“After getting the courage to go…”: An Interpretative Phenomenological Analysis of the customer experience of people who stop going to therapy.

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Sara Broadhurst

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ABSTRACT

Objectives: The study investigated the customer experience of people who had chosen to stop going to therapy, after one to three sessions of 50-60 minutes. In addition, it sought to understand if this experience influenced their future likelihood of using therapy and what they would recommend to others about therapy.

Design: Qualitative interview study.

Methods: Six people participated in semi-structured interviews, of between 60 and 90 minutes, about their customer experience of therapy with a psychologist or counsellor in Aotearoa New Zealand, who stopped after one to three sessions. The qualitative experiential methodology of interpretive phenomenological analysis was applied to the interview transcripts.

Results: Using the four customer experience stages as a framework, the analysis generated themes and subthemes which provided insight into the customer experience and dropout decisions. First, in the pre-experience stage negative connotations still exist about mental health, although these have improved over time. Second, in the pre-purchase stage, participants were anticipating the therapy experience, with subthemes of process and expectations. Third, in the purchase stage, the details matter. Included are four subthemes: the physical space, customer feelings, therapist in-session behaviours and the termination experience. Finally, in the post-purchase stage, participants remained optimistic about therapy, with the subtheme that participants would recommend therapy to others, but with caveats. The participants' decision to engage in future therapy or to recommend therapy to others was not influenced by having an unsatisfactory experience.

Conclusions: The results of research to date on the causes of client dropout from therapy is broadly inconclusive and there is little research from a qualitative or customer experience perspective. Considering each stage of the customer experience brings a different perspective to the variables that influence dropout. In addition, it provides valuable insight into the customer's decision to terminate, the things that need to be true for people to

participate in future therapy and what they say to others when recommending therapy. This study makes a number of contributions for therapists looking to reduce the dropout rate of people attending their service.

PREFACE AND ACKNOWLEDGEMENTS

My interest in the topic of people's experience of going to therapy was prompted by the change in response I have received over the years when I had suggested to someone that they might want to go and speak with a psychologist or counsellor. I have worked in human resources in multiple organisations for over 20 years and frequently talk to employees about their wellbeing and encourage them to utilise the usually free to them, employee assistance programmes. In the early 2000s, when I would suggest this service to people, a typical response would be "Oh, it's not that bad" with some sense that I was judging them or the implication that people only seek help when the situation is dire. In more recent years though, the response has changed. It seems likely that some of this is as a result of a changing cultural construct where mental health and wellbeing has become much more normalised. Interestingly to me, when I now recommend to people that they go and talk to someone, a much more typical response is "Oh, I tried that, it didn't work". I was surprised by that response and disappointed that people were having an unsatisfactory experience. I was also curious about why that was and interested in whether this would influence their willingness to go to therapy in the future or suggest it to others.

It has been a privilege to have the time, space, and support to undertake this research. I acknowledge the librarians at Massey University, who constantly exceed my customer expectations for their speed of response, helpfulness, and time. I appreciate and value the consistency, encouragement and support of my supervisor, Associate Professor Dr Matthew Shepherd. I always felt heartened and re-energised after our catch-ups - tēnei te mihi ki a koe Matt!

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for your time, generosity of spirit, reflections, and ideas. I feel confident that what you have shared will make a difference to the customer experience of others attending therapy.

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GLOSSARY OF TERMS

Term	**Definition** (Te Whanake, n.d.), unless noted otherwise.
Ao	World, worldview
Aotearoa	Used as the Māori name for New Zealand
Kaupapa	Topic, policy, matter for discussion, plan, purpose
Māori	Indigenous person of Aotearoa New Zealand
Mātauranga	Knowledge, wisdom, understanding, skill
Pākehā	New Zealander of European descent
Rangatahi	Younger generation, youth
Tāngata whaiora	People seeking wellness (Paterson et al., 2018)
Tāngata whenua	Local people, hosts, indigenous people
Tikanga	Correct procedure, custom, habit
Whānau	Extended family, family group

Chapter One: INTRODUCTION

Mental distress is a widespread health concern, with one in eight people globally living with a mental disorder (World Health Organization, 2022). It is estimated that 50-80% of New Zealanders will experience mental health challenges in their lifetime (Paterson, et al., 2018). Not every one of those people will necessarily require mental health services (Narrow et al., 2002), and in reality, the majority of people receive no treatment (Kazdin, 2017). In the United States for example, nearly 58 million adults, or one in five, experienced mental distress and over 50% of those people did not receive services to support their health (National Institute of Mental Health, 2021). Rather than seeking help from a mental health specialist, people who experience mental health issues have been found to be more likely to try and feel better by talking to friends, making health lifestyle changes and behaviours, or getting outside (Wellcome, 2021).

If people can access healthcare, there are effective, evidence-based mental health treatments available (Barkham & Lambert, 2021; Calati & Courtet, 2016; de Jong & DeRubeis, 2018) and the accepted findings are that psychological treatment over time contributes to improvement in mental health (Barkham & Lambert, 2021; Cuijpers et al., 2019). The numbers vary in terms of the proportion of customers who will have improvement. For example, there is a general finding that 65% of people receiving treatment will have positive outcomes compared to 35% of the no-treatment group, using a treatment size effect measure (Lambert, 2013). Duncan et al.'s (2010) review of studies found that the average treated person is better off than 80% of those with no treatment. Positive outcomes have been found to have occurred for approximately 60% of customers by the end of treatment in randomly controlled clinical trials (Lambert, 2013) and lower in naturalistic settings such as clinics (Hansen et al., 2002). The topic of people ceasing therapy is important because research has found that psychotherapy is generally more effective than a placebo or spontaneous remission, in helping people with their mental distress (Lambert, 2011; Saxon et al., 2017). However, some research has found little difference in outcomes between treatment completers and those that choose to end treatment early (Björk et al., 2009; Szafranski et al., 2017), so the findings are not unequivocal.

When considering rates of attrition, the numbers of people who stop going to therapy are significant, ranging between 20 and 75% (Baekeland & Lundwell, 1975; Barrett et al., 2008; Swift & Greenberg, 2012; Wierzbicki & Pekarik, 1993). The research has also found that there are less positive mental health and wellbeing outcomes for people who end therapy early (McMurran et al., 2010) or even the potential to get worse (Reis & Brown, 1999). Although it may also be that the detrimental effect is due to a poor therapy experience, rather than dropout (Bowie et al., 2016). The people around the person experiencing mental distress may also be affected. Individuals who terminate therapy without seeing positive therapeutic change may be demonstrating symptoms which impact on others (Swift et al., 2012), such as their whānau and friends or people in places they visit regularly including their workplace, community groups or neighbourhood. There are also broader economic consequences where an individual's wellbeing is not optimal. Bloom et al. (2011) identified mental distress as an approximate cost to the global economy of US$2.5 trillion in 2010 and estimated this would more than double by 2030. The Royal Australian and New Zealand College of Psychiatrists (Sweeney et al., 2016) estimated that the annual cost of burden of disease from serious mental illness was $3.1 billion in Aotearoa New Zealand in 2014. In the workplace, a lot of focus has been placed on costs associated with sick leave, absenteeism, and turnover, but presenteeism is also a key cost. Presenteeism is when employees are at work but not performing at their usual level and estimated costs are five to ten times higher than those of absenteeism (Evans-Lacko & Knapp, 2016).

In addition, many clients end treatment without discussion (Knox et al., 2011), so the therapist may also be negatively impacted by the sudden disappearance of their client, and this may affect the way in which they approach future clients, their own professional development and even their own wellbeing (Piselli et al., 2011). As there is increasing and unmet demand for mental health services (Paterson et al., 2018; World Health Organization, 2021), the resource wastage that occurs when a customer does not turn up for an appointment also impacts on others who are unable to access that service in a timely fashion. The finding from longitudinal studies that most people will experience at least one episode of mental disorder (Poulton et al., 2015) means each wasted session adds to the barriers to therapy.

The research question of this study was to explore the customer experience of people who stopped going to therapy, after one to three sessions, to consider how this might influence the participants' future likelihood of using therapy and whether they would recommend therapy to others. The aim of the study is to provide insight, information, and potential actions and to add to the current knowledge set for researchers and therapists about ways in which dropout rates may be decreased. For the purpose of the current study, "customer" or "person/people" are used to describe the person accessing the service. Other terms which are often used are client, consumer, patient, or user. Customer is preferred here as it aligns with the research and theory on customer experience which is central to this study. However, client or patient will be used where it is the term being used in a piece of research under discussion. As the most popularly used term (Hellstern & Robinson, 2023), and for ease of reading, the term dropout will be used in this paper for the action of not continuing therapy. Although it should be noted that this term has pejorative connotations and it is important to be aware of our own assumptions, as not all dropouts are necessarily treatment failures (Pekarik, 1983). Similarly, for ease of reading, the term therapist is used to refer to any mental health professional, clinician or counsellor and the term therapy is used to accommodate both psychotherapy and counselling.

Chapter Two: LITERATURE REVIEW

This study considers the customer experience of people who stop going to therapy and takes a hybrid approach by drawing on models and thinking from marketing and psychology on customer experience and therapy. Marketing and psychology have long been connected in the specialised discipline of consumer psychology, so this approach is not new. Success in marketing is underpinned by better understanding and influencing customer beliefs, decision-making, loyalties, preferences, and other constructs which are of deep interest to psychological research and understanding (Allan, 2018; Schmitt et al., 2015). Customer experience research is centrally focused on what happens from the customer's perspective, how they felt about it, how they describe it to others and what they action they may take (Holbrook & Hirschman, 1982; LaSalle & Britton, 2003; Pine & Gilmore, 1999). However, research that leads from the customer voice, as opposed to the therapist's view in a health or wellbeing setting, has only become the focus more recently, due to broader socio-political changes (Pilgrim & Waldron, 1998). Much of the extant research on dropout continues to take the therapist or researcher view in determining definitions, causes and consequences (McMurran et al., 2010; Roseborough et al., 2016; Swift & Greenberg, 2014). In this literature review, the current research on customer experience and people who stop going to therapy is summarised to provide context for the current study. Following from this, the literature review also considers how customers views are captured about therapy experiences currently and then the voice of customer, with a focus on people with a lived experience and Māori, as tāngata whenua in Aotearoa New Zealand. The goal of this study is to identify by exploring and amplifying the participants' own words what supports or diverges from existing research in the field. This aim is to identify changes that practitioners might make to deliver a service customers want to keep using, as well as suggesting ideas for future research.

Customer experience

This section considers how globally ubiquitous services are, the construct of customer experience has developed over time, customer complaining behaviour and therapy as a

service. This section also considers how customer experience influences the future use of a service and recommendations to others.

Service

The definition of services includes "wholesale and retail trade, restaurants and hotels, transport, storage and communications, finance, insurance, real estate and business services, and community, social and personal services" (United Nations International Labor Organization, 2016, p. 77), therefore includes therapy. Services have become globally dominant as a percentage of Gross Domestic Product (GDP), in recent decades ("Data Bank", n.d.), a sample of which are presented in Table 1.

Table 1

Services Value Added (% of GDP) in 2020 by Country

Country	Services, value added (~% of GDP) (2020)
Aotearoa New Zealand	67
Australia	66
Brazil	61
China	54
Germany	63
India	48
Italy	67
Russian Federation	56
United Kingdom	73
United States	78

"Data Bank", n.d.

Not only do services make up significant proportions of the economy, but individuals are also deeply familiar with customer service as a concept. Partly because the largest proportion of people work in service industries. In 2021, 50% of people were estimated to work in the service sector globally, compared to 23% in agriculture and 27% in industry

(manufacturing). In Aotearoa New Zealand, that number rises to 74% (The World Bank, n.d.). This is similar to other high-income countries such as Australia (79%), Canada (79%), France (78%) and the United Kingdom (79%) (International Labour Organization, 2015). This means people are familiar with the idea of customer service and customer experience from a consumer perspective, having bought services, but also most people are also employed in organisations where they receive training, have performance expectations, and physically deliver a customer service experience every day of their working lives. Customer experience is deeply embedded in our culture.

Development of Customer Experience

The concept of customer experience was coined in the 1980s as marketing theory shifted from a rational and transactional approach based on price, product, or quality to a more experiential approach (Holbrook & Hirschman, 1982). By the 1990s it had become mainstream, with some arguing that experiences are another economic offering, separate from services or products (O'Sullivan & Spangler, 1998). Thinking on customer experience was significantly influenced by Pine & Gilmore's work (1999) on businesses 'staging' an experience and Schmitt's (1999) work on operationalising the customer experience for business benefit. From there, emphasis was placed on the sense that customers have a lived experience when engaging with a company (LaSalle & Britton, 2003). Subsequently, thinking shifted to customer experiences which are co-created by both the customer and supplier (Carù & Cova, 2007; Verhoef et al., 2009) through the environment, artefacts, technology, people, and skills that are utilised. There is no single industry-agreed definition of customer experience (Arici et al., 2022) and given its importance to marketing theory (Jain et al., 2017), it will continue to evolve over time. Typical areas of current research interest, and which are relevant to this study, include factors such as how memorable the experience is (Kim & So, 2022), the individual, personal nature (Verhoef et al., 2009) and the multi-dimensional nature of the experience for the person (Brun et al., 2017). Also, temporal factors are relevant, such as impact on future behaviours, including loyalty (Srivastava & Kaul, 2016) and experience over key moments, rather than as a transactional event (Homburg et al., 2017).

Frameworks and models to describe and measure customer experience have been developed. Bueno et al. (2019) undertook a systematic review of 33 papers in the marketing field, focussed on how customer experience is measured in the service sector. They found that there are three commonly measured stages: pre-purchase, purchase, and post-purchase. They proposed an additional stage for measurement; that of pre-experience, before the person has considered engaging with the service. Pre-experience includes items such as general predisposition, knowledge of and beliefs about the industry, knowledge about how to access it and general purchase intentions. In some regards these four stages are like the stages of change, modelled by Prochaska and DiClemente (1984); precontemplation, contemplation, preparation, action, and maintenance. There is a time before the person knows they want to purchase or change; that is pre-experience or precontemplation, followed in the models by stages in which the individual takes action over time and subsequently reflects on that particular purchase or change. Because the construct of customer experience continues to evolve, there are varying models of measurement available. Becker and Jaakkola (2020) in their systematic review of 136 articles on customer experience note that the five most measured customer experience dimensions are cognitive (thinking or conscious mental processes), affective (emotions, feeling, mood), physical (environmental and technology), sensorial (taste, hearing, smell, touch and sight) and social anticipation and responses (relational with others and with the person's ideal self and values and beliefs). In the experience of going to see a therapist, these dimensions may play out differently at the various stages. In summary, consideration of the customer experience pays attention to multiple dimensions (cognitive, affective, physical, sensorial, and social) over four touchpoints (pre-experience, pre-purchase, purchase, and post-purchase). In the current study, the Beuno et al. (2019) stages of purchase are used to frame up the interview with participants and to provide them with an easily understood shape to the conversation. Questions are asked of participants and the content of the interviews is then considered using the five dimensions identified by Becker and Jaakkola (2020).

Consumer Complaining Behaviour

Sometimes customer experiences result in dissatisfaction. Consumer complaining behaviour (CCB) has been an active area of research interest since the 1970s (Khamitov et al., 2019), with the establishment of Hirschman's (1970) exit, voice, and loyalty model. CCB seeks to understand how customers respond to unsatisfactory experiences (Istanbulluoglu et al., 2017). Day and Landon's (1977) model of consumer complaining behaviour is considered a cornerstone framework of subsequent research (Kitapci et al., 2019) and is made up of public, private or no action. The model has been updated so that private actions now include social media posts or commenting on public boards, even though the customer view and supplier's response, if any, are potentially publicly visible (Herhausen et al., 2019). To illustrate, Table 2 summarises the Day and Landon (1977) model, with additions to allow for technology channels (Kitapci et al., 2019).

Table 2

Consumer complaining behaviour – excluding 'no action'

Public Action	Private Action

• Complain to:
  ○ The provider.
  ○ Regulators.
  ○ Advocates.
• Take legal action.
	• Exit the provider.
	• Boycott the provider.
	• Tell or warn others about your experience (negative word of mouth).
	• Posting on websites or social media to share your experience.

Arora & Chakraborty (2021) in their bibliometric analysis of 729 articles found that the research has sought to understand which unsatisfied customers are more likely complain, considering factors such as person-situation interactions, customer demographics, contextual variables, and customer-provider relationships, with little indication of clear findings or obvious actions.

