomised control and pragmatic trials (Öst et al., 2015). Nonetheless, of those who receive this intervention, only 40-52% experience full remission (Farris et al., 2013). Potential reasons for this have been cited to include, finding it too difficult to fully engage with CBT, or discontinuation before therapeutic gains have been made (Abramowitz, 2006; Eddy et al., 2005; Whittal et al., 2008).

For service users who have been offered CBT, but have found it unacceptable or of minimal benefit, it is important to investigate the reasons for this. Rachman (1983) proposed a framework for examining treatment non-response that comprised two categories of explanation: ‘serious treatment failures’ and ‘technical treatment failures’. Serious treatment failures refer to instances in which the service user fails to respond despite the treatment and its delivery being at least ‘adequate’ (Rachman, 1983); whereas technical treatment failures are instances in which the service user fails to respond because the treatment is fundamentally inadequate or the therapist does not adequately deliver the treatment (Rachman, 1983). For example, the therapist may claim they are offering CBT, but in practice the therapy may not include key therapeutic components (e.g. they may not accompany the service user to contexts where symptoms are prominent, as required to support and generalise the effects of ERP).

When exploring reasons for ‘serious treatment failures’, patient characteristics have been examined as predictors of non-optimal response. Characteristics identified include comorbidity, particularly in the form of severe concurrent depression, as well as reduced insight or overvalued ideation (Foa, 1979; Foa et al., 1999; Steketee et al., 2001; Veale, 2002). Symptom severity and type of OCD symptoms have been shown to predict poorer treatment

response in some studies; however, in other studies this has not been evidenced (Lomax et al., 2009; Mataix-Cols et al., 2002). VanDyke and Pollard (2005) suggest that the presence of ‘treatment interfering behaviours’ (TIB) may be associated with non-optimal response. Pollard (2006) defines TIBs as “any behaviour the therapist believes is incompatible with effective participation in therapy or the pursuit of recovery” (Pollard, 2006, p 62). Pollard (2006) suggests that patients’ readiness for therapy should be addressed, which may include working with the patient on any beliefs that may not be conducive to working collaboratively in therapy, on identified ‘skills deficits’ or ‘emotional dysregulation’, or on difficulties with ‘incentive or motivation’ (Pollard, 2006). However, almost by definition, sufferers may exhibit many TIBs at the start of therapy. It is therefore important that this formulation does not result in transferring responsibility for treatment failures to patients.

Determining the proportion of patients who fall into technical treatment failures is challenging in the context of psychological interventions, where a clear definition of what constitutes an ‘adequate’ version and ‘adequate’ delivery of treatment is not widely available or agreed upon. Stobie (2009) conducted a study with the aim of establishing a benchmark regarding the specific techniques that should be included in ‘adequate’ CBT for OCD. A panel of expert researchers and clinicians identified 19 aspects of therapy that should be included for CBT for OCD to be considered adequate. The study also identified 16 techniques that would not constitute CBT for OCD. The results of this study, in combination with the National Institute for Health and Care Excellence (NICE) (2005) guidance, provide a helpful benchmark for what constitutes adequate CBT for OCD. In light of this benchmark, research conducted at a specialist OCD treatment service in the UK found that only 16% of patients defined by referring services as ‘treatment refractory’ had been offered a technically adequate treatment when they first sought treatment for OCD (Stobie et al., 2007). This suggests that a substantial proportion of OCD treatment failures may fall into the ‘technical failure’ category.

To date, the research on non-optimal response to therapy has predominantly been undertaken from the perspective of the therapist, through a ‘serious treatment failures’ lens, and little is known about the perspective of the service user. In particular, no in-depth qualitative research has been conducted to examine the perceived reasons for treatment failure from the perspective of those with OCD who have experienced recurrent CBT treatment failures.

The purpose of the current study was to gain an in-depth understanding of why CBT has not worked from the perspective of service users who have experienced multiple treatment failures. We recruited individuals with OCD who had previously experienced ≥ 2 CBT treatment failures. In order to identify the extent to which any factors identified are specific to OCD as opposed to CBT in general, we also included a comparison group of participants with Panic Disorder (PD) who had similarly experienced multiple CBT failures. PD was chosen as a comparison group as research has shown that the level of impairment of individuals with PD prior to treatment is often similar to those of individuals with OCD (Quilty et al., 2003). All participants completed in-depth, qualitative interviews focused on their perceived reasons for previous therapeutic failures. In addition, to characterise the sample, we assessed the technical adequacy of previous CBT treatment experiences using a standard checklist. The specific aim of the current study was as follows:

1. To gain an in-depth understanding of the experience of CBT that has failed to help, from the service user’s perspective, including the reasons participants perceived their treatment had been unsuccessful.

Method

Design

The adequacy of participants' previous treatment was assessed via completing the self-report Treatment History Questionnaire (THQ). Qualitative interviews ($N = 12$) were chosen as the most suited method for exploring service users' experience of treatment failure (Edwards & Holland, 2013).

