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Stagnation in Psychotherapy: A Transtheoretical Approach

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Doctoral training in clinical psychology emphasizes the importance of utilizing empirically supported psychotherapy methods in pursuit of effective psychotherapy. When treatment is stagnant or ineffective, the focus of training and supervision is often geared toward searching the evidence-base for alternative psychotherapy approaches, or referring to a provider with expertise in a specific method. Using a case example, this paper offers guidance on possible roadblocks to effective psychotherapy treatment, and clear areas to explore before concluding whether psychotherapy is the most helpful intervention for a patient.

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The name and identifying information of the individual in this case example have been changed significantly to protect the identity of the individual.

Abstract

Doctoral training in clinical psychology emphasizes the importance of utilizing empirically supported psychotherapy methods in pursuit of effective psychotherapy. When treatment is stagnant or ineffective, the focus of training and supervision is often geared toward searching the evidence-base for alternative psychotherapy approaches, or referring to a provider with expertise in a specific method. Using a case example, this paper offers guidance on possible roadblocks to effective psychotherapy treatment, and clear areas to explore before concluding whether psychotherapy is the most helpful intervention for a patient.

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What We Know About Psychotherapy Effectiveness

The common factors hypothesis was originally developed by Saul Rosenzweig (1936). Rosenzweig ascertained that a therapist with an effective personality is more strongly linked to psychotherapy outcomes than the means or methodology behind the therapists' treatment (Lambert & Ogles, 2014). Research behind the common factors theory and its characteristics has grown considerably since the 1930s. According to Lambert and Ogles (2014), the common factors hypothesis includes the following key components:

> (a) different therapeutic approaches are relatively equivalent in effectiveness across various populations and disorders; (b) these orientations or approaches to treatment propose widely differing theories of psychopathology, treatment, and change; (c) factors common to the orientations (and to the psychotherapy and the psychotherapy situation generally) may be the most parsimonious explanation for the observed equivalence in efficacy; and (d) a therapist with an "effective personality" using any theory of change that implements the treatment with some consistency can help bring about positive outcomes. (p. 500-501)

Potential commonalities across approaches include "catharsis, advice, cognitive mastery, exposure, feedback, insight, reassurance, mitigation of isolation, success experiences, therapeutic alliance, therapist expertness, trust, affective experiencing, and many others" (Frank & Frank, 1991; Grencavage & Norcross, 1990; Lambert, 2013; Weinberger 1995, as cited in Lambert & Ogles, p. 501, 2014). There is no research base to prove that one evidence-based psychotherapy

approach is more effective than another. However, we do know that theoretically based treatments are more efficacious in comparison to no-treatment and placebo treatments (Lambert, 2005). Additionally, there is no significant difference in psychotherapy outcome data between experience and training level of the clinician, demonstrating that education and professional training have little correlation to psychotherapy outcomes (Stein & Lambert, 1995). Positive outcomes occur with and without training in specific therapeutic techniques (Lambert, 2005). Michael J. Lambert's research is based upon the premise that nearly all therapies emphasize the importance of clients reviewing and discussing their fears rather than avoiding them, regardless of the theoretical orientation used to do so. Rather than promoting or ranking specific graduate training programs or psychotherapy modalities against each other, many clinicians and researchers believe there is a collection of ingredients utilized in psychotherapy that lead to positive outcomes known as the common factors.

Research has also shown a correlation between the quantity of psychotherapy sessions and positive treatment outcomes. Lambert and Ogles' (2004) research concluded that just 10 psychotherapy sessions can alleviate symptoms in a sizable portion of patients, while 75% of patients will demonstrate more substantial improvements after about 50 sessions of treatment. They also explain how clients' responsiveness to treatment will vary depending on the nature and severity of their symptoms. For example, populations experiencing more characterological and interpersonal problems will respond more slowly than populations struggling with distressing psychological symptoms (Lambert & Ogles, 2014). In sum, their research shows that open-ended, relational psychotherapy can take more than 50 psychotherapy sessions to create lasting psychological changes.

Lorenzo-Luaces and DeRubeis (2018) highlight how psychotherapy effectiveness research can be organized along a continuum. On one end of the spectrum are researchers who argue for the importance of techniques or treatment protocols for the treatment of specific diagnoses. This research is more heavily grounded in evidence from randomized clinical trials (RCTs). On the other end of the spectrum is research that demonstrates how effective psychotherapy is rooted in "common factors" as the agent of change. This research is more commonly compiled through meta-analysis. In a recent review of psychotherapy effectiveness literature, Cuijpers et. al (2019) conclude that we still do not know whether the factors that bring about change in psychotherapy are common factors, specific factors, or both.

The debate over effective psychotherapy is current and lively worldwide. Rodríguez (2018) introduces a newer camp in the research debate, which emphasizes the importance of focusing on *who* is providing the treatment rather than *what* treatment is being provided. Rodríguez explains that the motivation behind this research is that psychotherapy is not conducted by the models, but rather by the psychotherapist and the relationships they foster. Therefore, the psychotherapists themselves and the relationships they foster with their clients should be central to the research. Rather than leaning on the medical model to conceptualize and treat patients, Rodríguez highlights the importance of research psychologists developing models better suited to the discipline. This line in inquiry highlights how much more ground there is to cover in understanding, measuring and disseminating information on the efficacy of psychotherapy.

In a similar vein is research exploring the importance of client and therapist "match." Theories of social psychology on similarity and attraction would suggest that clients who perceive their therapist's identity as more like their own would have better therapeutic outcomes

due to an inherent sense of comfort and understanding. Previous narrative and meta-analytic reviews highlight how people of color show preference for working with therapists of their own race or ethnicity (Ertl et al., 2019). While this evidence supports theories in social psychology, it does not apply directly to client-therapist match or demonstrate a clinically significant effect of racial, ethnic, or cultural match on therapeutic outcomes (Ertl et al., 2019). Given the complexity and heterogeneity within identity categories, researching client-therapist match can be difficult. For example, a client and therapist with similarities in terms of race, ethnicity, or culture may still be dissimilar in their personal norms, values, beliefs, and identifications (Cabral & Smith, 2011). Ertl et al. (2009) point out that due to the multi-faceted and dynamic nature of identities, a "perfect" identity match between therapists and clients is not possible on every given identity variable (e.g., race, ethnicity, socioeconomic status, gender, sexual orientation), "thus, a nuanced approach to match that considers multiple overlapping identities in conjunction with salience of identity may more adequately capture the complexity of identities and what "match" between client and therapist would be." Zane et al. (2005) posit that identity matches do not necessarily ensure matches in attitudes, beliefs and expectancies. Therefore, they assert that therapists should focus more on identifying how their views may be discrepant from those of their patients (and address those), regardless of whether they share similar identity markers. These findings highlight the importance of client-centered, multicultural competence training for all clinicians and is a significant factor to investigate when exploring stagnation in psychotherapy. Finding a match between therapist and client is made even more difficult when there is little diversity in the field of mental health practitioners. Increasing the diversity of practitioners in the field is crucial to the improvement of accessibility and approachability of mental health support for

diverse populations, as well as increasing the likelihood that clients can find someone that feels like a "match."

Psychotherapy Effectiveness and Response Trajectories

Lambert (2005) highlights how it is not known which factor(s) is involved in the success of early responders in psychotherapy and purports that it is likely an amalgamation of common factors. He found that early responders often improve in treatment before specific treatment modalities or a specific theoretical orientation can fully influence the psychotherapy treatment. Furthermore, early responders to treatment may carry personality traits that influence their receptiveness to psychotherapy. Examples of these traits or states include resilience, motivation for therapy, and mental preparation for the difficult work. He also notes that early response in treatment may indicate goodness of fit between client and therapist and could reflect an effective working alliance that can be detected as early as the third session of treatment (Lambert, 2005). Stagnation in early stages of treatment may signify a need for changes to the treatment plan, goal setting or goodness of fit for the clinician and/or psychotherapy model.