A considerable proportion of dissatisfied customers do not complain to the provider, known as non-complainers. In the Day and Landon (1977) model they take “no action” or “private action”. In research, it seems to be generally accepted that most dissatisfied customers do not complain (Chebat et al., 2010; Panda, 2014; Voorhees et al., 2006) but there appears to be little means of confidently quantifying the size of that majority. Numerous studies have found these numbers of non-complainers range from 21% (Customer Care Management and Consulting [CCMC], 2023), 61% (Siddiqui & Tripathi, 2010), to 90% (Tax & Brown, 1998) or even 95% (Smith et al., 1999). The National Customer Rage Study (CCMC, 2023) analyses customer care and complaint handling in the United States of America, repeating core questions from an original 1976 White House study and nine National Customer Rage Studies completed between 2003-2020. CCMC (2023) asked respondents to identify the main reasons that they did not complain and concluded that “non-complainers are increasingly feeling a sense of ‘learned helplessness’” (p. 27), due to believing nothing could or would be done and frustrations about the process to complain. Their findings are supported by other research which has found there are supplier aspects that may influence why dissatisfied customers do not complain directly to the seller or give up on their efforts to gain satisfaction. These include the anticipated or actual hassle costs of complaining, such as long wait times in the contact centres, multi-step processes or the need to speak with multiple people for resolution (Dukes & Zhu, 2019), customers do not know how or where to complain or feel that nothing will change as a consequence of complaining (Siddiqui & Tripathi, 2010) or they believe there is a low likelihood that the provider will fix the problem (Blodgett & Anderson, 2000). In addition, complaining often requires some interpersonal interactions between the customer and provider which may create a barrier, such as customer anxiety and the fear of offending someone (CCMC, 2023).

Some non-complainers will take no action. In their systematic review of 195 articles, Kitapci et al. (2019) found that “no action” was the least studied of the options. Hirschman’s (1970) exit, voice and loyalty model was extended by Rusbult et al. (1982) to include neglect as a fourth factor. The absence of complaining behaviour and taking no action may be associated with neglect and loyalty behaviours instead (Ro & Mattila, 2015). Loyalty may be about a customer who is willing to give the provider another chance, hoping things will improve over

time, whereas where a customer shows neglect, they may be indifferent to the provider and believe that it is not worth taking action.

Non-complainers may still action dissatisfaction. In terms of private actions, dissatisfied customers are most likely to exit (Mittal, 2016), without telling the supplier of their dissatisfaction. Private actions are obviously problematic for providers as they lose a customer and potential future customers, without knowing why. The reach of non-complainers, who may take private action through social disclosures, has changed over time. Grainer et al. (2013) found in the 1970s people would talk about their unhappy experience with 10 other people, whereas in their 2011 survey, they found socially connected customers can tell an average 280 people about their poor experience each time they make a post on a social networking site. Customers may of course take actions simultaneously across both the private and public sphere, especially where their complaint is not resolved to their expectations (CCMC, 2023; Gyung Kim et al., 2010), such as complaining to the service provider while also telling others about their poor experience.

In summary, it is unknown what proportion of dissatisfied customers will complain to the provider. It seems that most customers do not complain directly, they simply exit the business and will take actions such as not buying from them again or telling others, either directly or through social channels. Customers who do not complain seem to have a view that there is no gain to be had from complaining or that it is too difficult, with more recent research indicating that, for some, anxiety or fear of consequences is a barrier to customers complaining.

Therapy-as-Service

Why should therapists care about the customer experience? Surely, so long as the person's mental health improves, that is all that counts. Pine and Gilmore (2011) present the idea that there is at least an economic imperative to consider moving from the construct of service to experience. They argue economic growth relies on experiences, which are different from and in addition to goods and services. The idea of seeing therapy through an economic lens is not entirely unexplored. For example, Swift et al. (2012) consider dropout

from a cost/benefit perspective. They take the rational, economist perspective that people are more likely to remain in therapy when the benefits outweigh the costs. In their approach, benefits for customers include aspects such as feeling supported by their social networks or therapist, believing that there is hope or experiencing a positive change. On the other side of the scale, costs such as actual time or money investments, or the emotional labour it takes to be in therapy. In addition to the economics, the world of product, service and experience is shifting rapidly, largely due to technology. The Internet of Things, artificial intelligence, and other developments in technology are likely to impact on the customer experience offering in the future to an extent that they will disrupt current offerings and bring to life entirely new ways of operating (Hoffman & Novak, 2018).

However, an economic and futurist perspective may not be enough to motivate many therapists to be interested in customer experience, as they are working in an industry where they already feel pushed to be more productive and cost effective (Shapiro, 2021). As Miller (2004) notes, many therapists have felt increasing pressure to perform, their offering has been commoditised and clients and their insurers are increasingly price conscious. Many of whom also did not become therapists in order to run a business and consider customer experience, but because of an interest in human behaviour and desire to help others (McBeath, 2019; Sanchidrián et al., 2020). At the same time, therapists can be concerned about, and even distressed by, their clients ending therapy early (Piselli et al., 2011). This indicates the customer experience perspective may be just one more source of pressure to therapists.

Certainly, little of the existing research on early therapy termination has focused on the customer experience. McMurran et al. (2010) reviewed 25 studies of people with personality disorders to identify factors associated with dropout. They noticed that many of the studies focussed on client related disorders, and stable dispositions and traits and that there was little focus on the service itself or the customer's opinion of the service. Knox et al. (2011) arrived at a similar conclusion that research on terminations is dominated by a focus on the therapist view with comparatively little research on the client's perspective. However, the study of customer experience in a health context is growing, more typically described as 'patient experience.' This seems to have had impetus from a lived experience

voice which is more valued than it has been in previous years along with changed regulatory, socio-political, and ethical environments. For example, in England, the National Quality Board (2022) has made it mandatory for this data to be collected and incorporated into health service development, quality improvement and delivery. In the United States of America, the Affordable Care Act (2010) embedded patient-centredness in the legislation and mandated the use of patient reported experience measures.

To summarise, there are a range of variables at play when thinking about the customer experience of therapy. These include therapists being motivated to help people and make a difference, feeling negatively impacted when customers do dropout, the construct of customer experience being a generally understood way of operating and one which will continue to develop, along with the growing pressure on delivering efficient therapy models. All these factors together turn dropout into a customer experience question that, with careful thinking and consideration, can be addressed in ways which are positive for both therapists and their customers.

Summary of Customer Experience

People are familiar with the construct of customer experience, both as users of services and, for many, as employees in the service industry ("*Data Bank*", n.d.; International Labour Organization, 2015; The World Bank, n.d.). Customer experience is a widely used marketing theory in commercial organisations (Jain et al., 2017). It is not so widely used in the health sector, although growing, and its use in mental health provides an opportunity to consider benefits for both the customer and for therapist. This current study is shaped by Beuno et al.'s (2019) four stages of customer experience and Bekker and Jaakkola's (2020) five dimensions. When customers have an unsatisfactory experience, it is unlikely that they will complain directly to the service provider. If they act, it is more likely that they take private actions, including exiting (Mittal, 2016).

Dropout

The amount of research on treatment dropout has increased exponentially in recent decades, from less than 10 articles, chapters, and books in the database of the American

Psychological Association in the 1960s to 200-300 each decade since the 1980s (Foschi, 2022). Unfortunately, however, there is no single standardised term or definition for someone who chooses to terminate therapy early and this creates problems when trying to understand the scope and cause of dropout. Terms used include attrition (Roseborough et al., 2016), dropout (Barrett et al., 2008), early termination (Bohart & Wade, 2013), early withdrawal, (Barrett et al., 2008), premature termination (Swift & Greenberg, 2014), therapy discontinuation (Janes et al., 2023), treatment non-completion (McMurran et al., 2010), unilateral and unexpected treatment termination (Cooper et al., 2023) and unilateral termination (Knox et al., 2011). Definitions of dropout are also inconsistent. Research considers elements such as the customer making a decision not to continue treatment without consultation with the therapist, failure to show for an appointment or to show for the final appointment, incompletion of a particular number of sessions or the treatment protocol, missing a set number of sessions, not commencing treatment after assessment, termination before a clinically-significant level of change has occurred, therapist judgement or therapist-initiated termination (McMurran et al., 2010). Other definitions used include "when a client unilaterally discontinues an intervention prematurely, before recovering from the problems that led him or her to seek out treatment and/or before completing the intervention's specified protocol" (Swift & Greenberg, 2014, p. 193) or "clients ending treatment before achieving an optimal response" (Roseborough et al., 2016, p. 803). These inconsistencies result in methodological differences, which then lack the similarity needed to allow meta-analyses which deliver meaningful conclusions and recommendations for change or action (Barrett et al., 2008; Swift & Greenberg, 2015). This lack of agreement about terms and definitions underpins the difficulty in understanding the size, causes and impact of the issues surrounding dropout.

Because of the range of terms and definitions, there is also a wide range of numbers used when trying to quantify the rate at which people dropout from therapy. Numbers range between 20 and 60% (Baekeland & Lundwell, 1975; McMurran et al., 2010; Reis & Brown, 1999; Renk & Denger, 2002; Wierzbicki & Pekarik, 1993). Lippens and MacKenzie (2011) determined a dropout rate of 16% in older adults (≥55 years) while 28-75% were found to be dropouts in children and adolescents (De Haan, 2013). In a meta-analytic review of 669 studies which considered a total of 83,834 clients, Swift and Greenberg (2012) determined a

weighted average dropout rate of 19.7%, with rates in the studies examined ranging from 5 to 74%. Swift and Greenberg (2015) argue this rate, which is lower than in some of the other studies, occurs because of changes over time in the way treatments are offered, increases over time in the reporting rates for dropout and changes in data-analytic techniques being used in research.

It also seems that many customers dropout quickly or before therapy has even started. Hansen et al. (2002) found that a third of customers do not return after the first session. Other research has identified that the modal number of therapy sessions is one (Connolly Gibbons et al., 2011) and Barrett et al. (2008) found that approximately 50% of people drop out of therapy by the third session. In addition, it should be noted that many studies do not consider customers who drop out in the pre-treatment stage; that is, when the person has agreed to treatment but discontinued before the first session occurred (Fernandez et al., 2015). This variable, depending on the dropout definition of choice, may suggest that these numbers underestimate the percentage of customers who are lost to the service.

The numbers may not be all that helpful, not only because of the wide range and inconsistencies in findings and the difficulties in misattributing dropout. A further problem, as de Haan et al. (2013) note, is that much of the source of systematic reviews are post hoc quantitative studies, most commonly efficacy studies in randomised controlled trials. As such, they do not approximate the complexity that is found in a naturalistic environment, such as a clinical practice or community programme. Therefore, the ability to generalise these results to what happens in a particular practice is questionable. What it does show however is that therapists should be expecting a significant level of dropout and taking action to pre-empt that.

Issues which influence dropout

The issues which influence dropout are grouped here into six factors, using a structure developed by Barrett et al. (2008, p. 250): “patient characteristics, enabling factors or barriers, need factors, environmental factors, perceptions of mental health and mental distress, and beliefs and assumptions about mental health treatment”. These are naturally

interconnected; for example, it might be assumed that someone of a younger age (patient characteristic) may be less likely to have the disposable income to pay for treatment (enabling factors) or that someone living in a rural community has had their perceptions and beliefs about mental health shifted through communications from services such as their regional Rural Support Trust (Rural Support: Health and Wellbeing, n.d.) but still has problems accessing face-to-face treatment (environmental factors). In addition, many of these factors and the ways in which therapy is delivered are changing rapidly. For instance, the increase in understanding the need for and value in delivering a culturally appropriate service (Bennett et al., 2014; Evans, 2002), broader societal understanding that mental health is important (Wellcome, 2021), shift towards community-based care (DeLeon et al., 2011), use of technology (Weinberg et al., 2023) and time-limited treatments (Foschi, 2022) might suggest that barriers to accessing treatment are decreasing. That may result in dropout rates also decreasing in the short-term and possibly very recent research may either over-estimate dropout rates or miss or misattribute new causes or contributing factors. Interestingly, these factors have little reference to the therapist-controlled influencers, such as practice, credibility, and in-session behaviour. The research has to date been weighted heavily towards considering the customer-related variables that impact on dropout (Cooper et al., 2023). Dissatisfaction with the therapist or the type of treatment is a key reason people have for terminating therapy, ranging between 22% and 46.7% in the findings (Swift & Greenberg, 2015). These matters will be considered in more detail in the Therapy Experience section (pp. 25-33).

Patient characteristics (demographic factors)

The research findings of the patient characteristics associated with dropout are mixed. An early review (Baekeland & Lundwall, 1975) indicated that younger people, lower socio-economic status (SES) individuals and women had higher dropout rates. In contrast, Wierzbicki and Pekarik's (1993) meta-analysis found an association between dropout and people of an ethnic minority, having a lower education level and SES status, whereas Garfield (1994) did not find an association with age and gender, but did find a relationship between lower income-levels, people of an ethnic minority, and lower education levels. In their review, Reis and Brown (1999) found a relationship between dropout rates and people

with lower income levels or of ethnic minorities but did not conclude there is a relationship between dropout and demographic factors such as age, gender, or relationship status. Similarly, Barrett et al.'s (2008) review of the research showed a relationship with dropout based on income levels and ethnic minority demographics and no relationship with age. In a summary of studies, McMurran et al. (2010) concluded that dropout was associated with younger age, lower education, and lower occupation levels. Lippens & MacKenzie (2011) found older adults may have a lower dropout rate and speculate this is due to likely higher levels of trust in the older population, and higher perceived levels of effectiveness, meaning that they are more inclined to continue treatment. Across more recent studies, being younger (Roseborough et al., 2016; Swift & Greenberg, 2012) is the only characteristic which has been found to be consistently associated with increased rates of dropout. Other factors such as ethnicity and employment status were similar for those who dropout versus those who completed treatment. There are contradictions in findings across other characteristics such as education level, gender, or marital status (Hinton et al., 2022; Roseborough et al., 2016; Swift & Greenberg, 2012). Given the inconsistency of findings, any association between demographic factors and dropout should be treated with caution (Cooper et al., 2023; Swift & Greenberg, 2012). Other influenceable variables, such as client expectations and therapeutic alliance, will likely provide more fruitful mitigations for dropout (Bohart & Wade, 2013; Cooper et al., 2023; Swift & Greenberg, 2015; Wierzbicki & Pekarik, 1993).

Enabling factors or barriers (service cost, social support)

People's abilities to both access and maintain therapy are mixed. Put simply, life gets in the way. Kazdin et al. (1997) identified that many people have barriers to treatment, such as conflict with others about going to therapy as well as the cost and time required, and that these barriers can increase the likelihood of someone ending therapy early. Barriers frequently identified in the research include a lack of knowledge about treatment options and availability, where to go, what happens and cost, along with systemic economic, legal and language limitations (Benjet et al., 2022; Choudhry et al., 2016). Other life factors such as physical illness, work conflicts or transport problems (DeFife et al., 2010) also impact on a person's ability to maintain attendance at therapy. Some studies have found higher dropout rates amongst those that have limited financial resources or insurance coverage (Khazaie et

al., 2016; Roe et al., 2006), although this is not consistent across all research (Hellstern & Robinson, 2023). Like many other services, the chances are increased of people exiting when it becomes too difficult.

Need factors (diagnosis, complexity, distress level)

This section considers the likelihood of therapy dropout in light of the diagnostic characteristics, complexity of mental health issues and the degree of distress the person is experiencing. In terms of diagnosis, again the findings are mixed. Early studies such as Baekeland & Lundwall's (1975) review found that some diagnostic criteria had a relationship with dropout, while other diagnostic criteria did not. Some research reviews have found that people diagnosed with a personality disorder may have a higher dropout rate (Barrett et al., 2008; McMurran et al., 2010; Swift & Greenberg, 2012; Schindler et al., 2013). Swift and Greenberg's (2014) meta-analysis of 587 studies examined whether there were significant differences in dropout rates between treatment approaches, across 12 different disorders. They found a non-significant difference in nine of the diagnostic categories and significant differences in dropout related to treatment orientation in three diagnostic areas: depression [Q(9) 22.69, p .01], eating disorders [Q(7) 14.63, p .05], and posttraumatic stress disorder (PTSD) [Q(7) 20.20, p .01]. Other disorders which have been found associated with dropout are eating disorders (Flückiger et al., 2011) and sexual offenders with elevated psychopathology scores (Olver & Wong, 2011). In their meta-analysis, Swift & Greenberg (2012) noted that the highest dropout rates were in studies that did not specify a particular disorder or treated a disorder that was not one of the 12 diagnostic categories they used. Beyond that though, the highest dropout rates were found with people receiving treatment for personality (25.6%) or eating disorders (23.9%). Swift and Greenberg (2015) surmise that this is due to "rigidity" of practice and "slow treatment progress" (p. 45) being common features of these disorders and influencing a person's decisions about the value of continuing in therapy. However, given all this attention, the research is not unequivocal that specific disorders are likely to result in higher dropout rates.