Participants and Recruitment

Participants were eligible for the study if they were ≥ 18 years, met diagnostic criteria (as specified by the Diagnostic and Statistical Manual of Mental Disorders 4th ed. (DSM-IV) APA, 1994) for either OCD or PD, identified either OCD or PD as their main problem, and reported having had ≥ 2 courses of CBT for this particular problem, which they perceived had been unsuccessful. One OCD participant was subsequently excluded, due to the participant reporting in the interview that their second course of CBT had been successful. A further participant with OCD was recruited. Purposive sampling techniques were used to recruit participants who self-identified as having either OCD or PD and had previously received treatment for this disorder (Robinson, 2014). Six participants were recruited via adverts placed on the website of a UK OCD charity and four via adverts placed on a forum of a UK anxiety charity. In addition, two PD participants were recruited via a research database from a specialist psychological treatment centre.

Measures

Structured Clinical Interview for Diagnostic and Statistical Manual of Mental Disorders (4th ed.) (SCID-IV) (First et al., 1996).

Participants were administered the OCD or PD relevant section of the SCID: a clinician administered diagnostic interview that is used to determine DSM-IV Axis I and Axis II disorders. The SCID is reported to have acceptable reliability and validity (First et al., 1996).

The Treatment History Questionnaire (THQ) (Stobie et al., 2007).

The THQ is a self-report measure that examines participant's reports of past therapies received, providing an assessment of their technical adequacy. The THQ collects information including participant demographics, course of the presenting problem, treatment sought, and information on previous treatment components. With respect to the latter, participants are presented with a list of different techniques, some of which are specific to CBT, whilst others are not, and are asked to tick which elements they recall being a part of their therapy. The THQ includes seven items that are designed to assess if the therapy received meets the minimum essential criteria to be defined as CBT (these items are presented in Table 1, items a. to g.). Participants must report that their therapy met all of the seven criteria for it to be deemed as CBT. The THQ also assesses 12 items which OCD experts regard as essential elements of CBT for OCD (Stobie, 2009). The THQ was originally designed to examine treatment histories of participants with OCD and was therefore adapted for the current study to be applicable for participants with PD by changing the disorder specific information and one of the adequacy criteria¹ (Table 1).

¹ In Panic Disorder a minimum of seven therapy session should be offered (NICE, 2011).

Table 1.

Minimum criteria used to determine therapy as CBT and the 12 items regarded as essential elements of CBT for OCD.

Minimal CBT criteria	
a.	Six or more sessions
b.	Sessions lasted for 40 minutes or more
c.	Exposure (self/ guided) must have taken place at some point during the sessions
d.	Homework must have been given during the sessions
e.	The main emphasis of the sessions must have been on the obsessional/panic problem
f.	The main focus of the sessions must not have been on childhood
g.	The therapist was not silent for most of the sessions
Items specific to CBT for OCD (1-12)	Modified for PD
1. Requesting your patient to go into situations on their own outside of the therapy room to face whatever they are afraid of	N/A
2. Changing the meaning attached to the thoughts	N/A
3. Setting homework exercises to do between sessions	N/A
4. Looking at links between thoughts, feelings, and behaviours	N/A
5. Drawing a diagram explaining the problem, which includes links between thoughts, feelings, and behaviours	N/A
6. Requesting your patient to deliberately expose themselves to frightening thoughts or things in your office	N/A
7. Concentrating on your patient's beliefs most sessions	N/A
8. Therapy sessions should last at least 45 minutes each	N/A
9. Going with your patient outside the therapy room to assist them in facing their fears	N/A
10. Setting the patient reading about the obsessional problem	N/A
11. Asking the patient to keep records of thoughts	N/A
12. Offering at least 10 sessions	At least 7 sessions

N/A = no change was made to these criteria as it was deemed to be applicable to CBT for PD. *Note.* Items 1 to 12 are listed in order of experts' mean rating of essentialness from highest to lowest.

Qualitative Interview²

A semi-structured interview was developed by two clinical psychologists (JM & PM) who work at a national centre of excellence for the treatment of OCD, and a service user with experience of CBT for OCD. Questions were designed to be a starting point for discussion (Forrester & Sullivan, 2018). Primarily, participants were asked to talk about their experience of their most recent course of CBT that had been unsuccessful, including the factors they perceived had influenced the outcome of their therapy. Following this, participants were asked to focus on the second most recent course of CBT they had undertaken and to discuss if they perceived there to be differences as to why it had been unsuccessful. The semi-structured interview was piloted twice, once each with a person with personal experience of OCD and PD. In response to the pilot interview feedback the questions and their order were modified, and optional prompts were added. During the interview the researcher encouraged participants to elaborate on their answers, provided prompts and sought clarification where necessary. Participants were invited to ask questions throughout the interview and on its conclusion.

Procedure

Ethical approval was granted by the NHS Research Committee (Re: 11/SW/0039). Individuals who contacted the lead researcher to express an interest in participating were contacted by phone to discuss the study and assess their eligibility to take part. If they met inclusion criteria, they were sent an information sheet, consent form and disorder specific copy of the THQ in the post. Participants provided informed consent and a time for the interview was scheduled. Individual, face-to-face interviews were conducted at the University of Bath and lasted approximately one hour (range 30-120 minutes). Interviews were recorded using a digital voice recorder and were transcribed orthographically, with identifying information

² The semi-structured interview schedule is available from the corresponding author on request.

removed and pseudonyms inserted. If participants requested further support, they were signposted to appropriate resources.