Research on trajectories of treatment responses provides useful information for optimizing treatment and guiding interventions. Fennel and Teasdale (1987), discovered that early responders to psychotherapy treatment fare better than late responders and have improved long-term outcomes after the termination of psychotherapy. In their study, they found that early responders followed a pattern of addressing one problem and moving onto the next in a more sequential order, whereas delayed responders revisited the same topic in therapy across numerous sessions (Fennel & Teasdale, 1987). This study suggests that working with delayed responders in psychotherapy may be just one (of many) factors to consider when deciding if psychotherapy is an effective treatment for a patient at a given time.

Unknown Factors in Psychotherapy

While there is considerable research focused on understanding the efficacy of psychotherapy, there are a myriad of confounding variables that complicate the delivery of a reliable therapeutic formula. Psychotherapy is not always effective and researching psychotherapy failures can also shed light on important factors to consider while providing treatment. Lambert (2010) notes how little consensus there is in the psychotherapy community surrounding what works, and how little information is available for consumers to feel confident about uniformity in the psychotherapy process. Lambert sees benefits in shifting the focus of research and teaching toward the common factors because it reduces polarization and supports practitioner flexibility in their approach. While he is a strong proponent of studying and understanding the common factors, he agrees that the common factors explanation alone does not reduce the confusion surrounding what is most helpful for clients (Lambert, 2010).

Lorenzo-Luaces and DeRubeis capture the state of psychotherapy efficacy research well, "psychotherapy works, probably through the working alliance, at least a little, and maybe through specific factors, at least for specific problems" (Lorenzo-Luaces and DeRubeis, 2018). The working alliance includes three elements: The bond between therapist and patient, agreement of the goals for therapy, and agreement about the tasks of therapy (Wampold 2015). Lorenzo-Luaces and DeRubeis argue that evidence for specific techniques in therapy is supported for only a handful of diagnoses, while evidence for the common factors approach contains methodological weaknesses and may not be as strongly supported as previously believed. Similar to Rodríguez (2018), they assert that more research needs to be conducted to expand beyond the bivariate relationships and that a model needs to be created to more accurately capture the complexities of the real world. While Lorenzo-Luaces and Debeis (2018)

acknowledge the importance of the working alliance in the therapeutic process, they conclude that focusing on the working alliance alone is not helpful in guiding psychotherapy from patient-to-patient or session-to-session.

Identifying Stagnant or Failing Psychotherapy Treatment

The literature provides insight into some of the elements that work in psychotherapy and highlights the depth of what we have yet to understand about the nuances of the psychotherapy process. Research also shows how therapy does not always work for everyone, and that patients sometimes leave psychotherapy worse off than they were when they started. Hansen, Lambert, and Foreman (2002), discovered that in both clinical trials and routine outpatient psychotherapy, 5-10% of adult clients deteriorate throughout treatment.

Research behind psychotherapy effectiveness is ample while there is a lack of research focused on investigating the factors involved in psychotherapy treatment failure. Mohr (1995) notes that research focused on the efficacy of psychotherapy includes categories for people who have gotten better after treatment and that there has been hesitation to include a category for people who have gotten worse. He explains that only two client variables have been identified in populations that deteriorate during psychotherapy treatment and they include “interpersonal difficulties” and “more severe problems at intake.” These variables have been investigated in a limited number or research studies and only recently has the concept of deterioration during psychotherapy treatment been given more attention. For some individuals, therapy is not appropriate or can even harm the client. Overall, research journals do not publish “non-significant” findings. Therefore, it is uncommon to find published studies discussing factors to treatment failure, especially within the therapy or the therapeutic relationship. This makes it

particularly difficult to quickly and easily identify components of psychotherapy that may be contributing to negative outcomes.

Additionally, mental health providers are not good at identifying clients who are at a high-risk for deteriorating during treatment (Lambert, 2010). Lambert's research indicates that therapists are not always aware of their clients' levels of distress. Therapists' perceptions of clients deteriorating during treatment is overly optimistic, believing that treatment is having a positive effect on clients even when it is not. Lambert (2010) argues for the importance of ongoing feedback treatment measurement tools to combat therapists' self-assessment bias. According to research conducted by Walfish et al. (2009), 25% of mental health professionals in their study rated their skills as falling into the 90th percentile when compared to their peers. Walfish et al. (2009) also discovered that mental health clinicians tend to estimate the percentage of clients that deteriorate during psychotherapy treatment (3.66%) to be lower than the rate found for routine care across a variety of treatment settings (8%). This research indicates that mental health providers tend to give themselves overly positive self-assessments and that they are not good at identifying when treatment is ineffective for their patients. This research is troubling as it implies that many therapy patients may be deteriorating in treatment unbeknownst to their providers. More accurate feedback for the provider, as well as reliable detection and intervention is crucial in effort to improve treatment outcomes.

Lambert and his colleagues spent years developing and studying a comprehensive feedback system for clinicians to monitor the progress of their clients and intervene more effectively to prevent deterioration throughout the course of treatment. While the results of his studies showed improvement in treatment outcomes for clients that were identified as higher risk for deterioration, about 13% of cases responding poorly to treatment continued to deteriorate,

even if they were flagged through the monitoring system (Lambert, 2010). Sometimes, psychotherapy treatment remains ineffective, even if the therapist has identified the treatment as failing and intervened accordingly.

Even with the appropriate tests and measurements in place for psychotherapists and clients, treatment is not always effective. This paper provides a guide for identifying psychotherapy treatment stagnation and offers practical and ethical steps for therapists to follow before making the determination that psychotherapy treatment is ineffective. Since the research lacks guidance for how therapists should proceed when they perceive treatment failures or plateaus, I will present a case example to illustrate a possible decision-making framework.

Case Background

During the time of this paper's development, Margaret Peterson was a 42-year-old white female. She identified as heterosexual and atheist. She was in a relationship for the first two years of treatment and was single for the last year of treatment. Ms. Peterson was employed as an office manager at a large company in the Denver Metro Area. Prior to seeking services at the Professional Psychology Clinic, the student-run clinic at the University of Denver, she sought brief psychological services after a sexual assault in her early 20s as well as during her cancer treatment in her early 30s. She started counseling again in 2014 at the Professional Psychology Clinic. She has consistently attended weekly psychotherapy since 2014 and was transferred to me in the summer of 2017. Ms. Peterson has a history of depression and anxiety. She has been on and off psychotropic medication throughout adulthood and was not taking any medication for her mood or anxiety symptoms at the time of the transfer.

Ms. Peterson grew up in a household with her biological parents and two younger siblings. She learned of a half-brother by her father whom she was not aware of until she became

an adult. She was born on the east coast and moved to the Midwest during elementary school. Ms. Peterson reported this move was the first time she recalls feeling sad. She said that she "didn't fit in" and was "bullied" by her peers. When Ms. Peterson was thirteen years old, her mother died of breast cancer. She noted that she first experienced thoughts of suicide when her mother was sick with cancer and recalls threatening God that if he took her mother then she would kill herself.

Soon after her mother passed away, Ms. Peterson recalled that her father purged her mother's personal belongings and rarely spoke of her again. Ms. Peterson felt it was difficult to grieve for her mother and that she soon transitioned into the role of "mother" to her two younger siblings. She assumed the responsibilities of caretaking, cooking and cleaning for the household. She remembers her father traveling for business trips on weekends and leaving her to attend to her siblings at the age of thirteen. The neighbors discovered the lack of adult supervision in her household and expressed concern to her father. Soon after, her father sent Ms. Peterson and her siblings to live with a relative out-of-state.