Regarding the complexity of issues that people are facing, the research considers other personal traits as well as comorbidity of diagnostic criteria. Knox et al.'s (2011) qualitative

interviews with 12 clients where they considered positive and problematic terminations, the reasons for attending therapy was similar amongst all research participants. However, those with problematic terminations more frequently expressed worries about grief and loss. Knox et al. (2011) infer that this difference may have made those individuals psychologically more vulnerable, with greater psychological or attachment needs than their counterparts. This may lead them to place greater expectations on the therapist and therapy process, which may not be achievable, and emphasising termination as another painful dissolution in their lives. McMurran et al. (2010) found people who dropout had lower levels of skills in areas which would enable successful treatment outcomes. They identified lower skills in social problem solving, persistence, and greater avoidance coping skills were more typical in people who dropout. When considering traits, motivation comes through as the most commonly identified, with levels either impacting on the likelihood of sticking with therapy through the challenges that will naturally occur or low motivation being associated with higher dropout rates (Baekeland and Lundwall, 1975; Lambert, 2013; Mütze et al., 2022; Olver & Wong, 2011; Reis & Brown 1999; Yelavich, 2021). Frayn (1992) grouped their study participants into two groups: early terminators (within the first month) and later terminators (two to nine months). They arrived at a view that early terminators had "insufficient motivation or the emergence of a powerful disorganising negative transference and resistance at a time before a significant therapeutic alliance is available" (p. 258). In contrast, later terminators were a more heterogenous group with a broader range of factors contributing to their reasons for ending therapy. Other protective factors may include psychological mindedness, that is, the tendency to be inward looking and seek to understand people and behaviour in psychological terms (Baekeland and Lundwall, 1975; Immel, et al., 2020; Lambert, 2013; Reis & Brown 1999). On the flip side, variables which seem to be associated with higher rates of dropout are defensiveness, impulsivity and low frustration tolerance (Reis & Brown, 1999), resistance (Olver & Wong, 2011) and therapy anxiety, safety behaviours and self-stigma (Yelavich, 2021)

Varying forms of comorbidity have been found to be associated with higher rates of dropout, such as anxiety with comorbid depressive disorders (Issakidis & Andrews, 2004; Karyotaki et al., 2015) or obsessive-compulsive disorder with comorbid depressive disorders (Kyrios et al., 2015). Conversely, there are studies that do not find any association between

dropout and comorbidity, such as Gersh et al.'s (2017) systematic review of 45 studies of people experiencing generalised anxiety disorder and a review of 20 studies of veterans with PTSD (Goetter et al., 2015). Consideration of the severity of mental distress that someone is experiencing when going to therapy also has mixed findings. Ogrodniczuk et al.'s (2008) research with people with personality disorder found that people who dropout are less distressed than people who complete treatment. With a slightly different lens, AL-Asadi et al. (2014) found people who withdrew from an online programme were less concerned about their mental health than those that did not withdraw. In contrast, a study with women undertaking integrated treatment for comorbid PTSD and substance abuse disorders (Killeen et al., 2023) found people were more likely to dropout where they had increased levels of PTSD symptoms. In summary, there are not consistent findings that particular disorders, customer traits or levels of complexity are associated with dropout rates. With caution, motivation and psychological mindedness may provide protective factors for persisting with therapy.

Perceptions of mental health and mental distress

While the American Psychological Association had discussed the need for better public understanding of psychology since 1892 (Benjamin, 1986), the first research on public perceptions was published in 1948 (Wood et al., 1986). The public perception of psychology has been the subject of many published and unpublished studies since that time. Wood et al. (1986) reviewed those studies along with findings from a telephone survey of respondents in four major cities in the United States. The common themes of the surveys were that while survey respondents were in the main positive about the profession, the understanding of psychologists and psychology lacked a fundamental base understanding of the benefits and practices of the industry. Public research for the American Psychological Association in 1995 (Farberman, 1997), using focus groups and telephone surveying, found that conservative attitudes towards mental wellbeing still prevailed particularly with older people and in non-urban areas. Mental health was largely considered in mental illness terms and outdated, pejorative terms such as "crazy people" were used by research participants (Farberman, 1997, p. 129). Participants were generally unable to describe when it would be the appropriate moment to make an appointment with a psychiatrist or psychologist.

(Farberman, 1997). In addition, participants often noted factors such as cost, insurance coverage, lack of faith in the outcome, and a belief that “you need to work out your own problems" (Farberman, 1997, p. 129) as reasons why they would not engage with psychological treatments. In terms of what participants were looking for from their therapist, the most important factor was working with someone who “you could trust and feel personally comfortable with” (Farberman, 1997, p. 134).

These views seems to be relatively stable over time. Patel et al. (2018) arrived at similar findings about public perceptions of provider roles in their qualitative research, also in the United States. They found that there is still a lack of clarity for the general public about the role of mental health professionals. The study also found that stigma about mental health continues to exist, including ideas that disorders such as schizophrenia and bipolar disorder are ‘untreatable.’ Atasuntseva et al. (2020) sought to understand adults’ views of child psychology resources. Respondents’ views were that psychologists were the preferred provider and had equivalent levels of effectiveness and trustworthiness ratings to paediatricians. When looking for a provider, respondents said that referral from a trusted source, the provider’s reputation, use of evidence-based practices and the therapist’s personal characteristics were key decision-making components. Both studies (Atasuntseva et al., 2020; Patel et al., 2018) noted that more public information is needed to grow knowledge and improve utilisation of mental health services. While these studies did not consider dropout, such views may impact on customers’ predisposition, expectations, experience and assessment of therapy and their decisions to dropout or continue.

Patel et al’s (2018) findings on stigma associated with mental health related matters are supported by other research. Choudhry et al.’s (2016) meta-synthesis of 15 qualitative studies about mental health perceptions and beliefs in a broad range of communities found the most common barrier to treatment was cultural beliefs around mental illness stigma. Over thirty percent of people in Aotearoa New Zealand responded that they would feel ‘not at all comfortable’ speaking about anxiety or depression with someone they know (Wellcome, 2021). Using a pooled dataset from multiple surveys in Aotearoa New Zealand over the period 2015 to 2018, Flett et al. (2020) found that one in five people who had experienced mental distress were either afraid to or avoided doing something because they

feared being discriminated against. In Britt et al.'s (2015) study with military personnel, participants' likelihood of dropping out was increased when associated with stigma-related career concerns, others treating them differently because of their mental distress and with self-stigma. Self-stigma, or "a concern in seeing oneself in a negative light" associated with seeking treatment (Britt et al., 2015, p. 143) and was a predictor of dropout in their study. As an additional perspective on stigma, mental health professionals have also been found to hold negative implicit attitudes and ambivalence towards people with mental distress, at rates similar to those found in people with no previous contact (Kopera et al., 2015).

While there are still disparate societal attitudes towards people experiencing mental distress, there has been a general trajectory towards a more compassionate outlook. However, there is no doubt that many people with lived experience have a lingering fear of shame, discrimination, and negative consequences, realistically connected to portions of our community who continue to espouse and demonstrate outdated views. It seems likely that these associations with stigma may be associated with dropout rates.

Environmental factors (accessibility, settings)

Until recently, most therapy has occurred on site at a clinic, inpatient or outpatient setting or therapist's office. Despite this, there has been little research around the impact of the physical setting on the customer experience or likelihood to dropout. Swift and Greenberg (2015) noted that external or environmental factors impact on the client choosing to dropout 40-55% of the time. Sharf et al. (2010) in their study of the relationship between treatment alliance and dropout found that the setting significantly moderated the relationship. The largest weighted average effect on dropout took place in inpatient settings ($d = 0.98$) and was a significantly larger effect than counselling centres or research clinics. Swift and Greenberg (2012) found that dropout rates were higher in university-based clinics compared to other treatment settings such as a private or public outpatient clinic or one affiliated with a hospital or medical school, a research/specialty clinic, or an inpatient setting. Higher dropout rates were seen in clinical settings than in clinical trials in Geotter et al.'s (2015) systematic review.

Therapy is becoming more available to people through online means. These include self-guided web-based interventions or therapy offered by a therapist via video. A study of a self-guided web-based intervention for people with depression (de Graaf et al., 2009) found that 38% of enrolled participants did not complete the first session and only 14% completed all sessions. In their meta-analysis of seven trials, Cuiljers et al. (2011) concluded that dropout in these circumstances may be exacerbated by the anhedonia and loss of motivation as typical symptoms of depression. They advised participant motivation needs to be high, and participants need to be able to effectively complete the programme without support, to mitigate for dropout. In a systematic review of 29 studies of computerised cognitive behavioural therapy for people with depression, Rost et al. (2017) found that the mean dropout rate was 31.5%, in a range of 0% to 63% in the studies included in the review. Participants reported that they stopped because of a lack of time, technical difficulties, computer-related problems, or experiencing the treatment as inconvenient. Similar to the dropout rates generally for in-person therapy, dropout rates for online treatment span a wide range. The hope that dropout rates might be lower because barriers associated with travel or uncomfortable settings are removed is not yet being demonstrated. In a study with people with musculoskeletal and mental health needs (Cheng et al., 2023), the options of digital, printed and in-person interventions were tested with patients and staff. Digital solutions were supported by all stakeholders, but participants required significant support to download and use the app even during the study. Without that support, they would have effectively dropped out. Therefore, this suggests online options require resources such as information channels or technology support. Without this resource, dropout rates will underestimate those people who cannot even get started.

Beliefs and assumptions about mental health treatment

Mental health literacy is made up of the beliefs, assumptions and knowledge that people have about mental health treatment (Jorm et al., 1997). These can be affected by factors such as personal experience, education, media, and cultural norms. Every customer arrives at therapy with some level of mental health literacy and this knowledge impacts on their willingness to engage in the first place, as well as their expectations about what will happen, perceptions of the therapist, treatment outcome, satisfaction, and potential to dropout.

Choudhry et al.'s (2016) meta-synthesis of 15 qualitative studies about mental health perceptions and beliefs in a broad range of communities found that beliefs and perceptions varied in different cultures. Even so, there were four common themes when people thought about mental health and distress. First, across the studies people believed mental health symptoms are both emotional and behavioural. Second, they described the problems that people with mental distress experienced as behavioural, physical, and emotional and that these happened within a context of life stressors, trauma, and coping. Third, in terms of the causes, participants believed the causes to be psychosocial and environmental such as stress, socioeconomic disadvantage, discrimination or trauma and other factors, as well as spiritual, biomedical, or genetic causes. Finally, when it came to treatment and help-seeking behaviour, multiple treatment options were believed to be valid including psychological and psychiatric treatment. Not surprisingly, given the belief by many in spiritual causes of mental disorders, seeking or utilising spiritual resources was also widely recommended for treatment. Social support and significant others, whānau and friends were also recommended as other resources for treatment and help. Several studies they reviewed found that people believed treatment should only be sought where the severity of the mental distress was high, and these views were stronger in communities where mental distress had a more extreme stigmatisation.

There seems to be little research available which explores the association between customer beliefs and dropout rates and, in many cases, beliefs and expectations are used interchangeably in the research (Stewart et al., 2014). The differentiation used here is that individual beliefs describe what 'should' happen where expectations describe what 'will' happen. Expectations are considered in the section Therapy Expectations section of this study (pp. 25-33). Elkin et al. (1999) found that where the treatment was aligned with people's beliefs around the causes of their mental distress and what should happen in therapy, they were more likely to stay in therapy. They proposed that therapists should be aware of customers' beliefs and predispositions and be responsive to those in the way in which they approach therapy. Swift et al. (2022) found less frequent dropout where customers believed that their spiritual beliefs were accommodated in treatment sessions Analysis showed that accommodation level of customers' religious and spiritual beliefs correctly predicted the dropout status of 75% of the participants. Windle et al.'s (2020)

systematic review of 29 randomised clinical trials found lower dropout rates when customers were receiving the psychosocial mental health treatment which matched their preferences. Similarly, Swift et al.'s (2018) meta-analysis of 53 studies found that where the customer's preferences were accommodated in therapy, there were decreased dropout rates and improved treatment outcomes.

In addition, where customers believe that treatment is failing (Swift & Greenberg, 2015) or not logical (Hofmann & Suvak, 2006), it appears they are more likely to dropout. A consistent finding in the research is that customers will frequently dropout at the point they believe that treatment is no longer needed (Roos & Werbart, 2013; Springer & Bedi, 2021). Therapists, naturally, also have beliefs and assumptions about mental health treatment. When it comes to dropout, therapists may be more likely to determine, especially when considering their own clients, that client factors or the situation caused dropout, rather than the therapist (Murdock et al., 2010). In a replication of that study by Dandachi-FitzGerald et al. (2022), they found it was more likely to occur in therapists who place a higher value on closure. In summary, there is limited research on the relationship between beliefs and dropout in therapy and much of the research conflates beliefs with expectations. The research that is available suggests that therapists would benefit from testing beliefs and assumptions with customers and, to limit dropout, accommodating those in their therapeutic practice.

Summary of issues which influence dropout

There appears to be little agreement on the issues that influence dropout, however there are some consistencies becoming known. The review of the literature suggests that, as a generalisation, demographic variables have not been found to have a consistent association with dropout. Similarly, there is not clear evidence that particular disorders, traits, or levels of complexity are reliably associated with dropout rates. With some caution, it might be considered that some factors may be reliably associated with an increased likelihood of dropout. These factors are multiple practical barriers to attending and ongoing discrimination and stigma. Therapists may consider customer motivation and psychological mindedness, for greater retention. Research on environmental factors is limited and use of

technology does remove some barriers but brings other complications. There has been little research on beliefs and assumptions, and much of this conflated with expectations. The research may suggest that therapists would find it worthwhile testing beliefs and assumptions with customers and influencing or accommodating these, to limit dropout.

Therapy Experience

This section considers what happens in treatment with relevance to a customer experience perspective, focusing on three areas. These are expectations, feedback, and satisfaction.

Therapy Expectations

People participating in therapy have expectations loaded in two ways; process and outcome (Norberg et al., 2011). Process refers to expectations about what will happen during therapy, how quickly the customer might see change, the roles of the various parties and timeframes. Outcome relates to the level of improvement and helpfulness of the therapy that the customer expects they will see. In qualitative research with 12 clients about their termination experience, Knox et al. (2011) found that many individuals with a problematic termination had been more rigorous about interviewing therapists before selecting that provider. This might suggest that this had resulted in greater or more fully developed expectations than typically experienced by customers who were more casual about choosing their provider. The researchers found that this behaviour seemed to be motivated by concerns around loss, which were experienced at a greater extent than those people who had a positive termination experience. Many customers will have had experience with going to therapy previously and this will impact on their expectations in their subsequent interactions. Research with adolescents found that those who had been to therapy previously had fewer negative expectations about future therapy than those that had no experience (Stewart et al., 2014). They speculate this may be because the young people began therapy the first time with fewer negative expectations or that the experience of going to therapy has shifted their expectations in a positive direction.

Therapy Process

Expectations of the treatment process include practical considerations that the customer envisages will occur during their treatment, including timeframe, type of treatment, therapist alliance and difficulty in therapy. In terms of timeframes, research consistently suggests that people expect their treatment to take a much shorter period than the treatment protocols suggest (Swift & Callahan, 2011) and only expect to attend a few sessions (Swift & Greenberg, 2015). In addition, dropout rates are higher when the time frames for treatment are not specified (Swift & Greenberg, 2012). Research has also found that where customers are not experiencing early improvements (Schindler et al., 2013) or where their distress worsened by the third session (Brown et al., 1999), they are more likely to dropout. Hansen et al.'s (2002) review of a database of 6,000 people found that 58 to 67% of people improve in an average of 13 sessions, but that the number of sessions received was an average five sessions and their rate of improvement was only 20%. It seems likely that, unless the topic of timeframes is specifically raised by their therapist, for many people they will think they are not improving or it takes too long (Swift & Greenberg, 2015).

In terms of treatment type, studies of whether a particular treatment is more efficacious than another has had such mixed findings that the "dodo bird verdict" Rosenzweig (1936) took from Alice in Wonderland "Everybody has won, and all must have prizes" (Carroll 1865/1962, pp. 19-20) has become ubiquitous in psychological thinking of common factors (Luborsky et al., 1975). This appears to be true for dropout also, with little difference in dropout rate between orientations of psychodynamic psychotherapy, humanistic, existential and supportive psychotherapy (Swift & Greenberg, 2015). Similarly, there was little differentiation in dropout rates between group or individual therapy (ibid), although some studies have found higher dropout rates in group therapy (Goetter et al., 2015). Swift and Greenberg (2012) found higher dropout rates when participants were in combined therapy; that is individual and group, potentially due to the increased demands placed on the client.

In terms of therapeutic alliance, there has been significant research emphasising the importance of therapeutic alliance to treatment outcomes and dropout (Flückiger et al.,

2020; Kaiser et al., 2021; Roos & Werbart, 2013). There is not a consistent definition of alliance (Horvath et al., 2011) but a useful description is that alliance is made up of three parts: shared goals, agreement on the treatment and an emotional bond (Duncan et al., 2004). As would be expected, the sense of being connected to and working together with their therapist seems to positively affect the outcomes for customers (Horvath et al., 2011). Sharf et al. (2010) reviewed the relationship between dropout and therapeutic alliance in their meta-analytic review of 11 studies. They found a moderately strong relationship between dropout and therapeutic alliance (d = .55), where people who had a weaker alliance with their therapist were more likely to dropout. Cooper et al.'s (2016) study focused on therapist behaviour in-session, in which they found that the therapist's adherence to the treatment manual, along with therapeutic alliance, was positively correlated with treatment completion. Other studies also have found adherence to manualised treatment seems to be associated with decreased dropout rates (Swift & Greenberg, 2015). This may be because, in doing so, the therapist explains what they are doing and why and this helps the customer's expectations to be managed. Adapting the therapeutic approach and style to the customer and checking in to understand their expectations about the relationship and treatment are reliable tools for therapists to use in order to minimise dropout (Norcross & Wampold, 2011).