Data analytic strategy

The data set comprised of 12 completed THQs and 12 transcribed interviews. Descriptive statistics were used to summarise the data obtained from the THQ, including the clinical characteristics of the sample and the assessment of reports of previous CBT.

The interview transcripts were analysed using reflexive thematic analysis (RTA), as described by Braun and Clarke (2006, 2013). RTA is a flexible method which is well suited to exploring people's experiences and how they make sense of them. RTA was chosen to enable patterns and themes to be derived from the data. The recommended six phase process was followed. The first author familiarised themselves with the data via transcription of the interviews and reading of the interview transcripts. The transcripts were then systematically coded. The data were approached from a critical realist perspective, which assumes that the data represent a valid report of the participant's reality, explained by the way in which the participant talks about their experiences and the meaning this has for them. The analysis was conducted by the first author, a clinical psychologist experienced in the treatment of both OCD and PD. An inductive approach was utilised, meaning that the data were the starting point for analysis rather than applying pre-existing theory to the data. However, it should be noted that the author's CBT orientation, clinical and academic knowledge is likely to have influenced the analysis and therefore to some extent a deductive approach is incorporated. Semantic and latent codes were identified. Codes were then arranged utilising a thematic map to identify initial candidate themes. A second clinical psychologist with comparable experience reviewed three transcripts from each disorder specific group. The second reviewer initially read through the transcripts and made notes on potential codes and then themes. Following this, they were provided with the theme structure that had been developed and were asked to comment on the themes and

associated interpretations. The second reviewer suggested three changes to themes which were further discussed, with two changes being made. A thematic map displaying the themes was developed for each disorder. The two thematic maps were compared to examine where the similarities and differences between the two disorder specific groups existed. The results from both groups were then merged to create one thematic map representing the findings from both groups. The first author then met with the co-authors to present the thematic map and to discuss and review both the thematic map and corresponding data. This review led to the merging of several smaller subthemes and the titles of overarching themes being refined.

Results

Participants

To contextualise the sample a demographic summary of participants' characteristics and treatment history is presented in Table 2.

Table 2.

Participant characteristics and treatment history

Demographics		OCD	PD
		<i>N</i> (%)	<i>N</i> (%)
Gender	Male	2 (33.3)	4 (66.6)
	Female	4 (66.6)	2 (33.3)
Ethnicity	White	6 (100)	6 (100)
Education	High school completed	2 (33.3)	1 (16.6)
	Diploma	2 (33.3)	3(33.3)
	Undergraduate degree	1 (16.6)	2 (33.3)
	Postgraduate degree	1 (16.6)	-
Employment	Unable to work due to OCD/PD	2 (33.3)	2(33.3)
	Employed part time	2 (33.3)	1(16.6)
	Employed full time	1 (16.6)	3 (50)
	Other (carer, retired)	1 (16.6)	-
		<i>M</i> (<i>SD</i>)	<i>M</i> (<i>SD</i>)
Current Age		46.5 (10.17)	38.8 (7.25)
History of OCD treatment		<i>Median</i> (<i>R</i>)	<i>Median</i> (<i>R</i>)
Number of past sets of therapy		3 (2-5)	2 (2-3)
Number of past sets of CBT		2 (2-4)	2 (2)
Longest duration of being free from OCD/PD symptoms (months)		6 (0-36)	10 (0-36)

N = Number of participants; *M* = Mean; *SD* = Standard deviation, *R* = Range

Reported adequacy of CBT and adequacy of CBT specific to OCD

It was found that 100% of both OCD and PD participants' *most recent course* of therapy met all the seven minimum criteria specified for an intervention for therapy to be defined as CBT (Table 1). Thus, the entire sample had received a minimally adequate version of CBT. However, for the penultimate course of therapy 33% ($n = 2$) of OCD and 50% ($n = 3$) of PD participants reported therapy that did not meet the defined minimal criteria for adequate CBT (one OCD and two PD participants had not been allocated homework and one OCD and PD participant reported that the main emphasis of the sessions was not focused on the problem).

When examining the 12 components of the THQ judged to be 'essential' elements of CBT for OCD, half of participants with OCD ($n = 3$) endorsed their most recent version of therapy to have included all 12 of the essential elements measured. All OCD participants reported that their most recent therapy had included at least six of the essential elements. This suggests that participants' treatment failure may have been due to 'serious treatment failures' rather than being due to 'technical treatment failures'. A similar level of adequacy was reported by PD participants when examining the wider set of disorder specific treatment criteria. However, fewer PD participants ($n = 2$) reported 'therapist assisted exposure' in their most recent course of CBT. For both groups, their most recent experience of CBT was recalled as being more technically adequate in comparison to their previous course of CBT.

Figure 1. Participants' recollections of essential elements of CBT in past courses of therapy.