Ms. Peterson and her siblings lived with this relative for two years, until her cousin died in a car accident. Ms. Peterson reports feeling guilty for the death of this cousin because she was asked to pass along a message to her cousin about errands that needed to be run. Ms. Peterson forgot to tell her cousin about the errands and believes that if she had remembered to share this information, her cousin would not have been in the location of the accident during the time in which it occurred. After the accident, Ms. Peterson and her siblings returned to their father's home with the belief that they would soon return to their relative's. However, they were never allowed to return, which Ms. Peterson described as very upsetting because she did not have the opportunity to say goodbye to her friends and family.

After high school graduation, Ms. Peterson remained at home to care for her youngest brother, because she did not want to "leave him alone [with their father]." Her other sibling left home after his high school graduation, which Ms. Peterson experienced as abandonment. She remained in her father's home until her youngest brother, nine years younger than she, graduated high school. Shortly after, she moved out.

She reported experiencing a sexual assault in her early 20s. After the assault, she sought psychotherapy services and identified feeling a great deal of anger toward the man who assaulted her, which persists today. She experienced fear and distrust toward men and refrained from dating and romantic relationships for ten years.

In her early 30s, Ms. Peterson was diagnosed with breast cancer herself and underwent a bilateral mastectomy and chemotherapy. She described a decrease in her anxiety and depression during her cancer treatment which she attributed to "acceptance" of her illness. She also pursued psychotherapy services once per month for two to three years during this time, which was all she could afford. After surviving breast cancer, Ms. Peterson pursued a career in the healthcare field to "give back" and remained involved in a community of people that were so helpful to her during a time when she needed medical intervention and support. After starting her new job, she was diagnosed with Chronic Fatigue Syndrome. She found relief after working with a holistic physician. She had been in remission from cancer for ten years when I started working with her.

Ms. Peterson worked closely with her initial therapist at the Professional Psychology Clinic to increase her self-confidence and to take steps toward dating. In November 2015, she started using a dating application on her phone. In January 2017, she began a more serious romantic relationship, which ended in July of 2017. Ms. Peterson learned she was pregnant with his child a few weeks later. While Ms. Peterson expressed ambivalence toward the pregnancy,

she ultimately decided to keep the baby and to raise the baby with her boyfriend. They moved into a home together shortly thereafter. In mid-October of 2017, Ms. Peterson learned that her baby had a chromosomal abnormality and was high risk for Down's Syndrome. She decided to terminate the pregnancy and struggled with feelings of grief and guilt associated with this decision.

Ms. Peterson and her boyfriend sought couples counseling at the Professional Psychology Clinic. She reported increased fighting and feeling "gaslit" by her partner. One evening, she shared she woke up to her boyfriend touching her in a sexual manner that felt non-consensual. She "froze" and was unable to ask him to stop, triggering memories from her previous assault. Ms. Peterson moved out of their home and back in with her father in Denver, CO. She experienced moving back in with her father as a "step backwards" and reported feeling shame about not being able to afford to live on her own. She also expressed frustration that the house was messy and that her father made disparaging comments about her life.

Case Conceptualization

Ms. Peterson internalized the belief that she does not deserve to be happy. She struggled to enjoy positive moments in her life because she believed that when something "good" happens to her, something "bad" will soon follow. She felt unimportant and that "does not matter." She reported thoughts that she "does not fit in," is "weird," and "unlovable." These beliefs made it difficult for her to develop and maintain long-lasting romantic relationships, which in turn negatively affected her self-esteem. The patient's life had become organized around these beliefs she held about herself and contributed to symptoms of anxiety and depression. The course of treatment section will provide more details on the case conceptualization and how it changed over time, as well as how these changes influenced the interventions used.

Course of Treatment

Ms. Peterson began psychotherapy with me in the summer of 2017 and ended in the summer of 2021. For context, the end of her treatment with me overlapped with the start of the global COVID-19 pandemic. Her initial presenting problems included anxiety related to her pregnancy, instability in her partnership, and dissatisfaction with her job that she reported wanting to leave for many months. She felt "stuck" in her job because she needed the health benefits, particularly during pregnancy. She also cited "fear of failure" at a new job as a strong deterrent to search for a new position. During this initial phase of treatment, I focused on rapport building and providing a comfortable transition from her previous therapist. My supervisor at the time was an expert in Cognitive Behavioral Therapy and introduced many interventions that we believed could address Ms. Peterson's depressive schema and negative cognitions. The specific maladaptive belief we targeted in therapy was, "when something good happens, something bad will follow." Ms. Peterson often cited this belief as a reason not to make improvements in her life. She would point to her history as evidence that joy or happiness would always be followed with grief and loss. At this juncture in her life, Ms. Peterson preferred to avoid all positive emotional states in order to stave off potential negative experiences.

Ms. Peterson was open and receptive to transitioning therapists and trying new interventions and techniques. However, just weeks into this new therapeutic relationship, Ms. Peterson learned the embryo had a chromosomal abnormality. Psychotherapy was understandably replaced with a holding environment for Ms. Peterson to process her grief and explore her options. She ultimately decided to terminate the pregnancy and subsequently started to experience increased feelings of grief and depression. She also began expressing ambivalence toward her relationship, weighing whether she wanted to commit to her partner and move in with

him or break it off altogether. Many therapy sessions in our early days together were focused on processing the loss of her baby and the confusion she felt surrounding her relationship. Ms. Peterson had strained relationships with her family members, limited social connections and was endorsing increased symptoms of depression.

Ms. Peterson decided to move in with her partner and after a brief honeymoon period expressed regret in her decision. She once again wavered about her commitment to the partnership. She would arrive to therapy with what felt like the "crisis of the week," typically related to interpersonal frustrations at work or an argument with her boyfriend. It became increasingly difficult to focus on behavior change and my CBT interventions were usually met with intellectual rationalizations for why they would not be effective, even before giving them a try between sessions. Ms. Peterson stated that she "couldn't remember" what we talked about in between sessions. She started to bring a notebook to jot down homework and methods to interrupt her negative cognitions but would forget to refer to her notebook throughout the week.

While maintaining a compassionate stance toward her difficult circumstances, I once again revisited more CBT interventions in hopes of initiating behavioral activation and gently nudging Ms. Peterson in a direction that would address her depression. During this phase of treatment, I also encouraged Ms. Peterson to identify small goals. These goals included calling a friend, visiting a favorite café in town, taking her dogs to the park, or working on a knitting project. Ms. Peterson engaged in these commitments less than half of the time. This method did not prove helpful as it did not seem to make any difference in her overall mood, and it concerned me that Ms. Peterson would feel "punished" or like a "failure" if the week's goals were not fulfilled. During the first year of treatment, our psychotherapy centered around building rapport, managing crisis, and failed attempts to incorporate CBT intervention strategies such as cognitive

restructuring, Socratic questioning, behavioral activation, thoughts logs, relaxation techniques and stress reduction strategies.

We began to incorporate more relaxation exercises, guided meditations, and visualizations into our therapy sessions. We explored more somatic psychotherapy routes, connecting Ms. Peterson's feelings to experiences in her body. We also identified her values and discussed small actions that would bring her closer to more value-driven living. These practices provided temporary relief but had little effect on her long-held belief that she was not "worthy" and destined for failure, regardless of her efforts. The goals for therapy continued to change week-to-week and it became clear that the root of Ms. Peterson's distress was more closely tied to characterological traits than situational depression or anxiety. A longer term, open-ended relational approach would be a more appropriate fit for our work together.