Customers will often expect and experience difficulty during treatment. In their study, Elliot et al., (2014) found that, prior to treatment, participants generally expected that it would be moderately difficult to resolve their problems. On being surveyed again at the third session, these expectations were significantly lower. In relation to dropout, they also found that expected or experienced difficulty was not associated with the participants' reported commitment to therapy and therefore not associated with likelihood to dropout. In their qualitative interviews with 14 participants, Timulak et al. (2017) found that nearly all participants found therapy to be difficult, but critically, they also found it to be helpful. Similarly, Marotti et al.'s (2020) IPA study with five teenage boys experiencing moderate to severe depression found that they understood therapy would be difficult but were prepared to continue where there was a purpose to the pain. It appears that customers expect therapy to be challenging, partly because what has led them to therapy is not easy.

Therapy Outcomes

One of the key expectations of people going to therapy is that there will be a positive treatment outcome, by whatever measure is important to them. From a practice and research perspective, treatment outcomes are generally considered in terms of the treatment size effect or a clinical significance of change measures. Using the clinical significance of change measures sees a lower percentage of patients experiencing a benefit. The clinical significance of change measure is made up of two factors for people receiving treatment; first, statistically reliable improvements are determined as a consequence of treatment (Jacobson & Truax, 1991), and second, following treatment people are statistically indistinguishable from population norms (Kendall et al., 1999). This results in a more conservative finding of the benefit of treatment; that is, the percentage of people who are determined to have benefited from treatment is lower. For example, a review by Eisen et al. (2007) found that 38% of inpatients benefited from treatment when using a clinical significance of change measure whereas 67% improved using the treatment size effect measure.

In developing a psychometric which measures client expectations, Norberg et al. (2011) found that positive outcome expectations seem to influence whether someone will consider engaging in treatment and that having positive process expectations might influence what happens once someone begins treatment. Lampropoulos' (2010) study with 112 clients and their trainee-therapists in a counselling training clinic found that there were positive treatment outcomes for both completers and dropouts. The therapists generally viewed the outcomes more positively for completers, but there was no difference between completers and dropouts in the customer view of outcomes. Lampropoulos (2010) found only moderate levels of client-therapist agreement on treatment outcomes and speculates that therapists may underestimate and customers may overestimate treatment outcomes in the case of dropout. Similarly, in a study of client and therapist views, Westmacott et al. (2010) found that where the customer had dropped out, the customer and the therapist had a divergent view on the customer's level of posttherapy distress; that is customers felt that their distress was much lower whereas the therapists felt that there was no change in functioning. Much of the outcomes research is premised on the belief that a customer

values a treatment outcome, above all other factors. However, research by Swift and Callahan (2011) found that individuals would accept a treatment with a lower recovery rate as a trade-off to working with a therapist who delivered a positive working relationship and could be described as "warm, empathetic and accepting" (p 1223). It appears that these findings on outcomes are inconsistent due to the differing definitions of dropout. Where a customer feels they are better, either sufficiently or entirely in their view, they would not consider stopping therapy to be a case of dropout (Roe et al., 2006). However, dropout criteria may have been met based on the definitions determined by completing a treatment programme, clinical measure, or therapist assessment of improvement. The dropout numbers are wide ranging and within that, it appears that customers may discontinue because of sufficient improvement 13 to 37% of the time (Swift & Greenberg, 2015). In comparison, when it is a mutual agreement to end therapy, the customer and therapist tend to be much more aligned about the level of decline in distress and increase in functioning (Lampropoulos, 2010). This is not unexpected if it is assumed that a mutual ending to therapy is likely to involve a number of conversations where views are shared and explored, leading to a greater alignment of perspectives.

Therapy Feedback

Just as seeking feedback from customers in a service context is common, so is seeking feedback in therapy, typically described as routine outcome monitoring (ROM). The purpose of seeking feedback is to put the customer at the heart of the exercise, amplify the voice of the customer and to interrupt the practice which privileges the therapist's voice (Duncan et al., 2004). The most widely used feedback tools (Lambert et al., 2018) are the Partners for Change Outcome Management System (PCOMS [www.pcoms.com]; Duncan & Miller, 2008; Prescott et al., 2017) which includes the Session Rating Scale (SRS) and the Outcomes Rating Scale (ORS), and the Outcome Questionnaire System (OQSystem [www.oqmeasures.com]; Lambert et al., 2013). In Aotearoa New Zealand, the Alcohol and Drug Outcome Measure (ADOM) is the outcome measurement tool mandated by Manatū Hauora Ministry of Health for use by community addiction services (Te Pou, 2023a) and the Health of the Nation Outcome Scales (HoNOS) for use with people accessing specialist adult mental health services (Te Pou, 2023b). As far as can be identified, a wide range of ROMs

are otherwise utilised by providers in Aotearoa New Zealand, including the World Health Organization Quality of Life (WHOQOL) measure, the Client Directed and Outcome Informed (CDOI) measures and the Camberwell Assessment of Needs (CAN) amongst others (Smith & Baxendine, 2015).

The research shows that seeking and taking action on feedback results in better therapy outcomes and decreases dropouts by as much as 50% (Brown et al., 2015; Miller & Duncan, 2004; Miller & Schuckard, 2014; Roseborough et al., 2016). In this way, feedback is also a means of collaborating with the customer, helping them to feel more proactive and in control of their experience, having a sense of being valued and normalising the experience of going to therapy. For therapists as well, it provides critical information delivering a form of quality control and direction for development, as research has shown that therapists may overestimate their performance when compared to others and when considering their customer's progress (Hogue et al., 2022; Probst et al., 2022).

Therapy Satisfaction

Satisfaction with treatment for mental health issues has been widely researched (Timulak & Keogh, 2017) and seems to be associated with other aspects such as perceived view of effectiveness, dropout rates and willingness to participate in therapy in the future. Satisfaction and loyalty in health care services was studied by Mittal and Lassar (1998) who found that satisfaction was driven first by the functional quality of the service, or the way that customers are treated. Once satisfaction was in place, loyalty would be driven by the technical quality of the work the customer received; that is what is delivered, such as improvement in health. As expected, people who dropout from therapy are more likely to express greater levels of dissatisfaction with the treatment they received than those that have a positive termination experience (Björk et al., 2009; Knox et al., 2011; Lippens & MacKenzie, 2011). Björk et al. (2009) in their retrospective satisfaction study, with people two to three years after they had received treatment for an eating disorder, found that almost half of the people who had dropped out were unsatisfied with their treatment, compared to 17% of people who completed the programme. They were more negative than people who completed the programme, particularly about both the treatment and their

therapist's skills. Using data from the Canadian Community Health Survey-Mental Health and Well-Being (CCHS-1.2), which included 12,792 people aged ≥55 years, Lippens and MacKenzie (2011) sought to understand more about older people's experiences of treatment satisfaction in relation to perceived effectiveness and dropout. A significant proportion (88.7%) of people were satisfied with the treatment they received. Greater social support seemed to make a difference, being significantly associated with higher levels of treatment satisfaction. The researchers surmise this may be due to people with lower levels of social support expecting more from their treatment and being disappointed when it does not eventuate. Research with clients about the most common reasons for termination (Roe et al., 2006) found dissatisfaction with the therapist (36.4%) and with psychotherapy (29.9%) were key drivers.

Like all relationships, the therapy relationship is vulnerable to misunderstandings, disagreements and rupture and it can take both participants, the therapist, and the client, to contribute to and recover these situations. Knox et al.'s (2011) qualitative interviews with 12 clients found that where the person had a "positive termination", they recalled helpful effects from the treatment, termination was undertaken in planned way with the therapist, and they were open to participating in therapy in the future. In contrast, for those who had a "problematic termination," they most often ended the treatment due to an unresolved rupture with the therapist, they are more likely to feel that the therapeutic alliance was less well-formed, and their perception of treatment outcome is mixed. Termination happened abruptly typically without discussion, and where people would consider therapy in the future they would only do so with a different therapist, while expressing higher levels of fear and hesitation. They theorise that people who have a problematic ending may see little benefit from their therapy, the only positive outcome being that the therapy has ended and any improvement in their mental health due to factors other than treatment. Bohart and Wade (2013) suggest that clients should be motivated to repair the rupture partly because of the time and money they have invested in the relationship. However, this does not acknowledge three key factors in customer motivation. First, people are often at therapy because they already have disrupted relationships in their life and therefore their energy for yet another tricky interaction is limited. Second, some customers will be at therapy because they doubt their ability to have positive relationships with others and therefore a conflicted

relationship with their therapist just reinforces any loss of confidence they may have. Finally, where customers do see this as a service interaction, they will be well used to the idea that if you cannot receive good service at one place, you simply stop buying that service and – maybe - look elsewhere. There appears to be little research with people who have had a therapy dropout experience of whether they would be willing to go back to treatment. This may be a result of the difficulty in tracking customers, as they might choose to source their therapy from another provider. In the broader health sector, research found that those who had experienced unhelpful healthcare subsequently made less frequent use of healthcare and were less inclined to seek help in the future (Colman et al., 2014). Research from people using Veteran Affairs' psychological services supports this, with reengagement rates of only 40% of people experiencing PTSD (Buchholz et al., 2017) and 48% of people with substance abuse disorders (Oliva et al., 2013). Research on rupture shows that where this can be recovered, additional benefits to the therapy and outcomes are provided (Safran et al., 2011). Knox et al. (2011) propose that therapists should check for ruptures or dissatisfaction, even when it does not seem likely, and lead on the process of recovering the breach.

Summary of therapy experiences which influence dropout

Expectations are associated with treatment success and may be influenced by previous experiences. People expect therapy to take less time than it does and timeframes should be specifically addressed with customers. There is little consistency in the findings that treatment type is associated with dropout, whereas a manualised approach and therapeutic alliance does seem to be associated with decreased dropout. This fits with customer experience research which finds that where customers have a negative experience, exit is the most typical response. Despite this, customers do seem to have an expectation that therapy will be difficult and are up for the challenge if they can see progress. Therapist and customer views of what constitutes a satisfactory outcome are often not aligned and these mixed views are impacting on the definition and findings on dropout. The ending is important as the customer's perception of the ending influences their view on the quality of therapy experience. Seeking and taking action on feedback results in better therapy outcomes and decreases dropout. Positive terminations are planned and discussed

between the therapist and customer. There is little research on re-uptake rates, but it does seem to suggest that people who have a poor experience may be disinclined to engage again. Unresolved ruptures are a key cause of problematic terminations and the research on rupture recovery shows this is positively associated with therapy outcomes.

Voice of Customer

Voice of Customer (VOC) is a widely utilised marketing technique to identify customer needs and requirements based on the customer's priorities, language and organising paradigms. This information is then used to develop, adapt, and deliver customer experience services and products, with the purpose of driving for greater customer satisfaction (Coppenhaver, 2018). Voice of Customer techniques are starting to be used in the health sector, although apparently not yet in mental health (Daly et al., 2021; Pierce, et al. 2023). VOC is a multi-step, multidimensional process which is too complex to be fully explored in this section. It is noted here as a contemporary, widely-used resource when considering the customer experience, providing methodology for potential future research into the customer experience of people attending therapy. However, the experience of two key customer groups, as it is currently understood, is considered here; that is, the lived experience view, and the view of Māori who have a critical place as tāngata whenua in Aotearoa New Zealand. This is to reflect and reinforce the purpose of this study, which is to explore the customer experience of people who attend therapy and their reasons for stopping.

Lived experience view

Lived experience and the IPA approach of this study are connected through Husserl's development of phenomenological thinking, with its mission to understand things on their own terms, and his coining of the term "lived experience" to describe that process (Gillard et al., 2021). For more than fifty years (Millar et al., 2016), contemporary mental health practices have supported consumers to be involved in decisions about mental health policies and services (World Health Organization, 2004; World Health Organization, 2010). Much of this is as a consequence of the growth and establishment of a consumer-led movement which started in the 1960s and 1970s (O'Hagan, 2015), along with broader socio-

political changes such as deinstitutionalisation, questioning of the legitimacy of biomedical theory, the rise of consumerism and choices in healthcare (Pilgrim & Waldron, 1998) and times in which "consumer groups and the general public have become suspicious of the authority of a professional elite which has the power to regulate and control human conduct as psychiatry does" (Randal, 1995, p. 395). More recently, mental health practices have shifted to explicitly recognise the power and importance of the contribution of people with a lived experience, (Malhi et al., 2021) although not without ongoing stigma, tokenism, and barriers even within the industry of health care (Happell et al., 2022; Lien et al., 2019; Scholz et al., 2018). Aotearoa New Zealand government's 2018 investigation into mental health (Paterson et al., 2018) noted that for improved services and impact, there is value in better understanding and incorporation of the views, ideas and input of tāngata whaiora and yet "people with lived experience of mental health and addiction challenges, including Māori and Pacific peoples, are often on the periphery of the planning, design and delivery of services" (Paterson et al., 2018, p 160). Since then, the authority of the consumer voice has been built into legislation in Aotearoa New Zealand – the Pae Ora (Healthy Futures) Act (2022). This required Te Tāhū Hauora (Health Quality and Safety Commission) to establish a Code of Health and Disability Services Consumers' Rights that "sets requirements for how health entities must work with consumers, whānau and communities in the planning, design, delivery and evaluation of health services." (Te Tāhū Hauora, 2022).

Traditionally, the research on mental health service utilisation and dropout is focussed on the provider or the therapist's perspective and is less focussed on the consumer view (Atasuntseva et al., 2020; Knox et al., 2011). There has been little research undertaken about dropout from therapy from a lived experience perspective (Springer & Bedi, 2021). Descriptions and exploration of the reasons for dropout from a lived experience perspective are generally only found within memoirs (O'Hagan, 2015; Randal, 2022). Current attempts to create an agreed definition of dropout do not include, and potentially even diminish, the voice and experience of the customer (Swift & Greenberg, 2014; Roseborough et al., 2016). The current study is motivated by and focussed on exploring the lived experience of people who have decided to stop going to therapy and hopeful that from those experiences, ideas for practising therapists and future research will emerge to result in more effective therapy experiences.

Māori experience of mental health and services

The Māori ethnic group experience diverse realities and are not a culturally homogeneous group of people (Kingi, 2018), so it is important that any assumptions or conclusions about Māori need to be considered as reference points within a broader holistic view. The data over time on Māori usage rates for mental health services, satisfaction in or dropout of psychological services is inconsistent and vague (Kingi, 2018). This perhaps reflects that there is limited research generally on cultural safety in mental health services (Yelavich, 2021). In consideration of what might be causes for therapy dropout for Māori, some history provides useful context. In previous years in Aotearoa New Zealand, the understanding of mental health disorders was largely limited to hospitalisation rates. Prior to 1970, Māori admissions to hospitals were lower than non-Māori (Durie, 1994; Pomare & de Boer, 1988). From the 1970s onwards however, psychiatric hospitalisation rates for Māori increased at a rate which was "dramatic and unexpected" (Kingi, 2018, p. 18) and were more likely, than the general population, to be as a result of a justice intervention rather than a more typical healthcare referral (Te Puni Kōkiri, 1996). More recently, research has expanded to also include community and outpatient services, as well as hospitalisation or inpatient rates and has shown Māori had higher hospitalisation rates than non-Māori and less access to mental health services (New Zealand Health Information Service, 2004). The causes of this change over time seem to be related to factors which were behavioural and environmental, including colonialisation, along with urbanisation and socio-economic influences (Kingi, 2018).

Aotearoa New Zealand's first epidemiological study of the prevalence of major mental health disorders was Te Rau Hinengaro: The New Zealand Mental Health Survey (Oakley Browne et al., 2006), in which it was found that Māori had a higher prevalence of mental health disorder than the balance of the population. In addition, younger people generally had higher prevalence rates of mental health disorders than the total population and at 25.4 years the Māori population is on average younger than the total population of 37.4 years (*2018 Census*, n.d.).

Oakley Browne et al. (2006) reported that Māori were found to be significantly less likely to make a mental health visit, summarised in Table 3. Given the higher level of prevalence, the lower access to help, and the disproportional differences between Māori and non-Māori (Kingi, 2018), this indicates a greater requirement exists to meet the needs of Māori with mental distress.

Table 3

Contact with Health Services for People with a Disorder in the Previous 12 Months

Population	**Contact with health services (percentage)**			
	Any provider	Mental Health Specialist Services	General Medical Services	Non-healthcare Provider
Total	38.9	16.4	28.3	11.7
Māori	32.5	14.6	20.4	9.1

(Oakley Browne et al., 2006)

The most recent data available is from the New Zealand Health Survey (NZHS), which is a continuous survey of people of Aotearoa New Zealand on a broad range of indicators of health behaviours, status, and access. The Annual Update of Key Results 2021/22 (Ministry of Health, 2022) found that a larger proportion of Māori experience greater mental distress, more have diagnosed disorders and have higher unmet needs than the general population. At similar ratios, 8.8% of the total population and 12.9% of Māori had unmet needs for professional help for their mental health in the previous 12 months.