Qualitative Analysis

Analysis of the experience of treatment failure and perceived reasons for this identified three overarching themes: 1) *Invalidating and Disempowering Experiences*, 2) *Factors Relevant to Formulation and Socialisation*, and 3) *Wider Barriers to Recovery*. The first two themes were shared by both OCD and PD participants, and the third was specific to OCD. Each overarching theme comprised three subthemes. See Appendix 1 for a visual representation of the overarching and subthemes.

Overarching Theme 1: Invalidating and Disempowering Experiences

This theme represented the interpersonal experiences and exchanges between the service user and therapist. Participants described what they 'brought' with them to therapy (i.e. presenting problem and their experiences of this) and how they felt this was received by the therapist. Participants reported on how they perceived the stance and intentions of their therapist. These factors were relevant to the building of rapport and the foundations of an effective therapeutic alliance or alternatively the undermining of it. Three subthemes were

identified; 1.1) *The feeling of not being understood*, 1.2) *Failure in OR loss of collaboration and effective therapeutic rapport*, and 1.3) *Factors that lowered expectations of likely success*.

Subtheme 1.1: The feeling of not being understood (OCD & PD).

This subtheme, which was present in both OCD and PD, represented the different ways in which participants did not feel understood by their therapist, and the reasons as to why this was important. Participants discussed the magnitude of the struggle that precedes help seeking. A deep sense of shame was often reported to be associated with admitting there was a problem and voicing the details of the problem. Feelings of vulnerability that accompanied telling the therapist about their problems were reported. Participants described the experience of feeling as though they had not been “got”, as being a failure on the part of the therapist to grasp either the specifics or the severity of their problem. This simultaneously contributed to the maintenance of underlying concerns.

It was a big thing for me to admit that, that was, what I was, and I was utterly ashamed. I felt so ashamed of myself, embarrassed, but he [therapist] didn't do anything to make me feel better or that I had a problem that could be understood. I don't think he understood my problem. And I don't think he understood me, how sort of intrusive and engrained the OCD had become in me, I don't think he sort of took that very seriously (OCD Participant 1).

She clearly, by the end of it [therapy] hadn't grasped that it [panic] was as bad as it was. I guess, being brutal about it she just didn't understand my problem (PD Participant 6).

Subtheme 1.2: Failure in OR loss of collaboration and effective therapeutic rapport (OCD & PD).

This subtheme encapsulated the ways in which collaboration can fail and highlighted how a non-collaborative approach can be central to disengagement. The value of the collaborative process, whereby the service user and therapist work alongside one another and have shared input, was emphasised by participants. This was reported as being fundamental, particularly when deciding on the focus of therapy (i.e. which aspects of the problem participants perceived most important or were interfering most in their life).

He [therapist] wouldn't do the exposure prevention again because he'd say, "I've already given you the tools, you know how to do it, you've got to do it, I'm not going to do it again, we're going to do more cognitive work and find other methods of tackling this washing problem that's come back again". I probably wanted more help with the contamination. I had hoped for more exposure and prevention, but he didn't want to do that because he said, "I've already taught you that" (OCD Participant 6).

Some participants reported regularly attending therapy with a list of new concerns they wanted to discuss. These participants reflected that this had been potentially unhelpful as it had diverted the focus of therapy and may have impeded therapy progress. However, it was reported that this pattern was not addressed effectively by the therapist, and this was linked back to the difficulties associated with the absence of effective therapeutic rapport.

I'd tend to come along with a short kind of list of immediate concerns. I think, maybe the therapist wasn't in a way tough enough with me, in a sense of saying "well, you're now talking about this, this week, but how does that relate to what we did last week". I wonder if the therapy did slightly lose its way (OCD Participant 2).

Within the OCD data, participants described failures in collaboration. These appeared to result from differences in opinion, which were not resolved in a collaborative manner. This included a view of CBT being prescriptive, rather than idiosyncratic. It was evident that OCD participants, having experienced several previous courses of CBT, had well developed ideas and expectations about how therapy should be and the elements it should include. Participants described bringing this knowledge with them to the therapy sessions and the difficulties that arose when their views were not shared.

I think the “traditional CBT” as she [therapist] called it, the exposure and ritual prevention, needs modifying for OCD. I don’t think you can just do the one size fits all [...] I feel she should have tried a different approach, and she should have listened to how I was feeling and what I was saying, rather than just expecting me to follow the program [...] One thing that I did mention to her that was useful, was distraction, and she said that was completely against what the therapy was trying to do, she said that distraction was just a way of not facing up to the problem that was making things worse. [...] I’d been reading a [OCD self-help] book and part of that included distraction, and I was finding that quite useful and helpful. But she was quite certain that it wasn’t [...] I was using it [distraction] to resist washing and doing something that I enjoyed instead (OCD Participant 3).

This subtheme also reflected the failure between the therapist and patient to establish an effective therapeutic alliance and spoke to how this was a focus for some service users in discontinuing CBT.