After about a year and a half, with the guidance of a new supervisor, I steered our conversation to center around clarifying our goals for treatment and keeping therapy content relevant to identified goals. Even so, the goals seemed to shift and change from "improving self-confidence" to "making new friends" to "finding meaningful work." Regardless of the changing goals, I became more resolute in my belief in using our relationship as a focal point of treatment to highlight areas of interpersonal difficulties. I incorporated immediacy into psychotherapy to work out interpersonal conflict in real time. We began using metaphors and searching for long-standing themes and behavioral patterns from her life that would play out between the two of us in therapy.

For example, Ms. Peterson once described feeling that she could not enjoy simple activities such as coloring because she is too much of a perfectionist. Coloring induces stress for her because she fears she will "mess up" the drawing or draw outside of the lines. She also stated

that she would want to be the best at coloring, and if her drawings are not revered as "the best", she would feel she had failed. This fear of not performing perfectly persists in many activities of her life and has been used as a metaphor in our psychotherapy. I often wondered if her fear of failure, and fear or her life improving, was getting in the way or her ability to engage in psychotherapy, for fear at failing at therapy too.

For the next two years, Ms. Peterson and I met weekly and explored a range of themes. We spent considerable time exploring her ambivalence about her job and relationships at work. It was clear that Ms. Peterson did not trust that she could make the "right" decision or keep herself safe. She often looked outside of herself for answers, particularly to me, as her therapist. For example, Ms. Peterson often asked me, "what do you think I should do?" or say, "I wish you would just tell me what to do." She frequently entered sessions telling me about the advice she received from Reddit forums or Facebook groups. She sought guidance on topics such as her romantic relationship, her friendships, her mental health, and her physical health from strangers on the internet. Feedback she received often dictated how she would feel about herself or her decisions. She leaned heavily on homeopathic remedies to "cure" her anxiety or depression and almost weekly provided updates on how the introduction or removal of a food item or supplement dramatically altered her mood. I sometimes felt that Ms. Peterson viewed herself as a bundle of chemicals that needed the correct input of nutrients or medications to balance her emotions. Once again, it did not feel like therapy offered a place for growth and healing, but rather a place to review her symptoms.

The psychotherapy ultimately transitioned to an eclectic, open-ended relational therapy approach from the initial CBT perspective. This evolution in treatment modalities were influenced in part by changing supervisions, as well as by different classes and supervision

groups in which I was constantly learning new therapy techniques that I felt could be beneficial for Ms. Peterson. CBT interventions used early on in treatment helped us identify many of Ms. Peterson's core beliefs and problematic thinking patterns that kept her feeling "stuck," depressed, and anxious. These beliefs and patterns were often referenced throughout treatment and appeared to empower Ms. Peterson to feel some control over the frequency and intensity of her distress. However, the shift to a more relationship-based style of therapy seemed to support deeper and more lasting change. The goal of this relational approach was for Ms. Peterson to experience what it is liked to be understood and appreciated, so she can consolidate that experience and strive for it elsewhere. By the end of therapy, she had made some progress in this area as evidenced by efforts to "look and feel good" so that she would feel confident dating again. She also enrolled in an online educational program to change careers so that she could remove herself from a work environment that she felt was toxic. As we neared our inevitable therapy termination due to my departure from the graduate program, Ms. Peterson reported that she felt she finally had access to a "treasure map." By "treasure map" she meant the instructions on how to live a more meaningful and fulfilling life, however, she continued to feel too scared to utilize the map. She reported that she is aware that she is "blocking" herself from doing the "therapeutic work" required to feel better, even though she now feels she knows what to do. For the first time in five years, Ms. Peterson made the decision to end psychotherapy treatment, rather than transfer to a new student therapist.

Clinician Reflection

I started working with Ms. Peterson toward the end of my first year of graduate school. With just one year of therapy experience under my belt, I was naïve to the complexities of psychotherapy. In some ways, I believed as a new therapist, "if I deliver the interventions, the

patient will improve." Working with Ms. Peterson was one of the first times that I felt "stuck." I now know that feeling "stuck" in treatment is a common experience, but I have many more tools at my disposal to move treatment forward.

I found myself frustrated with Ms. Peterson's lack of progress. I believe this stemmed from my own insecurity about feeling ineffective or "not good enough" as a therapist to be helpful to her. Because of the "crisis of the week" nature of the therapy, I felt that Ms. Peterson could be talking to anyone and that we were not building a unique relationship. My role as a therapist felt unimportant and I remember wondering if Ms. Peterson was looking for someone to talk "at" rather than "to." I started to experience my own ambivalence and it was related to whether or not I wanted to work with her. Each week started to feel like I was failing.

Fortunately, I had wonderful supervisors that would point out the parallel process at play. Ms. Peterson felt "stuck" in treatment and therefore I felt "stuck" in my growth as a clinician. I felt confused and worried about Ms. Peterson and concerned that I may not be best suited to be working with her as a therapist-in-training. I wondered if a more experienced clinician would have already experienced a breakthrough with her, and if there was something I lacked that would make a difference in improving her treatment. When Ms. Peterson questioned her confidence and ability to take care of herself, I also questioned my ability to provide her with useful treatment.

Our training as psychotherapists is very focused on the evidence-based research supporting effective psychotherapy. We rarely explore the common experience of stagnant or failing treatment, the effect it has on the clinicians, and practical steps for how to manage this situation. The words "stagnant" and "failing" in this paper refer to my own personal experience of working with Ms. Peterson and are not words that she herself used in treatment. I use

"stagnant" and "failing" as the words to describe the bulk of this therapy case because they are true to my experience as the provider for Ms. Peterson's case. Ms. Peterson and I also discussed the stagnation in our treatment often as we openly wondered about the usefulness of our time together and what roadblocks may have been preventing us from moving closer to Ms. Peterson's psychotherapy goals. These words may not be helpful, effective, or therapeutic in all circumstances and it may be more useful for some to use the term "therapy plateau." I have developed suggested areas for therapists to explore when they find themselves in stagnant or failing psychotherapy as well as indicators to help identify this stagnation.

Protocol for Stagnation in Psychotherapy

This section is structured in a way that breaks out different domains for the therapist to explore when the psychotherapy process is not effective. The domains are listed in italics below, with explanation for what this domain of psychotherapy means, and how to identify if there may be a problem in this specific domain. I then apply each domain to Ms. Peterson's case to illustrate a practical application of how to address any potential problems.

Identify Stagnant or Failing Therapy

The first step to improve stagnating or failing therapy is *identifying* that the therapy is stagnant or failing. As discussed in the literature review, clinicians are not good at identifying ineffective treatment, and have an overly positive self-assessment bias. Gathering feedback about psychotherapy progress should be an ongoing process that the therapist monitors and documents each session. The initial screen for identifying stagnant or deteriorating psychotherapy is client verbal feedback. If the client is expressing that their symptoms are remaining the same, or worsening, over multiple weeks of treatment, this is an indicator that the therapist should re-visit the treatment goals and intervention strategies. Another way to self-assess psychotherapy

progress is through peer consultation or supervision. These conversations lend themselves well to identifying therapist blind spots or overly positive self-assessment when the relationship is open and honest.

Oftentimes, clients will not explicitly share their stagnant or worsening symptoms, or they do not have the vocabulary or awareness to articulate their experience effectively to the clinician. In these situations, clinicians can incorporate validated feedback systems into the psychotherapy process to monitor outcomes. The research literature highlights numerous examples of feedback systems, one of which is a tool called the Session Process and Outcomes Measures Web Form I (Hill & Kellems, 2002).