Table 4

Aotearoa New Zealand Unmet Needs for Services

Population	**Unmet needs for mental health care and addictions services (percentage)**	
	2021/22	2016/17
Total	8.8	4.9
Māori	12.9	6.6

(Ministry of Health, 2022)

The data over time shows a persistent gap in the experience, support, and access to resources between Māori and non-Māori. In addition, Māori are more likely than non-Māori to be treated in hospital, to be readmitted, secluded, and compulsorily treated under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (Cunningham et al., 2018; Jansen et al., 2009). The NZHS survey (Ministry of Health, 2022) also found that Māori were more likely than the total population to rely on family, whānau and/or friends and less likely to talk to a professional when seeking help for their mental health.

While specifically excluding studies considering mental health, Graham and Masters-Awatere's (2020) systematic review of 14 studies of Māori experience of health services is insightful about the experience of the broader health sector. They found in the general Aotearoa New Zealand health system that Māori consistently experienced barriers between themselves and the health care they were entitled to. These obstacles were grouped into organisational structure (including experiences of racism and cultural alienation), staff interactions (a lack of rapport with the health workers, poor communication and rushed workers) and practical barriers (cost, transport, time). Many of these are factors which appear to be connected to areas of interest for dropout rates, such as poor therapeutic alliance, not meeting customer beliefs, preferences and assumptions, customer dissatisfaction and practical barriers to attendance. Graham and Masters-Awatere (2020) conclude that these issues lead, quite rationally, to Māori disengaging from or avoiding health services and being unable to discuss tikanga Māori-based tools with health

professionals. Similar to the way in which therapists may blame client issues rather than service issues when customers end therapy (Dandachi-FitzGerald et al., 2022; Murdock et al., 2010; Swift & Greenberg, 2015), the research finds that the establishment (the health services and health workers) may blame Māori for not engaging and taking responsibility for their health (Penney et al., 2011) rather than considering that there may be service issues which sensibly result in such disengagement by people, and could be addressed by the health provider.

Longitudinal studies provide an important resource to understand and describe the changes in key aspects of the cohort participants' lives, and to characterise findings for the broader population. Given Māori have a pre-colonial history and also carry the intergenerational trauma of colonialism (Pihama et al., 2014), longitudinal studies provide a useful opportunity to better understand the strengths and issues that cohort members, and the wider population, carry and which affect health and other outcomes. Two longitudinal studies in Aotearoa New Zealand are the Christchurch Health and Development Study (CHDS) and the Dunedin Multidisciplinary Health and Development Study (Dunedin Study). While the demographics of participants reflect that of the broader community within which they are based, both studies acknowledge that they add little to the understanding of Māori mental health (Gillies et al., 2017; Poulton et al., 2023) and therefore nothing to understanding of therapy dropout. They are referenced here however because of the potential that future longitudinal studies offer. More recent longitudinal research has commenced with a greater focus on Māori context, increasing the proportion of the cohort who identify as Māori and/or utilising Māori research principles in order to generate findings. Theodore et al. (2019) have proposed a framework for longitudinal research that '… is controlled by Māori, addresses issues at the heart of Māori concerns, prioritises Māori in the study design and interpretation of findings' (p. 21) in order to better reflect the population of today and leading into the future. These provide potential for future insights in Māori experience of mental health and contributing factors to dropout. However, these research studies are at early stages and the discovered knowledge and impact of this longitudinal research may be some time away (Allen et al., 2023; Edwards et al., 2022; Morton et al., 2020, Signal et al., 2022).

Current research on dropout from mental health services for Māori in Aotearoa New Zealand is on a small-scale and limited to services delivered through the public health system. Pagey et al. (2010) studied the characteristics that might contribute to retention for young people with coexisting substance use and mental health disorders in outpatient alcohol and drug group therapy. They found that Māori ethnicity, and/or a number of other factors including Pacific Island ethnicity, past or current legal charges, youth drug court (YDC) involvement, having a diagnosis of cannabis dependence, and a diagnosis of conduct disorder had an impact on ongoing participation, although YDC involvement was the one significant predictor of retention. The researchers concluded that the relationship between the individual characteristics and the YDC involvement was what made the difference in the retention rates, although they did not explain why. Newton-Howes & Stanley (2015) reviewed a residential rehabilitation drug and alcohol service in which 62.2% of the participants completed the programme. They found that Māori ethnicity and family conflict were the only reliable predictors of completion but noted that the reason for this was not clear. Christie et al. (2018), in their study of retention rates for adolescents in a voluntary outpatient substance abuse treatment, found that Māori, along with Pacific people, were more likely to be engaged than their European clients, but they speculated this may be due to sample bias as the participants could choose between this service which did not offer a culturally oriented treatment and services that did. Given the small number of studies exploring dropout in Aotearoa New Zealand mental health services, it is hard to arrive at any conclusions.

Since the 1990s, Kingi (2018) concludes that mental health services for Māori have shifted positively. There is a growing workforce skilled in Māori mental health, tools based on tikanga, and service embedded in standard practice. Additionally, Māori mental health is aligned with and leverages other health initiatives through government initiatives such as Pae Ora (Ministry of Health, 2015). There is no comparative data to provide a baseline. However, factors which seem to mitigate for dropout, such as decreasing stigma, increased accessibility, alignment with customer preferences, treatment process and therapeutic alliance suggest that these developments would contribute to lower dropout rates for Māori.

Summary of Voice of Customer

Voice of customer methodology has not been widely used in mental health but provides an opportunity for thinking differently about customer experience. There has been little research to date on dropout taking into account the perspectives of people with lived experience or Māori, as key customer groups in Aotearoa New Zealand.

Summary

What we already know

- A lot of people experience mental distress in their lifetime, and therapy helps.
- In Aotearoa New Zealand, Māori are likely to experience higher rates of mental distress than the general population.
- Service is significant proportion of global GDP, and the majority of people work in the service industry in Aotearoa New Zealand, making them familiar with customer experience models.
- There are many definitions of dropout used and this creates difficulty in arriving at conclusions about causes and inconsistency in determining the rate of dropout, which ranges from 20-80%. Definitions and research tend to take a clinical or therapist perspective, with much less research taking into account the voice of customer.
- The evidence is equivocal that customer characteristics, particular disorders, traits, levels of complexity or treatment type are associated with dropout rates.
- Variables such as clarity on timeframes, motivation, effective therapeutic alliance, actively seeking feedback from the customer, accommodating customer preferences, creating shared expectations, and creating a path to a positive termination seem to support retention rates.
- People appear to be particularly vulnerable to dropout following the first session, when practical barriers get in the way, stigma (self or public) is greater, or the customer's view is that treatment is no longer needed.

What this study adds

- An interpretative phenomenological analysis of the customer experience of people who have gone to therapy and decided to stop after between one to three sessions.
- Exploring how this impacts their likelihood of going to therapy again in the future.
- Considering how this experience might impact on their likelihood of recommending therapy to others.
- Provides suggestions for action that therapists may want to consider implementing to mitigate for their customers choosing to dropout.

Chapter Three: DESIGN AND METHODOLOGY

Design

The research question explores the customer experience of participants and how this might influence their future behaviours. Palmer (2010) argues that customer experience is best measured using qualitative and phenomenological approaches because of the focus on the unique perspective. There are several well-regarded methodologies used for qualitative research.

Interpretative phenomenological analysis

Interpretative phenomenological analysis (IPA) was selected as the methodology that is particularly suited to the current study question, because of its attention to individual experience. IPA was developed in the 1990s by Jonathan Smith as an experiential research methodology in health psychology (Smith, 1996) and is rooted in Edmunds Husserl's work on phenomenology (Husserl, 1913/1983), and seeking to understand things on their own terms rather than in the context of a hypothesis, theory, or construct. Other approaches which have influenced IPA (Smith 2015; Smith & Fieldsend, 2021) are the philosophy of hermeneutics (Heidegger, 1927/1967) with its emphasis on interpretation. In the case of IPA, there is a form of double-hermeneutics at play – the person interprets their experience, and the researcher thinks about what the person's interpretation means (Shaw, 2019). Other influences on IPA are cognitive psychology in its attention to sense-making (Hollon & DiGiusseppe, 2011) and idiography as a philosophy with its focus on the individual (Smith et al., 1995). Maurice Merleau-Ponty's philosophical constructs around perception, how we perceive our context and "body-in-the-world" (Merleau-Ponty, 1945/1962, p. 164) and Jean-Paul Sartre's thinking around "understanding human experience in relation to the existence of others" (Smith & Fieldsend, 2021, p. 149) are other key philosophical constructs which influence the IPA approach. The spotlight on the person is the primary focus and not secondary to generalised groups, populations, or theories, as in nomothetic research (Shaw, 2019). Because of the focus on the detail of the experience, it is particularly helpful when considering a complex or novel experience for the participant (Smith, 2015). In addition,

using IPA methodology allows for flexibility in approach and research questions, as well as encouraging researcher reflexivity having reviewed the literature and heard the participants' accounts (Alvesson & Sköldberg, 2017).

Smith (2015) notes that IPA effectively "combines both empathic hermeneutics with questioning hermeneutics" (p. 26). That is, an IPA approach seeks to understand from the participant's perspective while at the same time asking critical questions starting with what, why and how. This critical approach acknowledges that individuals and situations are complex, participants may struggle to describe what they are thinking or feeling, not wish to disclose everything, or seek to protect themselves from judgement from others or themselves. The mixture of an empathic and critical approach provides the opportunity for the researcher to wonder or explore further, rather than simply taking in the picture as described. The overarching key question guiding this study was: (1) What was the customer experience of people who chose to stop going to therapy? This then led to the following two questions which are a result of the participants' experience: (b) Does this affect their potential future use of therapy? And (c) How does termination affect their likelihood of recommending therapy to others? These questions are very much focussed on the participants' personal experience and interpretation of the event of seeing a therapist, in which case IPA is an appropriate approach, (Smith, 2015).

Hypotheses

When using an IPA approach, the research question is typically broad, with only general limitations. This is to allow the participant experience and interpretation to lead the way, rather than being constrained by a finite set of responses, theory, or previous findings. As such, an IPA piece of research does not generally attempt to test a predetermined hypothesis (Smith, 2015) but is focussed on the research question and the explanations or theories which may result from that (Sullivan, 2019).

Ethical Considerations

The study was reviewed and approved by the Massey University Human Ethics Ohu Matatika 2, Application OM2 23/34. Ethical considerations included informed consent, anonymising data to protect confidentiality, password protection to online resources, participant permission sought and received for any quotes used in the study and participants were able to withdraw their consent, without question, within an advised timeframe. Volunteers for the current study were sent an information sheet (Appendix A) and provided with the opportunity to speak with the researcher if they had further questions. Written consent (Appendix B) and demographic data (Appendix C) were provided by all participants prior to interview. Participants received a copy of the transcript after the interview and were able to provide further comment if they wished to do so. Participants were also able to withdraw their consent without question, within an advised timeframe. None of the participants made changes to the transcripts or withdrew their consent. As the current study was drafted, the researcher sought permission from the relevant participant for specific quotes to be included. This provided another check for confidentiality but also recognised the agency of the participants to determine where their words were used.

A key ethical consideration in the research was ensuring that the experience of the interview did not negatively impinge on the participants' mental health. In particular, the researcher was cognisant of obligations under the New Zealand Psychological Society (2012) Code of Ethics, specifically Principles 2.1 Promotion of Wellbeing and 2.6 Well-being of Human Research Participants. This responsibility was met through the ethics application and approval, participants being reminded of mental health resources in the pre, during and after stages of the interview and the researcher being alert to signals of distress from the participants. None of the participants expressed distress pre, during or after the interactions.

Participants

Determining the number of participants was a key consideration in the planning for the current study. In terms of sampling, items which make up 'information power' (IP)

(Malterud et al., 2021), that is, study aim, sample specificity, established theory, quality of researcher–participant dialogue and sample variation were considered. The study aim was narrow as it was not a study of the customer experience of all people who have gone to therapy. This constriction tends to a smaller sample size because it is a subset of a broader group. The sample specificity refers to the specificity of the participant experience. In this case, eligible participants had chosen to stop after one to three sessions which makes their experience different from a broader sample of people who have stopped at some point, or the general population who have used therapy. In terms of established theory, the literature review shows that there has been a significant quantity of research on why people stop going to therapy, much of it with inconsistent findings but little of the research taking a customer experience approach. As the interviews occurred and analysed, consideration was made of whether the extant research findings were being heard in the participant experience, or not. This contributed to considerations of whether further interviews needed to be undertaken. This was not necessarily about data which simply supported what had been previously known but whether the data could provide insights on the topic, progress on current thinking, or suggest further questions for future research. In addition, the researcher reflected on each interview and carefully considered whether their style and approach had quickly built rapport with the participant and also whether there had been sufficient challenge and questioning to help the participant examine their experience at more than a superficial level. Finally, the data was largely homogenous when considering sample variation, as shown in Table 6. In addition, the participants were not asked about the reason that they sought therapy, both in the participant information sheet (Appendix A) and advised in the introductory words of each interview. However, based on their self-disclosure in the interviews, the researcher's understanding is that they all sought therapy due to life events, rather than any of the participants experiencing chronic mental health distress. While the timeframe in which they sought therapy ranges from 20 years to just over a year prior and many were in different life stages at the time of the experience, it is the researcher's perception that they are also consistent in having well-established careers and family situations at the time of interview. The adequacy of the sample was revisited throughout the collection and interview process for confidence on the validity of the results (Malterud et al., 2021).

Theoretical saturation, the point at which no new information is being identified or common themes emerging, is a frequently used condition in testing for sample size (Moura et al., 2022). While Malterud et al. (2021) argue against the use of saturation as a measure, it appeared to be another useful factor to test the sample size, in conjunction with consideration of IP items, as it offered a slightly different perspective. Recruitment of participants was considered frequently from planning through to interview stage and stopped at theoretical saturation. Table 5 outlines the stages in the research at which decisions were made about likely sample size.

Table 5

Sample Size Consideration Items

Item	Stage for Consideration	Factors for consideration	Sample size conclusion
Study Aim	Planning	The study aim is narrow and IPA research can legitimately interview as few as one person (Shaw, 2019).	1-4
Sample Specificity		Specific in that participants need to have chosen to stop therapy after one to three sessions	1-4
Established Theory		Significant theoretical background, although less on early leavers and little on customer experience of therapy, but much of it conflicting	2-6
Quality of Dialogue	During interview stage and after each interview	Interviewer skilled in interviewing on sensitive topics, rapport established, participants challenged, and each interview reviewed before the next	2-3
Sample Variation		Largely homogeneous group, both demographics and experience	3-4
Theoretical Saturation		On reviewing the interviews, new information was not changing the themes	4-6

In terms of sample composition, participants were recruited using LinkedIn, "the world's largest professional network on the internet" ("*What is LinkedIn*," n.d.), utilised largely for career and professional networking purposes. This was because the researcher's understanding of people's experience of going to therapy was principally through workplace-based conversations and the researcher has a well-established network on LinkedIn. Further to homogeneity, users of LinkedIn tend to have higher levels of education and income than the general population (Blank & Lutz, 2017; Hargittai, 2020). Given their ongoing activity on the network, it is understood the participants' mental distress have not significantly disrupted their capacity to work, to any meaningful extent. The participant group were similar in their demographics. Based on information provided by the participants, the researcher concluded that at the time of the interview, they were all knowledge workers, with established careers, and stable family situations. Table 6 provides a participant biography. Names have been changed to protect confidentiality.

Table 6

Participant Biographical Details

Pseudonym	Biographical Details
Ashley	Aged between 35-49 years, married or in a civil union, employed full-time (30+ hours per week), with education at a university level and identifies as European and female. Describes a positive experience with a therapist about three or four years ago where she attended two sessions and "every single box had been ticked." For context, Ashley has therapists in her whānau.
Hannah	Aged between 18-34 years, married or in a civil union, employed full-time (30+ hours per week), with education at a university level and identifies as European and Pasifika and female. Hannah described an unsatisfactory experience of two sessions with a therapist, six to seven years previously. For context, Hannah is a registered psychologist.

Pseudonym	Biographical Details
Joanne	Aged between 50-64 years, married or in a civil union, employed full-time, with education at a university level and identifies as European and female. Describes an unsatisfactory single session with a therapist approximately 20 years – "I was so traumatised. Traumatised is the only word for it." In the interview, Joanne was able to compare this against subsequent positive experiences. For context, Joanne has significant work experience in customer experience and works in a leadership role where she discusses mental health issues with team members. She described one session.
Michelle	Aged between 50-64 years, never married or in a civil union, employed full-time, with education at a university level and identifies as European and female. Michelle's interview was focussed on an unsatisfactory experience (two sessions) approximately two years ago; however, she compared this against a satisfactory experience (one session) four years ago, with different therapists. For context, Michelle has a therapist in her family, grew up with a family member experiencing chronic mental health distress, has experience in mental health coaching and has facilitated EAP services into organisations.
Nicole	Aged between 35-49 years, married or in a civil union, employed full-time, with education at a technical or trade level and identifies as European and female. Described an unsatisfactory experience with a therapist and was able to compare that with a subsequent more satisfactory experience. For context, Nicole came to Aotearoa New Zealand from another country and saw different cultural contexts to mental health issues in the different countries.
Sandra	Aged between 50-64 years, married or in a civil union, not employed and looking for work, with education at a university level and identifies as European and female. Describes an unsatisfactory experience with a therapist approximately 1.5 years ago, where she attended three sessions. Subsequently, Sandra went to another therapist and described a positive experience.