I guess you have to, have a bit of a therapeutic sort of connection, and I guess we just didn’t have that at all. I probably just really irritated him [therapist] or something, I

don't know [...] I didn't feel like he was wanting to help me [...] He wasn't a horrid man, but I just don't think he related to me, and I think you sometimes need to be able to relate to that person. I actually wrote to him and said that I didn't want to continue, because I just felt like, we weren't really getting anywhere (OCD Participant 1).

Subtheme 1.3: Factors that lowered expectations of likely success (OCD & PD).

Participants in both groups reported that the way in which their therapist spoke about the therapy they were providing was often not specific to the disorder, or, in their opinion revealed that the therapist was inexperienced in providing such treatment. This instilled doubt in participants' minds with regards to the therapist's knowledge and ability to provide a treatment that would be relevant and potentially helpful.

With the whole rumination about harming the baby thing, he said himself, until he'd been to this conference, he'd never sort of heard about it, which made me feel even worse. I mean he was a psychologist and he was quite an older man, so I think he'd probably been in practice quite a long time, but I just felt the whole point of me going was being missed. I think sometimes practitioners have been in the job for so long and perhaps they don't always do more learning, they just do what they already know. If that was me, I'd go off and I'd read a bit about it, he clearly hadn't done any of that, which made me lose all confidence in him (OCD Participant 1).

I don't think my therapist had an expectation that I could be cured [...] And at the end she said that, "CBT is excellent for curing phobias, but it's not such a, not so likely to cure panic or anxiety" (PD Participant 4).

Independent of therapists' level of skill, participants talked about their confidence in their therapist based on the therapist's delivery of the therapy. This relationship was bidirectional, with therapists reportedly conveying a lack of confidence in their patient's ability to make substantial progress or the likely effectiveness of the treatment itself.

My symptoms started about aged 21, and I'm now 66. I'm quite an experienced sufferer from OCD. And so, I think we both agreed, which I think was sensible, that it's unlikely that I'd make absolutely dramatic progress [...] I think he [therapist] literally kind of said, you know, in the first or second session, "I don't think we're going to be able to do very much with you", but he remained positive (OCD Participant 2).

Overarching Theme 2: Factors Relevant to Formulation and Socialisation

In this theme participants described aspects of the content of the CBT they had received and the difficulties they experienced with engagement, due to how they made sense of the content and how it was delivered. Three subthemes were identified which included; 2.1) *The leap between theory and practice*, 2.2) *Poorly communicated rationale* and 2.3) *Too terrifying to take part: Partial engagement*.

Subtheme 2.1: The leap between theory and practice (OCD & PD).

Participants described a gap between talking about what one might need to do to begin to overcome their problem and the act of undertaking this in practice in real life contexts. Participants described the lengths that they perceived ERP or Behavioural Experiments (BE) needed to go to, to be effective (i.e., staying in the feared situation until anxiety had habituated). Participants described thinking that the ERP or BE had not gone far enough to be effective, although they reported that they had often not communicated this to the therapist.

We did get out of the office to do things, it was challenging but not challenging enough. It didn't, it wasn't taken far enough. At the time I was having a lot of trouble with shops, and crowded places, so we went into shops but very briefly really. It seemed quite, not paying lip service, we didn't stay there very long. I still felt anxious when I left the shop, I don't think it was sufficient exposure (PD Participant 4).

Some participants reported that while they were able to engage with therapy from a theoretical perspective, they did not find it helpful from a practical point of view.

Examining the thought processes, and the responses that you're making. I mean, I have found it quite interesting in terms of understanding the fight or flight reflex, and the, you know, what's going on with the brain, and why these things happen. But I didn't find it at all effective in actually treating my disorder (PD Participant 5).

Emphasis was placed on the perceived importance of undertaking ERP or BE in-session supported by the therapist, to be able to do this beyond the session autonomously.

It was all based in her [therapist] office, we didn't go out at all or have any exposure treatment. If the therapist could have come with me to start with and shown me what I needed to do, it's a big step from them saying what it is you need to do and then being able to go home and do it on your own. I think that is the main thing that could have helped because you're actually physically doing it and facing your fear (OCD Participant 5).

Subtheme 2.2: Poorly communicated rationale (OCD & PD).

This subtheme depicts participants' experiences of their understanding of the meaning and purpose of aspects of the therapy process, including the ERP/ BE they were asked to undertake in therapy. Participants in both groups described experiences in which they did not have a clear understanding of the rationale, it was missing, or was no longer memorable in their mind. This resulted in the associated task appearing to lack validity and feelings of frustration with the therapy process.

He [therapist] tried to encourage me to keep up with it and to keep it going, because, I'm not sure of the reasons why, but it was like, "how do you feel leaving the house today", and then I think there was strategies of coping, but I can't remember what they were I'm afraid (OCD Participant 4).

One of the things he [therapist] would encourage me to do would be to take the bus further afield to somewhere like (location) which is like maybe 15, 20 miles away, and just come back, you know, just for the sake of doing it. But I'd think, what's the point in doing it without a reason for going there, you know? (PD Participant 3).

Participants with PD also raised questions about the overall value and suitability of CBT as a treatment for PD. A rationale for how CBT could work for their difficulties had not resonated. Several participants reported that their problem was too chronic, severe, or entrenched for CBT to be a suitable treatment.