Clinical Application in Ms. Peterson's Case. I often felt therapy treatment was stagnant or failing while working with Ms. Peterson, even without the use of a screening tool. I recognized this early in our work together because our appointments felt different than the work I was doing with many of my other clients. For example, I would find myself feeling frustrated with the repetitive nature of the content of our sessions. I often left our appointments feeling drained, rather than energized by the collaboration and productiveness I found with other clients. Additionally, Ms. Peterson's self-report in our weekly sessions indicated that she was not feeling better, and oftentimes feeling worse than her baseline. In this case, psychotherapy stagnation was obvious because Ms. Peterson herself was telling me directly that her therapy goals were not being met. However, she felt it was important to stay engaged in therapy in hopes that it would "start working" over time. She also became more receptive to feedback and open to new ways of approaching therapy as our work together progressed. I did not learn about the Session Process and Outcomes Measures Web Form I (Hill & Kellems, 2002) until I started researching for this

paper. In retrospect, I would have considered working a tool such as this into our therapy sessions to provide a more structured way to discuss the psychotherapy process.

Is There a Problem with the Working Alliance?

The working alliance includes three elements: therapy goals, tasks, and bonds (Wampold, 2014). Has your client identified clear and reasonable goals? Is the weekly therapy content relevant to these goals? If not, what is getting in the way? The second element of the working alliance includes agreement of the therapy tasks. If you have an agreed upon goal with your client, do you and your client agree on how to use the therapy space to reach those goals? Is homework an integral part of the therapy treatment? Has it become clear what is useful and not useful to talk about during appointments?

Lastly, if you have both goals and agreed upon tasks of therapy with your client and therapy is still ineffective, the next step is to look at the therapy bond. The therapy bond can be explored in conversations with peer consultants or supervisors. Many elements of the therapy bond can also be examined through Hill & Kellems' (2002) Session Process and Outcomes Measures (see Appendix A). Particularly statements such as “I did NOT feel a bond with my helper,” “I liked my helper,” “I trusted my helper,” and, “I worked collaboratively with my helper.” These questions, of course, can and should also be asked directly to the patient. However, it is important to keep in mind that the patient may not be able to answer these questions openly and honestly if there is a poor therapeutic bond or problem with the working alliance.

Clinical Application in Ms. Peterson’s Case. In Ms. Peterson’s case, she was reluctant to identify goals and often deferred to me as her therapist to tell her what she needed to work on in therapy. We spent many months identifying a goal and working toward the completion of the

goal for only one or two sessions before Ms. Peterson would bring up a new and "more important" topic or goal to discuss. Ms. Peterson's difficulty sticking to a goal, or difficulty remembering her therapy goal, appeared to be an avoidance strategy that played into her fear that "when good things happen something bad will follow." We spent many months exploring and understanding the root of this fear and its interference on her therapy progress. However, it was clear from the beginning that we had an insufficient working alliance due to our inability to stick to a goal. Or perhaps, the emphasis on the goal of symptom reduction early on in the CBT oriented treatment missed the mark on what Ms. Peterson truly needed.

In the case of Ms. Peterson, we could not identify a consistent goal for therapy, therefore we were unable to maintain agreement about the "tasks" of therapy. Many of our sessions were filled with the "crisis of the week," interfering with our ability to focus on a goal. We carved out time in our therapy to discuss both of our beliefs of how therapy should look and feel, slowly co-creating a space that felt more like therapy and less like an opportunity for Ms. Peterson to vent about her weekly stressors.

Regarding our therapy bond, I often felt unimportant and easily replaceable as Ms. Peterson's therapist. I had the feeling that Ms. Peterson did not want to invest too deeply in our relationship with the knowledge that I would ultimately leave the clinic and she would start over with a new provider. Our sessions did not feel as if they were building upon one another, leading me to imagine that they would unfold in a similar fashion if, for example, a substitute therapist sat in for me one week. At the time, I was not familiar with Hill & Kellems' Session Outcomes and Therapy Process questionnaire, but I incorporated many of the questionnaire's topics into our sessions with the support of my supervisors. I began to share my subjective experience of working with Ms. Peterson during sessions and processing both of our reactions together.

Is There a Problem with the Theoretical Orientation/Treatment Modality?

If the working alliance is healthy and therapy is still ineffective, it is helpful to look at the clinician's theoretical orientation. Research shows that using theory-based treatment is more effective than placebo or no treatment (Lambert, 2005). Are you using an evidence-based treatment model in your practice with this client? Is it possible your client would be more responsive to a different style of treatment?

Clinical Application in Ms. Peterson's Case. My work with Ms. Peterson was initially rooted in a more cognitive behavioral style of therapy. Multiple modalities were utilized over the course of the three years, including Acceptance and Commitment Therapy (ACT) and psychodynamic psychotherapy. Ultimately, it became more apparent that Ms. Peterson's delayed response to treatment was more related to characterological aspects of her personality than situational depression or anxiety. Targeting symptom reduction with coping skills proved unhelpful and it became clear that Ms. Peterson's interpersonal style contributed to difficulties at work and in her personal relationships throughout adolescence and adulthood. I ultimately adopted a longer-term, open ended relational style to psychotherapy to best support Ms. Peterson. Consultation and supervision was a great way to receive guidance on reviewing the goodness of fit for different theoretical orientations when I was approaching stagnant or failing treatment with Ms. Peterson.

Is There a Problem with the Therapy Setting?

Psychotherapy occurs in a variety of settings including hospitals, community mental health clinics, and private practices. The psychotherapy setting and its influence on therapy will vary person-to-person and setting-to-setting. For example, is there something about being in therapy that is contradictory to the client's self-experience? Are they from a culture where they

are not allowed to have a close connection with someone outside of their family? Are they in a medical setting with a 10-session limit imposed by their health insurance? Are they worried about the cost of therapy? Is therapy taking place over video hindering the client from finding a private and secure location to talk? Is video technology interfering with the working alliance? In these circumstances, the client may not be in a situation that permits them to be a therapy patient. It is important to look at your client's current circumstances, social history, culture, etc. and ask yourself, can therapy really work for them given the current therapy setting?

Clinical Application in Ms. Peterson's Case. The psychotherapy relationship with Ms. Peterson took place in a student-run clinic affiliated with the University of Denver Graduate School of Professional Psychology (GSPP). The setting in which my work with Ms. Peterson may have been in impediment to her therapy goals for a few reasons. First, our clinic offers a sliding fee scale based on income. Ms. Peterson paid a session rate of $15, the lowest fee on our scale. It is possible that the structure and context of our student clinic sent the message that therapy was not a place to take advantage of the fifty minutes to do hard work and focus on psychological growth, but rather a location she could go to find a sounding board and receive validation for her suffering. At first, we did not have a psychotherapy relationship, but rather an exchange more commonly found in the relationship between a patient and a medical doctor with an extensive review of symptoms and deference to the "expert" in the room. The session content focused more on the "crisis of the week" rather than complex and meaningful relational patterns and lasting psychological changes. During the last year of our work together, Ms. Peterson had moved in with her father and was no longer paying rent. This would have been an opportunity to discuss raising the therapy fee to a more appropriate level in hopes that this higher fee could motivate Ms. Peterson to make more meaningful use of the time.

The student clinic is also structured in a way that allows me to move onto the next step of graduate training and leave the clinic, leaving Ms. Peterson to transfer to the next therapist, similar to how she was transferred to me in the beginning of our work. This structure undermined the importance of our unique relationship. It meant that I was an interchangeable aspect of her treatment and that she could realistically be assigned a new therapist every two to three years. Why would Ms. Peterson become too attached or invested in a therapist, knowing they were always going to leave her? This is inherently counterproductive to the relational style of psychotherapy I was hoping to build with Ms. Peterson and possibly detracted from her ability to really see me as an important relationship in her life (a pre-requisite to successful psychotherapy). While I could not change the setting in which I was treating Ms. Peterson, I did use this knowledge to inform my conceptualization and respond in a more clinically relevant and therapeutic way to the content brought into session.