IPA based research is committed to having a relatively homogenous sample (Smith, 2015) as given the small sample size, random or representative sampling is unlikely. In addition, the findings are not intended to be generalised to a broader population, but to explore at a deeper and more detailed level the experiences of the research participants. Therefore,

given the homogeneity of this participant group, it is likely that interviews with people with different characteristics would result in described customer experiences and findings which are different to this study.

Measures

Demographic form

The participant demographic data form (Appendix C) asked for age, educational experience, employment situation, ethnicity, gender, and relationship status. Given the small sample size and the research findings that demographic factors are not reliably correlated with dropout, demographic factors were largely exploratory and intended more to identify possible questions for this study's interviews and for future research. Collection of the data was also useful however to ensure that the researcher was sensitive to the socio-cultural context of the participants and provided opportunity to think carefully about the participants' comfort in the research and interview. In the analysis stage, this data prompted the researcher to consider why participants may have particular views and what may be influencing those experiences. It was also a useful reminder to the researcher to remain acutely conscious of the validity of the participants' views and remain open to alternative interpretations.

Interview protocol

The interview format was a semi-structured interview, which is the most used form of data collection in IPA based studies (Smith et al., 2009). The draft interview framework was tested on a non-participant volunteer who met the participation criteria, and subsequently adjusted based on their input. They provided feedback about their experience of the interview, and this was incorporated in the final interview approach and frameworks. This was a valuable step as the pilot interview provided useful feedback on potential areas of confusion for participants, as well as interviewer techniques, to better meet the needs of the participant. For clarity, the data from that interview is not included in the current study.

Six participants were interviewed online using Zoom and recorded using Fathom to create the transcript. The researcher reviewed each transcript against the recorded interview and corrected any errors. Interviews lasted between 60 and 90 minutes, with an average time of 71 minutes. Participants saw a customer experience structure (Appendix D) and were asked to recall in detail their experience of attending therapy and their decision to stop. The semi-structured interview asked each participant to consider the same framework, to respond to each stage sequentially and to focus on the areas in which they had the most interest. In line with the phenomenological principle of being focused on the things that matter, participants were encouraged to focus on the areas that were more meaningful, important, and resonant for them and to tell the interviewer when there were questions on areas which were of less interest for them. The researcher asked follow-up questions based on participant answers. In addition, participants answered two further questions: (1) "What would need to be true for you to go and see a therapist again in the future?" and (2) "Given your experience, how likely would you be to recommend to someone else that they go and see a therapist?" See Appendix E for the interview protocol.

Net Promoter Score

The net promoter score (NPS) was developed by Reichheld (2003) and since then has become one of the most widely used global measures of customer loyalty. It helps organisations to better understand customers' subsequent purchase decisions and how customers talk about them to others, leading to customer retention, brand, and reputation implications (Dawes, 2023).

The typical NPS question is "How likely is it that you would recommend [company X] to a friend or colleague?". Customers are asked to respond to this question on a scale from zero to 10, where zero means not at all likely and, five means neutral and ten means extremely likely. "Detractors" (customers who speak poorly about the service and actively discourage others to use it) are those who rate the question a zero to six, "passive customers" (customers who are broadly happy but overall indifferent) score a seven or eight, and a nine or 10 rating is given by customers described as "promoters" (would definitely use the service again and recommend to others). The NPS is calculated by subtracting the

percentage of detractors from the percentage of promoters (Reichheld, 2003). Therefore, scores range from -100 (all respondents are a detractor) to +100 (all respondents are a promoter). NPS has also been used in the health sector, including mental health (Leggat, 2016; Bitencourt et al., 2023), with mixed reviews about its validity for understanding the customer experience (Adams et al., 2022; Krol et al., 2015; Wilberforce, 2019).

The study was seeking to explore whether a satisfactory or unsatisfactory experience influenced participants' likelihood of encouraging others to engage in therapy. Therefore, the typical NPS question was adjusted slightly to firstly set context; that is "Given your experience" and, secondly, with a focus on mental health services, rather than a particular provider; that is "how likely would you be to recommend to someone else that they go and see a therapist?" Participants were not asked to provide a rating, as it was determined that a combined NPS would provide little value given the small sample and the idiographic focus of the research.

Data Collection and Analysis

Data was collected through semi-structured interviews, lasting between 60 and 90 minutes, which were framed around the various stages of customer experience. As can be seen in Appendix E, open-ended questions focussed on each stage, and then led to further questions to explore the participants' responses, utilising the customer experience dimensions identified by Becker and Jaakkola (2020). Questions about termination were based on Knox et al. (2011). Participants received a copy of the transcript after the interview and were invited to provide any deletions, additions, or changes to the transcript that they wanted to. No participants made changes.

IPA is a dynamic process where the participant is seeking to describe and understand the event and the researcher is seeking to make sense of and interpret the participants' account. Table 7 shows the structure of the analysis process once interviews have been undertaken (Smith, 2015; Smith & Fieldsend, 2021) and outlines how the researcher physically collated the interview transcript and subsequent steps.

Table 7

IPA Transcript Analysis Approach

Step One	**Step Two**	**Step Three**	**Step Four**
Transcript	Note-taking	Experiential Statements	Personal experiential themes
This column is the transcript of the interview in which the person describes their experience. The researcher read and re-read the transcript to better understand the participant's worldview.	In this column, the researcher commented on the transcript noting what was interesting, particularly rich, or strongly expressed, along with their initial response. The comments summarised experiences, began sense-making, or paraphrased, noted associations, self-reflection, or preliminary interpretations.	The researcher then developed "a concise and pithy statement of what was important in the various comments" (Smith et al., 2009, p. 92) in a particular part of the transcript. These short statements outlined both the participant's experience and the researcher's interpretation, using the participant's words.	Finally, for each individual interview, the researcher looked for connections and commonality across the experiential statements. Made up of superordinate themes and subthemes, they used extracts from the transcript and begin to link to psychological theory or the findings in the existing literature and were clearly grounded in the specific participant's experience.

This process of four steps was completed for each participant's interview prior to moving onto the next, consistent with an idiographic approach and focussing in detail on the person before carefully moving to explore anything more general (Smith & Fieldsend, 2021).

Table 8 provides a sample extract from the interview with one of the participants, Sandra, along with the researcher notes.

Table 8

IPA Transcript Analysis - Sample from Sandra's Interview

Step One	**Step Two**	**Step Three**	**Step Four**
Transcript	Note-taking	Experiential Statements	Personal experiential themes
Yeah, I did look around a little bit, but I guess the thing with therapy is you figure you never know. So, someone's given me this recommendation. I'll go. And you know what, if it doesn't work out, or if I don't connect or whatever, I can always remove myself.	Name from trusted source. Decision didn't require investigation. Connection is necessary ingredient.	"If it doesn't work out… don't connect… I can always remove myself"	Choice of therapist in pre-purchase stage is casual but P has identified connection as important for success. She has agency to stop

The themes were underpinned by consistencies in language, events that were particularly memorable or emotionally charged and sometimes repeated or referenced again by the participant. Once the themes had been identified, the researcher undertook a process of disconfirming analysis; that is, actively looking for participant words and sense-making which did not fit or conflicted with the themes (Smith, 2015). The purpose of this was for the researcher to challenge any early thoughts on themes, test whether the participant view had been fully heard and check for researcher bias. Finally, comparisons were considered between all participants' themes in the current study (Shaw, 2019) and these are detailed in

the results. Underpinned by the systematic reviews of customer experience, the themes were then grouped into a matrix made up of the stages of contact (Bueno et al., 2019) and the customer experience response dimensions (Becker & Jaakkola, 2020). Throughout data collection and analysis, the researcher made reflexive notes intended to surface, challenge and revisit assumptions, interpretations, and conclusions throughout the process. A summary of this is included in the Reflections section (pp. 107-108).

Chapter Four: RESULTS

This is a qualitative study in which six individuals (see Table 6 for biographical details) were interviewed and participants described a customer experience with a particular provider. Table 9 provides contextual details of the participants' experiences and views.

Table 9

Participant Interview Contextual Details

			Described Customer Experience			
Pseudonym	**Been to therapy prior to this experience?**	**Been to therapy after this experience?**	**Number of sessions**	**Experience took place ~years ago**	**Funder**	**Satisfactory or unsatisfactory experience**
Ashley	No	Yes	2	3-4	Self	Satisfactory
Hannah	Yes	Yes	2	6-7	Employer	Unsatisfactory
Joanne	No	Yes	1	20	Self	Unsatisfactory
Michelle	Yes	Yes	2	2	Employer	Unsatisfactory
Nicole	Yes	Yes	1	1.5	Employer	Unsatisfactory
Sandra	No	Yes	3	6	Self	Unsatisfactory

From the interviews and following the analysis stage, four superordinate themes and seven subthemes were identified, as outlined in Table 10.

Table 10

Superordinate Themes and Subthemes

Stage	Customer Experience Stage	Superordinate Themes	Subthemes
1	Pre-experience	Negative connotations still exist	
2	Pre-purchase	Anticipation	i. Process ii. Expectations
3	Purchase	The details matter	i. Physical space ii. Feelings iii. Therapist in-session behaviour iv. Termination
4	Post-purchase	(Still) Hopeful and positive	i. Yes, but…

Stages one to four follow the customer experience structure outlined in Bueno et al. (2019) and stages two, three and four have subthemes. Item four's subtheme summarises the participants' views on the specific questions asked which related to their future use of therapy and the likelihood that they would recommend therapy to others.

Stage One Pre-experience – Theme: Negative connotations still exist

In the pre-experience section of the interview, participants were asked to describe the general view, whānau and friends' opinions and their own perception of mental health, therapy, and therapists, prior to having gone to therapy. Because their therapy experience was in the past, participants also described what has changed over time to now. It should be acknowledged that in attempting to recall opinions from some time ago, participants' views are naturally influenced by subsequent and current experiences, context, and interpretation.

Participants were consistent in their view that the approach to mental health in Aotearoa New Zealand is better than it was but still with a significant level of negativity. In answering this question about how mental health was generally perceived around the time they chose to engage in therapy, they naturally moved to a compare and contrast description of how things had been then versus how mental health is viewed now. Some of the participants described growing up with quite different views around mental health to those that currently prevail.

> I think there's ages and stages where it perhaps was really frowned upon if someone had a mental health issue and you might be locked up, to be never spoken about it… I even remember when I literally had … a baby and I'm sure I had postnatal depression. I thought if I go and talk to anyone about this, I'll be locked up in some psychiatric ward and I'll never be seen again. Someone will take my child off me, and I'll never see (them) again… But I think today there's a lot of openness and realisation that mental health is something that's very important to be taken care of. But I think it's been a journey over probably 30 years or so, you know, where it wasn't accepted, it was people were kept away if you had a mental health issue. (Michelle)

> I think it was pretty much instilled right from… very, very early on. So, it would have been, through childhood, quote, "not to be silly" probably, you know. [Participant laughs.] Which is just probably showing emotion or getting upset about something. … I still remember … as a teenager … seeing people in the community walking around thinking that's Mrs. So-and-so whose son had committed suicide. And that's especially women, I think. I've just seen a number of people who just seem to carry on and just manage it best they can, I guess as well… we went through a phase of 'harden up'. Before we went into this (current) phase, which is far more, I think, open and understanding. (Sandra)

Participants consistently believe that the general view to mental health had changed over time. There were mixed views about why this had occurred with participants mentioning factors such as broader societal changes around other factors such as sexuality and gender, the COVID pandemic, positive stories in the media, well-known people who have talked

publicly about their experience of mental distress and changes in structural factors such as legislation and government interventions. For instance, Nicole specifically mentioned changes to the health and safety legislation in Aotearoa New Zealand and Ashley and Michelle talked about changes in schools, including counsellors' availability for students.

A number of participants also specifically referenced a two-way causal relationship between mental wellbeing and physical health.

> I guess there's those aha moments when one of them was, that's when I guess people have started to talk about the importance of physical well-being related to mental well-being… And then I couldn't help to think well, if you think about how your body can react to stress, well it totally makes sense that physical activity can then improve mental health as well, you know, the connection. (Sandra)

However, all participants also felt that there is still room to improve and work to be done.

> …our kids kind of are way better than we were as kids but they still talk about, you know, people who've got issues and it's got a negative connotation attached to it …my generation was still very much blocked by the generation before us and and shouted down …but I think now there's enough people of my generation who are trying to lift up the next generations to say you've got a real role to play in climate change and mental health awareness and LGBTQI and …I think that this will definitely shift over time. (Ashley)

Participants expressed a view there is still a stigma around mental health and this is found in a variety of spheres such as in the media and what they hear from friends and colleagues. The participants' common opinion of the workplace was it had become more supportive and positive over time. A number noted that, in previous years, mental health was never discussed in the workplace but more recently employers had become active in their messaging and resources. However, some noted the practical and unresolved tensions associated with mental health in the workplace.

> …there's a lot of scepticism and hesitancy to disclose the extent of what was going on for them (employees) and yeah, lot of, I guess sensitivity. And people didn't want it to be known that they were coming to see a psychologist or seeking mental health support. (Hannah)

Although Joanne noted in her experience 20 years previously, she had been fortunate to work with a particularly supportive group of colleagues who, separate from the organisational structures, enabled her to retain membership of the group and a sense of positive employment when she was experiencing mental distress.

> …my work colleagues, they were really good. ... I remember, I couldn't be literally, it's embarrassing [Participant laughs] ... So, I was sitting there with scissors, and they just gave me the most menial task, I was literally cutting things out of paper, so I was feeling productive. I was still being involved, but I didn't have to actually do anything that required, couldn't, any sort of mental capacity at all. (Joanne)

Some participants also articulated a broader view that there are funding and access issues to sourcing therapy, although none of these participants experienced that issue. They were all able to access therapy easily and within a timeframe that they considered acceptable. They were also able to either afford the therapy themselves, seemingly without issue, or received therapy paid for by their employer. Despite their own experience however, a number mentioned these funding and access barriers as known facts.

In summary, the participants felt that the stigma surrounding mental health had improved over time. Their view was that the general understanding of mental health is more compassionate and understanding but that negative connotations associated with people who experience mental distress still exists.

Stage Two Pre-purchase – Theme: Anticipation

The pre-purchase stage of the interview was concerned with understanding the participants' thoughts and actions once they had decided they wanted to see a therapist. Participants

used a broad range of channels to find a therapist. Three of the participants sourced them through employer-engaged psychological services (EAP), although it should be noted that two of those three also refer people to and had some role in managing EAP in their employer at the time. One got a name from a health professional she trusted, one had her first appointment organised by a family member and one found the therapist through a website which listed therapists in her region. Given how similar the participants are in many other regards, it should be noted that even in this small sample, they had such different ways of sourcing the therapist and it cannot be assumed that a single channel is sufficient.

In discussing whether public health or EAP would be an option, public health was generally not considered an option by this group in terms of not knowing how they would even access it and timeliness. None of the participants talked about discussing their mental health with their GP. For those that did not use the EAP service, there were questions about eligibility, whether that was an option given their topics for treatment were not work related and the quality of the service.

> My view on the public health system is that if you want something immediately, you're not going to get it immediately and you're just going to have to wait… With EAP, …my impression was that you would kind of just get anybody and that anybody may not be skilled in the areas that you wanted them to be skilled in... My impression was that they just wouldn't be invested in me … they'll just be sitting there in the EAP offices just like churning in one person after another coming in about X, Y and Z and like do they really care? (Ashley)

Participants also noted their limited understanding of what services were available and how therapy would work.

> I really had had no exposure to what was out there. Aside from EAP. I didn't, I was curious to what I could access … and even down to things like you know, how much would it cost and how long would it take for me to get an appointment and like I was just curious about the process. I suppose I was curious about what was on offer... (Ashley)

Participants were asked if there were any qualities they were looking for in the therapist, which they used as criteria when selecting the person they would see. There were a range of factors and little consistency. Only one participant had a preference for gender and other demographics were either not mentioned by others or specifically noted as not relevant by some participants. Three talked about connection or similar terms such as approachability, empathy or understanding and three were somewhat specific about what they were looking for in the therapist's professional expertise, referencing methodology, clinical areas of interest or qualifications. None of the participants appeared use the therapist qualities as a deciding factor, with Sandra's comment perhaps best reflecting the general view.

> …I did look around a little bit, but I guess the thing with therapy is you figure you never know. So, someone's given me this recommendation. I'll go. And you know what, if it doesn't work out, or if I don't connect or whatever, I can always remove myself. (Sandra)

Subtheme: Process

In terms of the process, some booked their first appointment entirely on-line through emails, websites, or apps and some through phone calls, but all participants' experiences were similar to Nicole's: "It was very seamless. It was very effortless."

Michelle's experience was slightly different to the others at this prepurchase stage due to the communications she had with the therapist.