The therapy I did, it wasn't, it wasn't useful for somebody that had suffered it for years. There's not much therapy, well I've not come across therapy, to deal with that end of it

really. I think it would be absolutely perfect for somebody who for the first time in their life is experiencing panic attacks (PD Participant 2).

Subtheme 2.3: Too terrifying to take part: Partial engagement (OCD & PD).

Within this subtheme participants in both groups articulated the belief that what they were being asked to do was not possible due to the high level of anxiety it would evoke. Some agreement was expressed regarding the tasks being a good idea, but a mismatch between this and the reality of undertaking them was evident.

Just that it's very hard to do, when you're absolutely terrified. And when I was really ill, I'd be terrified constantly [...] So when I got to therapy and he'd [therapist] say we're going to do this and this, I'd be like "oh, get lost, you know, I'm dying here" (PD Participant 3).

Unique to OCD, participants described being unable to fully engage with therapy due to the idea of different obsessions varying in their levels of value and associated responsibility and risk. This variation resulted in a willingness to tackle some obsessions and prohibited them from tackling others. Linked to this, participants reported the experience of engaging in 'half exposure,' continuing to utilise safety seeking behaviours.

I was able to cut it down, but not stop. I think it was the 'what if' scenario. If I didn't check and there was a fire, for instance, I would lose everything [...] Somebody saying your work's not good enough wouldn't affect me as much, as if my house burnt down, for example (OCD Participant 4).

Overarching Theme 3: Wider Barriers to Recovery (OCD only).

This overarching theme and its three subthemes were all specific to OCD. It concerned factors that were central to the individual that made overcoming OCD more difficult. These factors were perceived by participants as prohibitive to their engagement, progress and generalisation of skills learned. Three subthemes were identified; 3.1) *Lack of family and social support*, 3.2) *Dealing with problems beyond diagnosis*, and 3.3) *Not enough therapy*.

Subtheme 3.1: Lack of family and social support (OCD only).

Participants perceived a lack of family and social support and consequent social isolation as being problematic. Several participants attributed a lack of familial support as contributing to their difficulty in overcoming OCD and perceived that better progress may have been made if external support had been available to them. The idea of not having anyone to be accountable to, or to help them, leading to their OCD becoming more pervasive, was expressed.

You can be taught the tools, but if you have nobody to be accountable to or to support you, you can't use those tools. I think that's my problem. Because I live [on my own], you know, my OCD means I'm very isolated socially. I don't ever, I don't let people into my flat hardly at all. I don't have anybody to help me to do it, you know. I don't think you can. I don't think you can overcome, people who overcome OCD seem to have, you know, other people around them. When you're on your own it's really, really hard (OCD Participant 6).

Subtheme 3.2: Dealing with problems beyond diagnosis (OCD only).

OCD participants highlighted major unmet social care needs that had a significant impact on their daily functioning, and their consequent wellbeing and ability to engage in CBT when it was being offered to them. Of course, such difficulties arise, at least in part, due to the

extent of the disability caused by the OCD itself, highlighting the circularity of the problem (i.e. the extent to which OCD is disabling can lead to numerous obstacles to engaging in treatment).

The problem with CBT, I've noticed, is, it's not part of an integrated service, it happens in a bubble, in a vacuum, which CBT therapists have absolutely no interest in the rest of the mental health services or where their therapy fits in, in your life. I've spoken to a lot of people about this because other people have said, "well, you know the therapy came at the wrong time in my life and it was really rubbish". For me it was 10 days before I was going to be made homeless, I had no money, wasn't working, I was getting into debt. So, to have therapy when those needs haven't been met, well, if you literally don't even know where your next meal is coming from, you know, your life is, you know, the priority is food, clothing, roof over head, before you start having therapy (OCD Participant 6).

Subtheme 3.3: Not enough therapy (OCD only).

This subtheme conveys OCD participants' views that not having enough sessions of CBT was a contributing factor to overall outcome. Participants reported that therapy ended before adequate progress had been made and a sufficient amount of therapy had been received. For some, this was due to the restriction on the number of sessions that could be provided by the service. In other cases, this was a result of the therapist leaving the service and the therapy ceasing as a result. One participant felt that the hourly 'format' in which therapy was provided was too short to achieve meaningful gains.

The sessions were cut off, I guess it was laid down, this many weeks were laid down by the local NHS and that's it, "off you go". I wasn't given any option about continuing

[...] there weren't any booster sessions or anything like that. I think I would have benefited from more sessions, to be honest with you (OCD Participant 5).

Discussion

The main purpose of this study was to provide an in-depth examination of the factors perceived to contribute to therapy failure from the perspective of OCD service users, with a focus on those with experience of multiple CBT failures. We included a comparison group with PD, to provide information about whether any issues identified were specific to OCD, versus reflective of wider contributors to therapeutic failures. The technical adequacy of participants' previous CBT was assessed by the THQ, and results suggested that participants in the study had undertaken at least one previous course of technically adequate CBT. Themes identified from qualitative analysis reflected participants' views on an individual level and therapeutic factors that contributed to treatment failure.