Is There a Problem with the Client's Environment?

Is psychotherapy ineffective due to the client's environmental constraints? Ask yourself, "are my client's symptoms a typical or healthy response to their environment or circumstances?" For instance, if you are working with a client feeling worried about their safety who is also undocumented in the United States, long-term relational psychotherapy may not be indicated. In this case, it would be more helpful to normalize rather than pathologize their anxiety, and shift to working on relaxation techniques and coping skills. Another example of this may be a patient seeking support regarding an increase in health-related anxiety during a global pandemic (e.g. COVID). Additional circumstances that would undermine open-ended relational psychotherapy work include a client seeking individual therapy when couples or family therapy is indicated,

someone suffering from current emotional or physical abuse, or current events that may influence a client's functioning.

The present day social and political climate in the United States is a prime example of a confounding environmental factor that could cause stagnation in the psychotherapy process, particularly amongst BIPOC (Black, Indigenous, and People of Color). At this time, BIPOC are experiencing an increased spotlight which, in many cases, leads to even more discrimination and racism. BIPOC are also disproportionately affected by the COVID-19 pandemic due to healthcare access and unequal distribution of BIPOC working jobs with higher risk of exposure to the virus. The stressors currently faced by BIPOC have more recently come into the limelight do not capture how these communities have endured generations of systemic injustices, trauma, and discrimination. Current circumstances may be exacerbating stressors related to minority identities, but they are no means new. Whenever working with diverse populations, it is imperative to explore the person's identity and work to understand how it may or may not correlate with their current symptomatology. It may provide a link to the roadblocks presented in the therapy relationship.

Clinical Application in Ms. Peterson's Case. Ms. Peterson did not identity as part of the BIPOC community, however, she did identify as a member of a lower socio-economic status and found great difficulty in "getting ahead," building financial savings, and felt great constraints in her options due to financial stress. The bulk of the stagnation in my therapy with Ms. Peterson occurred while she was living with her boyfriend who she felt was verbally abusive and at times, sexually abusive. She felt ambivalent about her relationship with this partner for almost two years. Additionally, she felt financially strained and did not believe she could afford to move out of their shared housing. During this time, it was difficult to work on changing Ms. Peterson's

psychology when she felt unsafe at home and financially stressed. While always prioritizing client safety and creating space for the processing of emotions related to her current circumstances was important, it was also essential to gently create some boundaries around these topics to ensure time and space to support Ms. Peterson's self-esteem and feelings of self-efficacy. I believe it was my job to validate her current experience while also guiding Ms. Peterson toward work that would allow her to develop the strength to leave the relationship and find safer housing.

The environment regarding the COVID pandemic and heated political climate during the last few months of our work together may have also influenced our clinical work. Ms. Peterson believed she contracted COVID-19 early in the spring of 2020 and recovered fairly quickly. This experience seemed to improve her confidence in her perceived safety because she believed that she had developed immunity against re-contracting the disease. This experience perhaps challenged a belief she held that her body was weak and prone to "worse-case scenario" responses to illness. Ms. Peterson described feeling "productive" and "useful" upon returning to work and filling shifts at COVID screening operations at work. I believe this change in environment may have led to opportunities to feel more connected to a larger purpose, while also increasing her feelings of self-efficacy.

Is There a Problem with the Therapist?

During stagnation in therapy, it is essential for the clinician to be able to ask themselves how they are bringing their own limitations into the therapy room. If the clinician has not yet done their own personal psychotherapy or self-reflective work, it is very possible they will bring a problematic bias or blind spot that could interfere with the treatment. If the clinician is not self-reflective themselves, it is difficult to know if their own inability to do "the work" is getting in

the way of treatment. It is not possible to ask a client to go farther than the clinician has gone themselves, emotionally.

It is also imperative that the clinician ask themselves if they are just working toward fulfilling their own view of psychotherapy, or if the case conceptualization is engaging enough to the client to create a collaborative atmosphere. It is possible that a therapist is working full steam ahead on what they believe are the most useful goals for their client. Therapists must be aware of their own values in order to gain awareness of when we may be projecting them onto their clients. Therapist projection onto the client is inevitable, as we as therapists are also human with our own subjectivities, however, we can seek consultation and develop self-awareness practices to shed light on how our projections may be interfering with the therapy process.

There may also be instances in which the therapist's own identity and/or personal biases or blind spots are interfering with the effectiveness of treatment. In the example of working with BIPOC communities, the therapist must be privy to the unique circumstances and stressors faced by the community which they are supporting. If not, it is entirely possible that the therapist could overlook crucial elements of a case conceptualization, leading a client to feel misunderstood, invisible, unwelcome, or a myriad of other ways that would interfere with a productive working alliance.

Therapists may also hold visible identity markers that could consciously or unconsciously interfere with a client's ability to work with them. There may be clients seeking psychotherapy support that feel uncomfortable w or unwilling to freely share their internal experiences with a clinician who looks a certain way. White clinicians supporting BIPOC must maintain awareness that their identity may make it difficult for their patients to feel safe or comfortable.

Another common example is a female-identified patient seeking treatment for sexual trauma. She may have a harder time feeling comfortable with a clinician that looks like, or reminds them of their abuser in some way.

Clinical Application in Ms. Peterson's Case. Sometimes I wondered if my intentions for our psychotherapy relationship and how I imagined psychotherapy "should" be interfered with my ability to collaborate more effectively with Ms. Peterson. For example, Ms. Peterson almost never disagreed with an interpretation of mine or a suggestion for a psychotherapy goal. Her passivity or poor sense of self made it very difficult for her to connect with herself and assert her needs and beliefs both inside and outside of the psychotherapy room. I often wondered if I was leading us down a path that felt unhelpful or irrelevant to Ms. Peterson but could not figure out a way to cut through her second-guessing and motivation to avoid relational conflict. It is possible that part of our stagnation in therapy was related to our inability to find genuine agreement in our psychotherapy goals or find mutual agreement on how psychotherapy sessions were supposed to look.

Ms. Peterson and I both identified as white women. While it is impossible for me to truly know how my identity and appearance influenced our therapy relationship, I often noticed Ms. Peterson loosely comparing herself and her situation to me. There was one session in which she directly shared her belief that my life must look nothing like hers, that I must have my life much more "together," and that I may feel some sort of judgement or disdain about the decisions she was making and her life circumstances. There was another appointment in which she shared that it hurt her feelings when she heard me sigh while closing the door behind her at the end of a session. Ms. Peterson shared that she felt she was a "burden" to me and that she believed this sigh indicated that I must find our appointments together "exhausting." These conversations

were difficult to navigate therapeutically but I made great efforts to hold the space for validation and reflection of these feelings. These comments also gave me insight into the discomfort that Ms. Peterson may have felt in working with me because of our seemingly similar identities. It may be easier for patients to make painful comparisons between themselves and their therapists when the share more overt identifies and this could cause problems of their own.

Has the Clinician Sought Supervision or Consultation?

In addition to consistent self-reflective practices, seeking supervision or consultation is always indicated when treatment is stagnant, and the therapist is feeling stuck. This area of exploration is listed last, but it by no means the least important or "last step" in deciding whether therapy is working or not. It is encouraged to seek supervision and/or consultation at any point in therapy. If you are not a current student with required supervision, consider maintaining a close network of peers that will provide honest and direct feedback. Maintaining practices of self-reflection and understanding how our personal evolutions and periods of growth and change influence our psychotherapy relationships is just as important as the effort we put into understanding and supporting our clients.