> …I think I told her in the email what I'd like to talk about… So, she came back with, 'oh gosh, you might need a lot more.' She kind of intimated that I was probably needing a lot more help, which then made me think, my gosh, there is something really wrong with me. [Participant laughs.] … I suppose you should be bit careful when you send something back to someone going, 'I'm not really sure I'm equipped, and you might need a lot more than what I can offer.' It's like 'oh god'. [Participant laughs.] (Michelle)

From there, Michelle's purchase experience was unsatisfactory, and this initial email exchange seemed to colour her view of process and outcome. She notes that she did not connect with the therapist in the way she expected to, leading to Michelle ending the therapy without progress.

> (In terms of the sessions) I think it was disappointing. Yeah, I definitely felt disappointed. (Michelle)

When asked about how they were feeling about going to see a therapist, participants were both optimistic and ambivalent. Participants were, in the main, anticipating change from their current feelings and situation as a consequence of going to see the therapist.

> …I was just feeling positive, looking forward to it, knew that I had accessed counselling like this in the past and I knew that it had been helpful. So, yeah, just kind of positive (Hannah)

Not all participants felt this way though, some had mixed feelings, both emotional and physical, about their upcoming experience and this continued right up until meeting with the therapist.

> Nervous. Because I've never been, I didn't know what to expect. But also, I guess, um… that feeling of well, this is good because it was going to fix me. Or fix this thing, this hurt that I was feeling. Yeah, make it go away… (While driving to the session) I was hot and sweaty, that nervous, the whole anxiety sort of feeling. And nervous because you don't know the person. That's sort of horrible, it was just a shaky nervous feeling. It's hot and sweaty. (Joanne)

Subtheme: Expectations

Participants' expectations about what would happen in therapy, were divided into two key areas. The first expectation was about solutions; that therapy would enable the participant to resolve the matter which was creating an issue in their life. Some described these as the

opportunity to learn or gain tools but for some, the expectation was as straight forward as a fix.

> I don't know what they're going to do. But I thought that just, I suppose, give me some solutions that I can just take off, yeah, and put a new dress on it and then I'm away. Yeah, … fix it up. (Joanne)

> I wanted a solution, but I understood that the solution would be work for me to do … if I hadn't come out of that with something pragmatic, that I could begin to work on, I probably wasn't going to be satisfied. (Ashley)

The second expectation was about the opportunity to talk to someone and for the participant to have their views and feelings acknowledged and validated. A number of participants saw this as a key part of the experience.

> …I was just kind of just wanting someone who I could just talk to and not feel guilty about it, basically just kind of rattle on about all my things that were going on and then to have a counsellor really just validate what was going on for me. And kind of, I just wanted someone who could summarise back to me what I was saying ... Um, I didn't want any judgments or advice or instructions of what to do. (Hannah)

Michelle pointed out that sometimes it is difficult for people to have expectations about therapy.

> I'm not sure when you make these calls sometimes that you know what it is that you need until you get what you need. And if you don't get what you need, then you're going to walk away feeling quite disillusioned. (Michelle)

Stage Three Purchase – Theme: The details matter

This part of the interviews considered the participants' experience while engaging with the therapist. This stage dominated the interview, ranging from 30% to 46% of the time with an average of 36%, suggesting this stage was particularly memorable and meaningful for

participants. In the interviews, it became clear that details of their experiences were easily recalled by participants and that these coloured their overall customer experience perspective. The items participants recalled with meaning were ones that might seem like innocuous details such as the spatial relationships of the chair they sat in, the tone of the therapist's voice, timekeeping, the content of emails and so on. It was clear from the participants that these factors influenced their view of the customer experience and could either mitigate for or reiterate their views in the pre-experience or pre-purchase stages and influenced their decision to drop out of therapy.

Subtheme: Physical space

In terms of the logistical details, four of the participants met with the therapist face-to-face and two met using online meeting technology. There did not appear to be an impact on experience based on whether the meetings were face-to-face or online. The only issue for one participant who met with the therapist online was that she had to do the meeting sitting in her car, which was acceptable to the participant but did not necessarily create an environment in which she could be at ease.

> So, what I ended up doing was just getting in the car and kind of going to, making sure that I had my own private space because it was something that was concerning me of, don't want to sit there and be in the house at this time… It's all fine. I think the only time that it was annoying was that it was the standard 'Can you hear me now?' [Participant laughs]. Especially with not being on Wi-Fi and stuff, it was that kind of thing that was kind of annoying. But besides that, it was okay. (Nicole)

For those that met face to face, one met in a central city office space.

> "It was actually quite nice because it was quite intimate. It was furnished very nicely, even though it was just an office building. And she'd put a lot of thought into how the room was set out and how it was furnished." (Ashley)

The only curious factor for Ashley was that people were required to register using a sign-in sheet which everyone else could see, as it was during the covid pandemic. She felt comfortable with this potential breach of privacy but wondered whether other people would be as at ease.

> …I don't really care but I remember thinking, I wonder if some people wouldn't actually like to have their name on this list… It brought about all those stigma things about oh, do people want people to know that this is where they've been, and this is what they're doing? I don't know. So, but I didn't, I was like, alright, I don't care. (Ashley)

Two of the other participants met their therapist at residential properties that had been converted into therapy rooms, while the therapist for the sixth participant met with their customers at their home. For one participant, the space felt clinical.

> "She had a desk, I can totally remember that… I had a, you know, sort of a chair, like an office chair. Its setting wasn't even relaxing" (Joanne).

For Sandra, who met at the therapist's home, this became a real barrier to being able to connect with the therapist. It is interesting that the physical space and the therapist's interpersonal style became conflated in her unsatisfactory experience.

> … this is where I had an issue with therapists that don't have a waiting room… the first time it was alright, I guess I felt it was a little bit odd and a little bit uncomfortable, so I wouldn't say at that stage it was a struggle per se… So, the second time I went there, I think that's when I dared to come, it was at least three minutes early to the start time and she sort of poked her head out and you know she wasn't a very warm, sort of fluffy person anyway. But she sort of said, look, um, I'll kind of, I'll be with you, you know, kind of at the start of the session or something like that. …I felt really bad, like oh my gosh, you know,... I've deemed to come in here too early. But then the third one, what happened is I got there bang on time. Again, just trying to be right. She came out sort of clutching her phone on her and said, just on the phone, I'll just be a

> moment. I was thinking, no, no, no, hang on a minute. This has got to work both ways, right? You're going to be so adamant about the time thing. And that's when I thought, you really need a waiting room, you really, really do. You'll want to be there and relaxed and know that when that person comes to get you, they are ready and they are going to give you an hour from all whatever, or however long it is from that moment, it feels better. From that moment, I know I am never going to a therapist that was operating from home. (Sandra)

Participants were asked about their recollections of the sessions themselves and their answers fall into two main themes. These are feelings and their observation of the therapist's practice. The experiences are quite dichotomous based on whether the participant had an experience which was satisfactory (Ashley) or unsatisfactory (all other participants).

Subtheme: Feelings

In terms of feelings, Ashley describes hers as follows:

> …I mean, it was all quite overwhelming. And I think I think it was quite overwhelming because you know, she, I had an immediate sense straightaway that she had the ability to ask the right questions. And to empathise whilst getting underneath the skin of what it, you know, she thought would be useful to help her provide me with some strategies. (Ashley)

So, while Ashley repeated the word "overwhelming," this was intended in a positive way in terms of her feelings. This experience created a sense for Ashley that she was meeting with someone who was operating in a skilled manner and understanding her concerns quickly. Whereas for the other participants who had an unsatisfactory experience, their feelings, both emotional and physical, about the experience were strongly negative and led to an unwillingness to engage.

> …I can remember feeling really awkward and I can remember not wanting to say anything. Because I didn't want to share anything with this person, at all. I just wanted to get out. I remember just feeling like vomiting actually because I just wanted to get out of there. And so, the whole thing just felt very… um… I felt like, I actually felt like an idiot. (Joanne)

> …It was kind of like, if you could do it like, really concave, you know, your gut and your heart centre [Participant hunches shoulders] I guess it's kind of like that. So that wasn't very helpful and did not contribute at all to opening up and feeling comfortable… I know that I'm now just kind of hmm. I don't actually want to talk to you (the therapist) really. I wouldn't want to talk to this person. And I'm feeling kind of judged and yeah, and not comfortable at all, so. (Sandra)

Subtheme: Therapist in-session behaviour

In terms of the therapists' in-session behaviours, participants were not asked about what led them to seek therapy and therefore the match of the technical capability of the therapist to their needs is not within scope of this study. In their observations of the therapist's practice, the participants' views were quite different based on how satisfactory their experience was. Ashley described a therapist "ticked all the boxes".

> I felt that the therapist was interested in understanding my needs, and that she had spent time asking the right questions to understand those needs, and that she had provided me with a tool that I could use so you know, I got a I got an outcome at the end of it. I was emotionally supported throughout, you know, so I was cared for during the experience. And yeah, it was well worth the money. You know, so it was value for money. (Ashley)

For the others, their observations of the therapist's in-session behaviour could be grouped into agenda, credibility, connection, and lack of progression. Some participants' experience was that the therapist had their own agenda and rather than being led by the participant's

concerns or interests, the therapist was following their own path. This led to a sense by some of the participants that they were effectively being invalidated by their therapist.

> And I was like, I was just like, no, this is not, this guy's got it wrong. It's like he's making all these assumptions. And so, he was like, he was like just like poking me for no reason. And I remember at the time, because I was the person who had wanted to be there, like I was the, I referred myself, right? ... I remember feeling that I was sort of letting him do this to me and I was sort of taking the bait. (Hannah)

> I thought how the heck she had rushed to this end without it understanding where I was even at. By the time it had sort of finished, I felt like I'd been through one of those old washing machines, with the blade that tossed you around and spat you out and you were supposed to be clean. …I was sitting there having to just sort of answer questions and talk, without it actually being a genuine, genuine session about me… I think I was so traumatised. Traumatised is the only word for it… Because she took me to a space that was even darker than the one that I was already in. That's how I felt… (Joanne)

For some participants, their experience led them to question the therapist's credibility.

> He was telling me his own stories about what was going on for the people that I was describing and completely just not listening to me. So that he lost all credibility in that second session, and I couldn't go further with him regardless. (Hannah)

> I had to explain the dynamics or my dynamics, just, again, I guess almost a full family tree of how life, my life was or is and stuff. And I felt like it wasn't necessary, I guess. And that wasn't in my problem statement. It was other things… And it was just kind of like, 'why are we going down this?' And there might have been a strategy. I just didn't see it or feel it. So, I just started to disconnect. (Nicole)

> …in retrospect, I do kind of wonder if, you know, should we be asking for some kind of road map, just something vague. You know, 'can we get somewhere within 10

> sessions?', for instance, and kind of 'where do we want to get to?' Just have some guidance to map something out… And I didn't have any of that. (Sandra)

As expected, connection with the therapist was a key theme for participants. This played out for those with an unsatisfactory experience as both a lack of action from the therapist to build connection but also some behaviours they perceived from the therapists which interrupted their own ability to connect to the therapist.

> It just didn't, I don't know, it just didn't feel a connection to that individual... It was just… the individual didn't misrepresent themselves whatsoever. It just could have been off day for both of us. Don't know. [Both laugh.] Sometimes things just don't feel right. (Nicole)

> Yeah, it was just no warmth there. It was more just someone listening, like I was talking about something that was just a very average day… You know, it was just like, God, you know, I'm pouring my heart out here and I'm traumatised, and you know, she's just kind of, there's just nothing there… It felt like an icicle, like a fridgy, icy kind of thing, really… There wasn't that warmth and connection. And it almost like it was more clinical than caring. (Michelle)

> (When asked if she raised her concerns with the therapist) I kind of felt she was judgy and I don't want to sound like I'm not up for a bit of challenge or anything like that. But I kind of feel that it would be my issue, wouldn't be her issue. Just felt like if I tried to raise it, yeah, it would become my thing. (Sandra)

> I thought I'd come to somebody who caring and kind, listening. Even though I wanted the situation to be fixed, I thought it would be in a nice way rather than a hard-hitting, slap me around the face, just go and do this. It was quite different to what I thought… I can remember um feeling that there was no... it wasn't very personable, it was kind of a... Just a very um functional... pragmatic view of what I was going through and what I... like it was so the... completely unheard. Not being listened to and not even,

> not being seen, even though I hate that cliché. So, totally not being seen... just getting that rapport, there was **none** [Participant emphasis] of that. (Joanne)

When asked if they thought the therapist had noticed that the connection was not ideal, participants felt they could not raise their concerns. Alternatively, the therapist might have noticed a disruption in the connection but participants did not recall any recovery actions taken by the therapist.

> He might have done because I didn't just go along with him the whole time. And I think he almost saw this as a sign that I was hiding something and that he needed to do his job, which was to dig deeper and all that bs. So, he definitely would have picked up that I wasn't happy… And I didn't have a bar of it. And I am quite polite though. Like I've got really good social tact. I wasn't outright combative or like there wasn't conflict. It was just me tap dancing basically. I was doing all this work to keep things potentially workable. I was trying to get something out of the session because, for goodness' sake, I'd rearranged a whole day for this thing. (Hannah)

> Oh, yeah. At the end when I was a complete mess, I think she probably would have realised, yeah then, but it was too late. **Way** [participant emphasis] too late. Yeah, yeah, but not early on. (Joanne)

> Yeah, I was definitely guarded, and I think she made some comment during the session, so I sort of stared out the window when we greeted each other, kind of hearing that. And that's when she kind of did the 'it's you, it's not me'. It did feel like that. And at that point, that just really reinforced what you and I talked about earlier on, which is why wouldn't I say to her, 'look, this isn't working for me for these reasons?' I just felt that, gosh, you know, at that point, I think she, yeah, I just couldn't see her saying, 'gee, that's really good, I hadn't thought about that, I will...' You know? [Participant laughs] (Sandra)

The participants did not recall the therapist asking questions about their therapy experience, that is, testing whether the therapy was satisfying from the participant's perspective or seeking feedback about their practice.

The lack of progression that participants experienced was a key part of their unsatisfactory experience. For some, this was felt early in the first session.

> I guess it was, for me, in retrospect it was lacking that kind of focus or direction. Where are we going with this? (Sandra)

> It was probably um uh it was probably about 20 minutes in when I was still trying to give background. And it was, and I felt like I wasn't getting anything back. Time's going to have to start wrapping up. And so, it's that more than halfway, almost halfway through a situation. And then you're like, 'okay, it doesn't feel like I've got progress'. Didn't feel like any progression is when I started to sit there and go, 'okay, I guess this is done' [Participant laughs] (Nicole)

> Well, … zero with, but like I got no progress at all, with (provider) at all. It was really disappointing, it was just disappointing, I think it was like, ugh I really thought I'd get something out, whatever it was. I was expecting to get something, whatever it was. (Michelle)

Subtheme: Termination

Another common point was the way in which the interactions with the therapist were terminated. Ashley was the only participant who had a proactive termination experience.

> She placed the idea with me that I could probably just start to give these things a go… And I didn't feel, I remember thinking at the time, she's not trying to fob me off here, she's actually saying, now is the time for you to begin the work, but my door is very open if you ever if you need to come back or you want more to discuss more. How do you feel about working on this on your own from here on in? Like I think we both had come to the kind of consensus together at the end of the second session that I was

> ready to just give it a go. And I felt fine about that... so very much the termination was very easy, and it was very mutual, and it was very done very, handled very nicely. (Ashley)

For the other participants however, the termination was initiated by them, having determined that they were dissatisfied with their therapy experience. None of the participants explicitly told the therapist that they were displeased with the service they had received, and all were polite despite their dissatisfaction.

> …because he was in a direct contact with me around the sessions, I think I recall just emailing back, 'oh I'm not going to have any more sessions thanks' but didn't, like, tell them why. Something that was like kind of short. And I don't remember him pursuing any further or anything like that… And I couldn't be bothered. You know it takes so much effort to like even engage in counselling once. I didn't, the benefits weren't going to outweigh the cost for me to engage in the game. So, I just sort of went, that was that. (Hannah)

> (How did the session end?) Oh, me saying 'I'm going to go back.' Just to get out of there. Oh yeah, no. I'll come back and I just knew no way. So, I just wanted to get out there. I said whatever I needed to do to be able to move on and get out, escape the room. (Joanne)

> Well, I just said to her, 'I think I'm all good.' [Participant laughs.] 'I'm all good. You know, thanks for the last two sessions, it's been really helpful. But I'm okay from here.' I like, was just really, yeah, I don't need a third conversation… (What was the therapist's reaction?) Yeah, well, 'ah that's good, you know where we are if you need anything else, you know'. There wasn't any kind of questioning about, 'well, you know, given what you've told me and what you've been through, I'm not really sure that that's…', there was none of that. It was all kind of accepting that I had got what I needed, and they were quite happy with that. (Michelle)

> …when she kind of suggested that um we try and meet again and stuff, I said, 'mmm, probably not' [Participant laughs]. I said, 'you know, I'll try and figure out another way of moving forward.' And by that time the session had ended and then she was, and she was like, 'oh, is there anything that we can, I can help with coping?' And then I was like, 'I don't know, what would you recommend?' And then, so it was the standard kind of things of, you know, try and work out or try and to do this and try and make time for yourself. So, that they just felt very generic and disingenuous… disingenuous as in… didn't feel like, um, all the background that I had been giving in the prior time um, any of that was taken into account of what I had been saying. So, it wasn't addressing the situation that, that I had been presenting or trying to present… So, it was kind of, yeah, Dr Google type of thing [Participant laughs] and I said 'okay thanks' and it kind of just petered out the conversation. (Nicole)

Sandra went to see her therapist three times before stopping the therapy, despite the experience only feeling '50/50' from the first session. She explained that she viewed the therapist as the expert and felt that she should trust the process, expecting benefits to reveal themselves over time. Despite the unsatisfactory experience, Sandra found it quite difficult to end the interactions.