The THQ indicated that participants' most recent course of CBT had been technically adequate for the majority of OCD and PD participants. This contextualised the current sample, suggesting that non-response is likely to have been, for at least some participants, due to 'serious treatment failures' (Rachman, 1983). Despite the likely technical adequacy of the CBT provided, according to standard checklists, findings from the qualitative analysis indicate that participants were dissatisfied with the therapy they had received and perceived aspects of its delivery to be inadequate. The reasons that participants perceived their treatment had failed them fell under three overarching themes, which encompassed perceptions of the therapist's engagement (Theme 1: *Invalidating and Disempowering Experiences*), the individual's ability to understand and engage with the therapy being offered (Theme 2: *Factors relevant to Formulation and Socialisation*), and personal and service related circumstances which related to participants' perception of their capacity to engage in treatment (Theme 3: *Wider Barriers*

to Recovery). Themes 1 and 2 were shared by participants with both OCD and PD, suggesting that the factors identified relate to therapeutic interactions and to CBT more broadly rather than to OCD specifically.

In theme 1 (*Invalidating and Disempowering Experiences*) a major factor that contributed to treatment failure, in the eyes of study participants, was a fundamental failure on the part of the therapist to understand the individual and their problem, and to give them confidence in the therapy being provided. Participants described invalidating and disempowering experiences, which were perceived to be a consequence of poor therapist insight, a breakdown in therapeutic collaboration and rapport, and communication by the therapist which led participants to lose confidence in them. The subthemes of theme 1 were interrelated, meaning that if difficulties arose in one of these areas it created a knock on or domino effect. For example, if in the early stages of therapy, the patient perceived the therapeutic interactions to mean that they had not been understood, this led the patient to lose confidence in their therapist's ability to help them, or to a loss in collaboration. This may then have led the service user to lose faith in the therapist's competence and in turn their own confidence and ability to take part in the therapy, affecting their engagement in the therapeutic relationship. The absence of an effective therapeutic alliance is likely to impact on the patient's trust and affect their willingness to explore and take required therapeutic risks, potentially resulting in the difficulties encountered with the leap between the theory and practice of ERP or BE which is inevitably required (as described within theme 2).

Within the CBT literature therapeutic alliance has often been viewed as a 'necessary' but not 'sufficient' aspect in itself to cause change (Beck et al., 1979). A meta-analysis examining the relationship between therapeutic alliance and outcome, concluded that there is a small relationship ($r = .22$, approximately 5-6% of the variance) between alliance and outcome and the strength of the alliance is associated with outcome (Martin, Garske, & Davis, 2000).

This meta-analysis also reported that patients generally view alliance consistently throughout the course of therapy, meaning that their initial view of the alliance is unlikely to change. This fits with the findings of the current study, highlighting the importance of the therapist establishing a positive effective alliance at an early stage of therapy (Martin, Garske & Davis, 2000). However, as emphasised by the results of the present study, an ‘effective positive alliance’, is not synonymous with a consistently ‘good’ relationship. An effective working alliance is the basis from which patients can feel safe and supported to take risks and make behavioural and cognitive changes. It is thus important that therapists are cognisant of this distinction.

Perceived problems in the therapeutic alliance were also evident in theme 2 (*Factors relevant to Formulation and Socialisation*). Within this theme, participants described a *poorly communicated rationale* (subtheme 2.2) being an obstacle to engagement, making the *leap of faith* (subtheme 2.1) that is fundamental to full therapeutic engagement much more difficult to take. Being *too terrified to take part* (subtheme 2.3) was also part of this theme for both OCD and PD participants, with some participants being too anxious to engage with tasks at all. OCD participants also reported only partial engagement, where they relinquished only some safety-seeking behaviours. Underlying these variations in difficulties with engagement is a *poorly communicated rationale* with regards to what is being done in therapy and why and how what is being proposed fits with the formulation. Perceived failure on the part of the therapist to be sufficiently convincing and supportive highlights some of the challenges to delivering interventions to highly anxious individuals. In their paper on ‘therapist drift’, Waller and Turner (2016) discuss therapists’ potential ambivalence towards the evidence-based use of CBT change techniques due to therapist concern regarding the perceived distress it may cause the patient. Waller and Turner (2016) refer to the idea of therapists employing their own ‘safety-behaviours’. Such safety-behaviours prevent therapists from encouraging patients to

change due to fear that they will be viewed less positively or the wish to protect themselves from the patient's emotional distress (Deacon & Farrell, 2013). Farrell et al. (2013) also discuss the use of therapists' suboptimal delivery of ERP due to therapists' negatively held beliefs resulting in cautious delivery (e.g. prematurely terminating exposure tasks, not venturing outside of the therapy room).