Trainees are often assigned to supervisors and have limited flexibility in choosing someone with whom they feel comfortable learning. Similar to the psychotherapy relationship, there are a variety of factors that must be in place for a productive and healthy supervisory relationship. It is important to take an honest look at the supervisory relationship when exploring potential roadblocks in therapy. For example, if a trainee is not comfortable disclosing insecurities, concerns, or even known mistakes they have made with their patients, this can inhibit the productivity and reliability that the supervisor will be able to offer relevant and helpful guidance. Another potential area of exploration is if the trainee and the supervisor have

incompatible styles of psychotherapy, or disagreements on conceptualization or intervention strategies. This tension can create a trickle-down effect in the therapeutic relationship that must be accounted for when exploring roadblocks in treatment.

Clinical Application in Ms. Peterson's Case. Given that my work with Ms. Peterson took place in a training clinic through my graduate program, supervision and consultation was a regular practice of mine. For the full three years that I worked with Ms. Peterson, I had weekly supervision with a licensed psychologist in a group supervision setting. This allowed for feedback and ideas from both the psychologist supervising the case (a total of two over the course of treatment) as well as the other psychologists-in-training. I was also fortunate to be paired with supervisors and peers that made me feel safe and comfortable in sharing my honest experiences with them. This style of supervision provided ample support when I was feeling frustrated and stuck with Ms. Peterson in therapy. It also afforded honest and direct feedback as I had developed close relationships with my peers and supervisors.

When is it no Longer Ethical to Provide Psychotherapy?

After a therapist has explored the above questions pertaining to stagnation in treatment, they may come to the conclusion that therapy is no longer appropriate for the patient. In Ms. Peterson's case, it began to feel that therapy was holding her back from living a more meaningful life. Ms. Peterson felt "broken" and coming to therapy each week served as a reminder of her "brokenness" and a place to recall distressing events, rather than a relationship where she could focus on psychological change and healing. I began to notice a pattern over the course of our work together that further supported my concerns that therapy was not only stalled, but potentially interfering with her recovery. During winter and spring break, when the student clinic closed, Ms. Peterson reported improved symptoms and "proved" that she could not only

function, but engage in her life in a more meaningful way (make plans with friends, attend family gatherings, etc.). When offered this observation in psychotherapy, Ms. Peterson quickly rejected the pattern and took a firm stance on the importance of therapy in her life. She shared that she believed she was "someone that would need to be in therapy for the rest of her life." Again, making me feel that psychotherapy was more of a "crutch" that she did not need. This also demonstrated how feeling "broken" in a way that only psychotherapy could "fix" perpetuated Ms. Peterson's narrative that life would never improve.

Rather than making plans to terminate therapy, we started to shift the conversation toward preparing for my inevitable departure from the student clinic. Ms. Peterson had always planned to transfer therapist-to-therapist every two or three years as psychologists-in-training— like myself— moved on in our training programs. This shift in focus from "terminating" therapy to just "planning not to transfer to a new therapist" was a fruitful change in perspective for Ms. Peterson. She no longer viewed me as just another therapist rotating through her rolodex of clinicians, but rather an individual building a unique, and therapeutic relationship with her. Within this frame, we were able to have the most productive weeks of our relationship. In this situation, the circumstances provided a much-needed boost in the psychotherapy process.

If my inevitable departure from the student clinic were removed from our psychotherapy process, I would argue that psychotherapy may have been contra-indicated for Ms. Peterson for the time-being. While I do believe there is always room for growth and positive psychological changes, the patient must be ready and willing to open themselves to a genuine connection with their therapist, share their vulnerabilities and commit to behavioral changes. In Ms. Peterson's case, allowing a space to revisit each week that reinforced her belief that she was broken and unfixable was not helpful and arguably fed the stagnation in our therapy. In her case, I may have

recommended a break from therapy, or a transfer to a community clinician that could offer a longer-term relationship and charge a higher fee for service. However, this option is only plausible given Ms. Peterson has the financial means or insurance coverage to work with a community provider. These structural changes may have generated a similar feeling of urgency for Ms. Peterson to approach psychotherapy in a more effective and useful manner.

Therapy Termination

Therapy termination is often discussed in graduate training in terms of how to do so when a clinician is moving to a new clinic, or the therapy goals have been met. Therapy termination is rarely explored as an option for stagnant or failing treatment. Once all potential roadblocks of psychotherapy treatment have been explored and addressed, and the therapist and patient determine that psychotherapy is no longer a viable treatment, the therapist should consider alternative referrals or treatment recommendations.

Ask yourself, "what are other avenues for healing or change that are not talk therapy?" In the case of Ms. Peterson, it was clear she was missing social connections and hobbies in her life. When we initially discussed therapy termination, I suggested she take the time used for her therapy appointments and fill that space with social plans with a friend. It seemed that spending time with a friend and growing her social network would be more beneficial to her mental health in the long run than spending an hour a week reviewing her misfortunes.

In this scenario, therapists must look outside of our treatment modality (talk therapy) and think holistically on what will be the best approach for a patient's healing. Perhaps acupuncture, yoga therapy, socialization, engaging in hobbies, religious counseling or gathering, group therapy, or even a vacation could be the best "medicine" for a patient struggling to make gains in psychotherapy. Work within the patient's culture and value system. How can the therapist make

a suggestion that moves the patient in direction toward more valued living and away from their maladaptive patterns?

Discussion and Introduction of Psychotherapy Efficacy Measure

This paper explores the literature investigating psychotherapy effectiveness and underscores the evolving debate around the necessary ingredients required for successful psychotherapy. In the search for answers to effective psychotherapy, it becomes clear that there is still a vast amount that we do not know about how or why psychotherapy works. Additionally, there is a lack of research published on treatment failure, possibly related to research journals' disinterest in publishing "non-significant" findings. This leaves clinicians to navigate stagnant or failing treatment with little empirical support or guidance.

This paper retrospectively examines the course of treatment with Ms. Peterson, a case spanning almost three years. During the course of treatment, there were numerous occasions in which I perceived treatment to be stagnant or failing. This paper provides a roadmap for clinicians who find themselves "stuck" with their own patients and showcases a successful, long-term psychotherapy case after many months-long periods of stagnation and sometimes decline. Toward the end of treatment, Ms. Peterson reported a decrease in symptoms of depression and anxiety and had also made behavioral changes in line with her goals of developing more self-efficacy and independence.

I have identified the main factors that I believe moved our therapy from nearly failing to a success through a combination of self-reflection from my work with Ms. Peterson and extensive research in psychotherapy effectiveness. The elements that I believe to have been most effective in jumpstarting Ms. Peterson's psychotherapy included many of the transtheoretical common factors such as exposure, feedback, insight, reassurance, trust, affect experiencing, and

a therapeutic alliance that slowly developed and strengthened over time. Progress with Ms. Peterson was slow and non-linear, which can be frustrating as a therapist but often typical for patients, especially those with long-standing personality traits that have caused problems for many decades. I often had to remind myself that many patients see significantly more improvement after 50 sessions of treatment (Lambert and Ogles, 2004). Additionally, time and commitment to developing the therapeutic alliance, which includes the bond between therapist and patient, agreement of goals for therapy, and agreement about the tasks of therapy (Wampold, 2015) was crucial in creating an environment conducive of change for Ms. Peterson I can look back on moments of time during the course of treatment in which the therapeutic alliance needed attention, most often around the bond between myself and Ms. Peterson. This was most pronounced during sessions when I felt that even after many months of working together, that I would be easily replaceable with another student therapist. It took time to nurture our emotional bond and support Ms. Peterson to come to a place where she felt safe and that our relationship was unique between the two of us, rather than interchangeable with previous therapists. Once we hit our stride and found mutual trust, consensual goals, and a structure of therapy that included meaningful tasks, the therapy relationship became a foundation on which Ms. Peterson could take risks and slowly integrate change into her life.