It is clear that the method in which CBT for OCD is delivered is important, with therapist supported in-vivo ERP, in conjunction with imagery, producing the greatest change in symptom severity (McKay et al., 2015). This raises the question as to whether it is possible that therapists themselves, may at times, be responsible for 'treatment interfering behaviours'. In Pollard's (2006) 'Identifying Treatment-Interfering Behaviours' (TIB) questionnaire, several of the items mirror the reports of participants regarding their therapist. For example, item two states: "Does not adequately or consistently acknowledge the problem's severity or its impact on others", item three: "Does not identify clear goals for treatment", item six: "Has difficulty explaining the treatment plan or the rationale behind it". This emphasises the importance of true collaborative working in CBT, and the importance of the therapist taking responsibility for checking in with the patient to ensure that there is a shared understanding with regards to what has been covered and discussion of both parties' views on this.

The implications of patients' treatment literacy should also be considered more widely. Participants in this study often had a clear idea about what they should be receiving in therapy. When the patient and therapist disagreed, it should be acknowledged that we do not have sufficient information to discern whether what the individual perceived to be necessary was in their own best interests. As a therapeutic rule, the onus remains with the therapist to discuss with their patient the efficacy of the therapy they are providing, and to develop a shared understanding of how the patient's problem works and how the treatment being offered fits

with this. However, clearly this can be particularly challenging where individuals have experienced multiple treatment failures.

The final theme (*Wider Barriers to Recovery*) highlighted complicating factors that were specific to OCD and were deemed to fall outside the parameters of either technical or serious treatment failures. These included a *lack of family support* (subtheme 3.1), the fact that individual were *dealing with problems beyond their diagnosis* (subtheme 3.2), and the perception that the amount of therapy available, as standard, was simply *not enough* to address their problem (subtheme 3.3). The negative impact of family accommodation of OCD on the sufferer (Steketee et al., 1998) and the distress experienced by family members (Amir et al., 2000) and their effect on treatment outcome is well documented, although was not reported in this sample. Instead, participants described a relationship between a lack of being accountable to others and the pervasiveness of their OCD. In addition, the reported lack of family and social systemic support was described to result in social isolation and difficulties in being able to fully take part in CBT. While a high level of comorbidity, particularly with depression (Overbeek et al., 2002) could have been expected to be a significant issue in a sample of participants who have previously not responded to CBT, this was also not raised. However, this was not specifically addressed or measured in this study which could potentially account for its absence.

Ten hours of CBT is identified as the minimum number of hours required for technically adequate CBT (NICE, 2005). However, in practice, and as reported by participants this is often not a sufficient number of hours to treat severe OCD. Moreover, the specific number of therapy hours that a patient is allocated is rarely the decision of the treating therapist but is rather a product of the treating service's policy. Within the efficacy literature an 'optimal trial' of CBT is considered to require much longer than 3 months (McKay et al., 2015). There is a clear dose-response effect, with the greater number of hours of CBT provided the better

the outcome for patients (Hansen et al., 2002). There is also evidence that more time is required when the therapist delivering the intervention is not a specialist (Fisher & Wells, 2005). The personal (and economic) costs associated with the experience of yet another unsuccessful course of CBT are serious (Boisseau et al., 2017). Ultimately, this could make the difference between whether the service user resolves their OCD or continues to be significantly affected by it.

Clinical Implications

The majority of participants with OCD were particularly treatment literate. They were informed on the elements they believed CBT for OCD should consist of and how it should be delivered. As these participants had experienced two or more courses of CBT there was room for comparison between treatments. The results of the present study suggest, that from a therapist's perspective, it may be useful to consider creating room early on in therapy to discuss this, to acknowledge and integrate the service user's prior experience, insights and knowledge. This may also be crucial for preventing the possibility of patients comparing previous treatments with the current therapy and thus potentially unintentionally undermining the current therapy they are attempting to undertake. Also, of relevance is remembering to return to basics such as collaborative agenda setting to ensure the focus of the session remains on OCD and in-session drift is prevented (e.g. collaboratively agreeing how new issues not relevant to OCD will be addressed or made time for in the session e.g. revisiting in the final 10 minutes of the session if still required at that point). The results of this study also suggest that considering the level of the patient's familial support and having a grasp of external issues that may be in play, may be therapeutically useful.

Limitations and Future Research Directions

A relatively small number of participants took part in this study; although purposive, it was nonetheless a sample of convenience. It should be noted that these findings are not intended to be generalizable but are transferable to this specific group of service users, providing important in-depth insights that would not be captured from quantitative studies alone.

In the present study, the THQ was used to gain information about participants' recollection of what was done in their previous CBT and to gain an insight as to whether participants had previously received technically adequate CBT. A limitation is the potential for recall bias in participants' report. Future research which cross validates participants' reports with case files would be useful in circumventing this potential recall bias. It would also be useful to include a broader and larger group of participants for a study of this nature.

The perspectives captured were confined to those of the service users, thus the perspectives of the therapist are required to provide a full understanding of the factors involved. Future research designed to individually examine both the service user and therapist's experiences before, during and after the course of therapy would be useful in gaining a more in-depth picture. Ideally, this study would be designed to capture therapist and patient dyads, with the dyads completing independent session-by-session outcome measures. This would allow for an examination of how closely matched the therapists and participants perspectives are in terms of what is happening in therapy. This design may help to further illuminate the factors that lead to non-optimal responses to therapy.

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Appendix 1: Thematic Map representing the identified overarching and subthemes.