Ms. Peterson's case inspired this therapist to develop the McCormick Psychotherapy Efficacy Measure. The McCormick Psychotherapy Efficacy Measure was developed to support therapists in identifying the domain(s) of psychotherapy treatment that may be contributing to stagnation or treatment failure. It is organized as a summary of the recommendations provided in this paper. The screener is taken by both the client and the therapist to highlight the areas of treatment that may require further exploration. Once areas of concern are identified, the

domain(s) should be discussed between the therapist and client in a collaborative fashion. The paper serves as a reference for the therapist to better understand each domain and offers a case example for how each domain was addressed in the case of Ms. Peterson.

Conclusion

I aspire to destigmatize the experience of stagnation in psychotherapy while also motivating therapists to continue learning and improving their skills. While this case serves as one unique example of a plateau in psychotherapy, I hope the lessons learned and the recommendations for addressing stuck or failing therapy will apply to any stagnant course of treatment. Rather than berating ourselves or questioning our competence, this paper intends to serve as a practical guide to empower therapists to reinvigorate the therapy process or to feel confident identifying when psychotherapy is no longer the most appropriate form of treatment.

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Appendix A
(Hill & Kellems, 2002)

WEB FORM I
SESSION PROCESS AND OUTCOME MEASURES—CLIENT

Instructions: Indicate how much each statement reflects your experiences in this session. Please note that all of these things do not occur in every session because helpers do many different things to be helpful. The term helper can refer to a therapist, counselor, or any other person in the helping role. *Circle one number for each item using the following scale:*

In this session, my helper...	**Strongly Disagree**				**Strongly Agree**
1. asked questions to help me explore what I was thinking or feeling	1	2	3	4	5
2. encouraged me to challenge my beliefs	1	2	3	4	5
3. did **NOT** help me think about changes I could make in my life	1	2	3	4	5
4. did **NOT** teach me specific skills to deal with my problems	1	2	3	4	5
5. did **NOT** encourage me to express what I was thinking or feeling	1	2	3	4	5
6. helped me become aware of contradictions in my thoughts, feelings, and/or behaviors	1	2	3	4	5
7. helped me think about my concerns	1	2	3	4	5
8. did **NOT** help me identify useful resources (e.g., friends, parents, advisors, schools, clergy)	1	2	3	4	5
9. helped me figure out how to solve a specific problem	1	2	3	4	5
10. helped me understand the reasons behind my thoughts, feelings, and/or behaviors	1	2	3	4	5
11. did **NOT** encourage me to experience my feelings	1	2	3	4	5
12. did **NOT** discuss with me specific things I could do to make change happen	1	2	3	4	5
13. helped me gain a new perspective on my problems	1	2	3	4	5
In this session, I...					
14. did **NOT** feel a bond with my helper	1	2	3	4	5
15. liked my helper	1	2	3	4	5
16. trusted my helper	1	2	3	4	5
17. worked collaboratively with my helper	1	2	3	4	5
I...					
18. am glad I attended this session	1	2	3	4	5
19. did **NOT** feel satisfied with what I got out of this session	1	2	3	4	5
20. thought that this session was helpful	1	2	3	4	5
21. did **NOT** think that this session was valuable	1	2	3	4	5

SESSION PROCESS AND OUTCOME MEASURES—HELPER

Instructions: Indicate how much each statement reflects your experiences in this session. Please note that all of these things do not occur in every session because helpers do many different things to be helpful. The term helper can refer to a therapist, counselor, or any other person in the helping role. *Circle one number for each item using the following scale:*

In this session, I...	**Strongly Disagree**				**Strongly Agree**
1. asked questions to help the client explore what s/he was thinking or feeling	1	2	3	4	5
2. encouraged the client to challenge his/her beliefs	1	2	3	4	5
3. did **NOT** help the client think about changes s/he could make in her/his life	1	2	3	4	5
4. did **NOT** teach the client specific skills to deal with his/her problems	1	2	3	4	5
5. did **NOT** encourage the client to express what s/he was thinking or feeling	1	2	3	4	5
6. helped the client become aware of contradictions in his/her thoughts, feelings, and/or behaviors	1	2	3	4	5
7. helped the client think about her/his concerns	1	2	3	4	5
8. did **NOT** help the client identify useful resources (e.g., friends, parents, advisors, schools, clergy)	1	2	3	4	5
9. helped the client figure out how to solve a specific problem	1	2	3	4	5
10. helped the client understand the reasons behind her/his thoughts, feelings, and/or behaviors	1	2	3	4	5
11. did **NOT** encourage the client to experience his/her feelings	1	2	3	4	5
12. did **NOT** discuss with the client specific things s/he could do to make change happen	1	2	3	4	5
13. helped the client gain a new perspective on his/her problems	1	2	3	4	5
In this session, my client...					
14. did **NOT** feel a bond with me …….	1	2	3	4	5
15. liked me …….	1	2	3	4	5
16. trusted me …….	1	2	3	4	5
17. worked collaboratively with me …….	1	2	3	4	5
My client...					
18. is glad that s/he attended this session	1	2	3	4	5
19. did **NOT** feel satisfied with what s/he got out of this session	1	2	3	4	5
20. thought that this session was helpful	1	2	3	4	5
21. did **NOT** think that this session was valuable	1	2	3	4	5

Appendix B

(McCormick, 2021)

McCormick Psychotherapy Efficacy Measure- Therapist

Instructions: Indicate how much each statement reflects your experience of psychotherapy with a specific patient up to this point in time. Circle one number for each item using the following scale:

		Strongly Disagree				Strongly Agree
1)	Therapy is helpful for this patient	1	2	3	4	5
2)	The patient and I are working toward the same goals	1	2	3	4	5
3)	We work toward our goals week-to-week and are not easily sidetracked by crises/weekly updates	1	2	3	4	5
4)	The patient is connected to me and collaborating with me	1	2	3	4	5
5)	My theoretical orientation is useful for this case	1	2	3	4	5
6)	The therapy setting is conducive to treatment	1	2	3	4	5
7)	There are limited social, political, or environmental factors causing distress to my patient	1	2	3	4	5
8)	My personal biases and psychology are not interfering in this relationship	1	2	3	4	5
9)	My identity is not interfering in this relationship	1	2	3	4	5
10)	I feel supported by a supervisor or peer consultant on this case	1	2	3	4	5
11)	Psychotherapy is indicated and ethical for this patient	1	2	3	4	5

McCormick Psychotherapy Efficacy Measure- Patient

Instructions: Indicate how much each statement reflects your experience of psychotherapy with your current therapist up to this point in time. Circle one number for each item using the following scale:

		Strongly Disagree				Strongly Agree
1)	It feels like psychotherapy is "working" for me	1	2	3	4	5
2)	My therapist and I have agreed on clear psychotherapy goals	1	2	3	4	5
3)	My therapist and I stay focused on these goals week-to-week and are not easily sidetracked by crises	1	2	3	4	5
4)	I feel connected to and understood by my therapist	1	2	3	4	5
5)	I like my therapist's style and approach to psychotherapy	1	2	3	4	5
6)	The therapy clinic is welcoming and comfortable for me	1	2	3	4	5
7)	I would struggle with the same problems regardless of social, political or environmental factors that may cause me distress	1	2	3	4	5
8)	I am paying an appropriate fee for psychotherapy	1	2	3	4	5
9)	Overall, therapy is helpful to me	1	2	3	4	5