> I think that's when um that's when she said, 'oh, what, you know, what, when should we see each other next?' And I said, 'I don't, I don't know if I will make another, another appointment.' Um, and she was really taken aback and quite shocked. And she said, 'oh, oh well, I, I had no idea you were thinking about that.' Um, and I thought, that might be telling, isn't it? [Participant laughs.] …she was just saying, 'well, why would you stop it? Stop it now?' And I said, 'oh well, what's the alternative? You know the alternative would be for me to keep coming back for years, you know,' or I said something like that. So that we didn't get into the, you know, she didn't ask me really why. And and as I said, I just don't think, I wouldn't have known to get into that with her… She sort of seemed to be taken back by that and she said, 'well, no'. [Participant laughs.] So yeah, I think she genuinely was surprised that I'd stopped it… Which isn't easy because you know that's being [Participant laughs] that's being sort of forthright and upfront, which is not usually my style… Because her manner wasn't

> sort of warm, I just sort of thought well, she probably wouldn't, apart from the money, she probably wouldn't, no, it wouldn't be an issue for her. Even though she was shocked, I think, yeah, I think, this sounds really bad, but I felt like I didn't feel like I was going to be hurting any feelings, if you know what I mean… I think if I found any sense of her being open, then I might have gone into why. But there's just some people you kind of feel that there's not really much point, so… (Sandra)

Stage Four Post-purchase – Theme: (Still) Hopeful and positive

In the post-purchase stage, participants considered their reflections on their experience and what had changed since then. In terms of emotional response, Ashley was light-hearted.

> I probably left that (first) session going every single box has been ticked for me and I'm going to rebook while I'm paying… At the end of the second session, typical me, I was like, I've got this now. I've got like lots of really good tools I can use and da da da da and honestly, I was like, I just want to now, I want to give it a go, the hard work starts. I've just got to start kind of working on this. And she, she'd been awesome. (Ashley)

Whereas for the other participants with their unsatisfactory experience, they had quite different feelings post their experience.

> I think a little deflated at that, but still hopeful and positive about therapy, just thinking this just wasn't really the right therapist… one word that comes to mind is tight. Which is tight in terms of, that's been prompted by you sort of saying how do you feel? With the slight tightness of body, because you have sort of [Participant hunches shoulders] and tightness of time? And access in terms of, yeah, sort of feeling like I'm being restricted and I'm not to go outside those... (Sandra)

> I just kind of closed it off and that was that really… I think, knowing me, I've just gone, oh, well, I'm obviously better, in a better state of mind than perhaps I thought I was. And I just get on with, you know, you just get on with stuff. Whereas if you, you know, if there had been a really deep connection with some really good questioning and

ability to talk to it, there could have been even further shifts or maybe some progress made. (Michelle)

I was frustrated at the end. I was a little bit more frustrated because it was like, oh, I was hoping for a better result and I didn't have it. And then it was, felt a little lost. And then it was, um, like, I could have just not wasted my time and it did a little bit feel like a waste of time, but it was irritating... it was just, yeah, it was just unsettling and felt anxious and nervous and I couldn't really sit still. And just so frustrated. So, yeah, I had a hard time concentrating. And then later on in the day I was like, okay, I'm fine. I went for a walk, calmed down a bit and was able to settle into something else. But it was, it was just very frustrating. (Nicole)

I wasn't even coping with how I was at that time, let alone thinking about all this other stuff that she then threw at me and then I had to cope with that. And so I was, and I felt that after mum said she had been through it, you know, the first time wasn't okay. But I needed someone to tell me that to know that it wasn't a me thing. That it just wasn't, yeah, it wasn't the style or the approach that I needed. But the traumatised would be from that being pushed into an area that just completely mentally couldn't cope with. And then obviously it's then created the whole physical, vomiting, went into that dark space, just not. And then it did, it created from then on, I couldn't get out of my head. (Joanne)

Yeah, just um annoyed, disappointed. A little bit validated you know, like I did know what I was doing. Um. But yeah, just annoyed that that happened to me really… I was having, I noticed a little bit of anxiety because I did also still have some stuff that I had to deal with. And so, I definitely had some like, noticed like some tension in my stomach at times, around that time… I was angry that there was a practitioner out there operating, not only to cause potential, yeah, harm to individuals that he's seeing that that makes it at less likely that others who hear about those experiences will be to seek the support that they need. (Hannah)

Despite these unsatisfactory experiences, some participants were able to identify the benefit of their experience which provided learnings for their future approaches.

> I probably need to let the individual know a bit more upfront that not going in the direction that we... I hadn't thought that we were going to go down. And I think sometimes I just let people just go ahead. I like seeing where their direction of thinking is and so, I just kind of let it go. But at that time, it's supposed to be my time, and not wandering off in new directions. And so, I think it's just making sure that I'm better able to say, 'I don't think this is direction that I want to go' a little bit sooner. But at the same time, I still have that kind of feeling of, ah, if it's just not working, then why force the relationship at the same time? … It's just like that style didn't suit me. I'll just try somebody else [participant laughs] so, kind of like a car. (Nicole)

> I think now it's made me a lot more understanding, a lot more aware that, you know, sometimes the first one's just not, there's just a bit that's just not there and that's okay… it's okay to feel the way you're feeling at the moment. You don't need to – just cope with that at the moment and then you'll get a little bit stronger and then go on to the next little bit. So, it's given me a lot more of an insight into myself. (Joanne)

> I realised after I like, 'I've got this' and like, in a roundabout way he helped me to see that, but in a really inappropriate way. (Hannah)

All of the participants have been to therapy, subsequent to the experience described in their interview and therefore none of them were put off attending therapy by poor experiences. Ashley, given her satisfactory experience, returned to the same therapist.

> I felt very welcomed to be able to access that again. And in fact, two years later … I did go back and see her because I just needed to and I only went back once, …And again, she was very welcoming and. And I haven't been back since. (Ashley)

All of the other participants were able to describe satisfactory experiences that they have had with other therapists.

I think the warmth and the empathy and the compassion… But to actually sit down and tell the story and have somebody who completely, you could have heard a pin drop in the room. Like you know she sat really quietly and listened to the whole story. I mean it was a very therapeutic experience and I think I felt quite a load lift over that two-hour time… So, it was an opportunity to, I was heard I suppose, I was heard, acknowledged and her genuine care was, you know, I definitely felt it. (Michelle)

I'm very in fact, yeah, I'm very unlikely to see a counsellor again after that… If I ever, ever since then, if I've ever wanted counselling, I've always insisted on seeing a psychologist, even though it probably doesn't need to be a psychologist. I just can't trust counsellors anymore and I, especially as a psychologist, wondered whether I needed a psychologist to be able to actually provide me counselling just because I am a psychologist. So, that's definitely something that's changed for me. (Hannah)

It was sort of a beautiful old villa in [location] that actually overlooked a park… So (a) there's a waiting room so I could get early and wait till she was ready. I didn't get any sense from her as I had from the first therapist where, you know, it's... And even though it was absolutely timed perfectly, you'd... I guess this is this maybe an underlying current or something else, there's people who I guess it's their profession, so they should be used to it where they say, I've allocated this level this amount of time. I can't go over it because I have clients coming after, but I can't give people the sense that it's [Participant laughs] like a machine. And she had that ability to do that. So that was good… I guess in some ways the first one felt a little bit like she was questioning rather than asking a question, if you know what I mean?... I found her (the second therapist) genuinely open and curious and definitely asking lots of questions and allowing me to find the answer… felt like the second person was genuinely open, curious, neutral. (Sandra)

… so, when you booked the appointment, they were like, thanks for joining. But then they said, here's some pre-work prior to the session. And then they had asked for it, like the day prior to the meeting, so that they would be able to look at the information. So, they had asked, like, what the family tree situation was, and then

> what even people important to you at work, who those were as well, to try and give a better picture of who your support group was… And then that way they had the names and relationships kind of in place. But then they said give us like a short paragraph on what is the trouble issue that you currently have… I thought it was like, do I really have to do this? [Participant laughs] … And then when I thought about, you know, what my issues were with the other one, I was like, okay, I can kind of understand this. And then it was, but as I was doing it, it also helped build the picture in my head, especially when I was writing my trouble statement. It was just to help put the picture together for me in my head as well, which was really helpful. So, it was therapy before the therapy kind of deal. So, as I was doing it, so it was really nice… And it wasn't a life-changing experience or anything, but it was helpful, and it helped me get through those times. (Nicole)

> Without being trite or anything, but you could there's space, that you could have your own physical space, but be relaxed and... There's just something about a nice soft couch that you can just sort of sink into… The more at-ease environment enables you to open up a lot more and being comfortable with that and it being okay to cry, doing whatever you need to do… I'm able to ask them questions and giving me time. And just being in the moment of whatever was happening and just being able to talk… And also, the one I'm thinking about, she didn't give me answers at all. It was actually a two-way discussion, which was quite, quite different... Gave me, I guess, some sort of things to think about. But didn't, I never ever felt pushed. It was more lead by me, I guess, actually. Lead by me, what I was willing to say rather than being pushed into answering questions. …it was just a lot slower; it was a totally different experience. (Joanne)

Michelle and Hannah have roles where they refer employees to EAP or psychological service providers. For both, their unsatisfactory experience has had an ongoing impact on their perception of the services they use. For Michelle, this experience has made her question the company with which she had the poor experience but also heightened her sense of responsibility about which providers she recommends to employees.

> I wouldn't talk to it with them, that company again. So that one person has probably given me a brand for the brand of the organisation… I've always worried about different EAP services where some are incredible and some are just appalling and, you know, it's trying to work out all the time who's going to provide the best experience for people. And knowing sometimes if you don't connect with a therapist, that there's somebody else that you might connect with. ... It worries me a lot that the first experience can make or break someone's decision whether they see somebody or not. After getting the courage to go and see someone because I think it is a courageous thing sometimes. (Michelle)

For Hannah this means she places caution around the use of counsellors, and she has a bifurcated view of the role of psychologists and counsellors.

> And I'm even far more biased against recommending that a client or someone I've come into contact with vaguely to to seek counsellors. And I'm almost probably overly cautious if anything to people saying, 'make sure you do your research. Be very, very quick to… find someone, look, you know, shop around, be very quick to decide they're not the right provider for you, don't feel like you need to keep seeing them'. So, I'm possibly more than I need to be, just because I've had this personal experience. I try not to be overly biased against it, but it definitely has impacted me. (Hannah)

Subtheme: Yes, but…

All participants were asked two additional standard questions 'What would need to be true for you to go and see a therapist again in the future?' and "Given your experience, how likely would you be to recommend to someone else that they go and see a therapist?" There were consistent responses. Yes, participants would go to therapy in the future and yes, they would recommend therapy to others. However, participants put caveats on these - there was a but. All participants said they would see a therapist and in fact, all participants had done so, between the experience described and before their interview for this study. In terms of the specifics that they would now look for, responses were a combination of their need, their sense of personal strength, and the therapist capability.

> …do you have the skill and capability, have the capability to do the job? Like for me, it's about capability. And, yeah, and for me, there has to be a really deep trusting connection of someone that you can confide anything into, and you know that it's going to be a reciprocated experience. (Michelle)

> I need to be in the place to be able to cope with that. Totally. Because there's always, you know, I know you cannot go unless you're feeling really strong. But I need to be strong enough to be to go and talk about that stuff. Totally. It has to be somebody that I feel… is right for me. (Joanne)

> I think the physical, logistical part of the, yeah, having a waiting room. Um. [Pause.] I guess ah that sort of session that you've talked about, which others do offer, is maybe having that first (phone call), to see if you gel. Because perhaps now that I've had that experience, I would be a bit quicker to be able to determine whether, to have that ability to determine whether it's worth progressing. Rather than maybe giving too much, um, yeah, to anticipating that it's going to be great if I just gave it a bit more time, maybe making that call earlier really. (Sandra)

> …when noticing that I'm not feeling on track and yeah, if I'm ever noticing that I'm, you know, for sort of more than a couple of weeks, not feeling great about myself or if I'm ever, but for me personally I tend to start feeling like a little bit like just a little bit of hopelessness about the future creeping in… this experience hasn't changed how readily I would get support from someone, it's just that it wouldn't be a counsellor. (Hannah)

Similarly, in response to the NPS question, all participants said they would recommend therapy to others. Ashley's comment on this is unequivocally supportive.

> I'm such a big advocate of it… I'm probably an evangelistic advocate… I mean, a year ago, even somebody was, somebody just had a blah at me in the kitchen at work early one morning. And, and I ended up sharing, I said, look, you know, I saw a therapist a few years ago and it was one of the best things that I ever did. And it was in, you

> know, it's random. It was in the kitchen at work. And, you know, like, with somebody I really hardly knew. But but I was prepared to put that out there in the, in the hope that maybe it would spark them to take action. (Ashley)

Participants were not asked in the interview to provide a zero to ten rating on the NPS scale. However, Joanne, who has experience in marketing and customer service, recognised the question as NPS, responded with "I would say eight." In NPS terms, an eight rating comes from a customer who is "passively satisfied" (Reichheld, 2003, p. 51), that is, someone who is ambivalent. This is reflected in Joanne's current actions. In the interview, she disclosed that she would get value from going to see a therapist currently, but she was not intending to do so immediately because "I need to be in the place to be able to cope with that." These mixed feelings that Joanne expresses, that is, appreciating the value of therapy but waiting until the right moment, almost perfectly match that passively satisfied view reflected in an eight rating on an NPS. Not only did participants say they would recommend therapy, most of the participants have recommended therapy to others, but they did place some caveats around those recommendations.

> I would recommend it to everyone. Everybody, but I think it needs to be, the timing and the context are so important. So, would I recommend therapy? Yes always, but it has to be at the right time for that individual. Totally. (Joanne)

> Very likely. Yeah, I think it's a very helpful exercise to do… I think so what I have done is told my friends or colleagues of, you know, it's really good to be able to get that independent view of what's going on. And there are a lot of different tools in their toolboxes that you may not have thought of or heard of or seen. It's really good, you know, they've gone to school for a while, they've had a lot of different situations that they've dealt with. Just because a therapist hasn't worked for you in the past, doesn't mean it won't in the future. You just have to find the person that's right for you. It's just like finding an independent friend, you know, just usually you need to have somebody that's there, that's going to be able to guide you through your life event. (Nicole)

Summary of Results

The experiences described by participants in the Results section reveal individual experiences of participating in therapy and the participants' thoughts on what would need to be true for them to participate in therapy in the future and whether they would recommend therapy to others. It is important to note that every participant had an individual experience, different from each other, and they certainly did not always have aligned views. However, there were several shared themes. In the pre-experience stage, the participants were consistent in their view that stigma around mental health has shifted but that there is still room for improvement. In the pre-purchase stage, in terms of process, participants used a variety of channels to source the therapist, even so they all found it easy and timely. They did not have particularly strong views about what they were looking for in a therapist and were somewhat casual about deciding the person they would meet with. Participants had mixed views about their upcoming meeting. In terms of expectations about what would happen in therapy, they were looking for a solution and someone to talk to. Participants provided detailed accounts of the purchase stage and what might seem like minor elements, such as the physical setting, were meaningful to the participants' experience. Their own feelings and the therapist's in-session behaviours, made up of agenda, credibility, connection, and lack of progression, were key subthemes of the customer experience in the purchase stage. Termination was also discussed, with only the participant having a satisfactory therapy experience also having a positive termination experience. The others ended the interactions with the therapist abruptly with little or no discussion about their experience. In the immediate post-purchase stage, participants' feelings matched their experience, positive or negative. With further reflection, most participants could describe something positive from the experience. Irrespective of the quality of their customer experience, all participants were positive about the value of therapy, would go to therapy again in the future and have done so. All would also recommend therapy to others, but with the caveats that the person, in particular, and the timing have to be right.

Chapter Five: DISCUSSION

This section considers the results of the interviews in relation to the extant research considered in this study. The lack of a consistent definition of dropout creates problems when trying to understand the size or causes of the topic. Proposed definitions tend to be therapeutic practice led, rather than customer led, for example, Swift and Greenberg (2015) propose dropout occurs where there is not "clinically significant change or reliable improvement criteria" (p 27). In addition, much of the premise on which the research is based is that dropout results in a negative impact on the client (Swift & Greenberg, 2012). However, this was not the case in this study, it was the opposite. For the participants who had an unsatisfactory experience, they described therapy that was not meeting their needs, has created an ongoing negative memory for them and in some cases created harmful effects. Their decision to end therapy was beneficial for all participants, however, in terms of exiting from an unsatisfactory situation. Ultimately, they have all had satisfactory therapy experiences, which presumably they would not have had if they had perservered with the therapy experience that was not meeting their needs. The assumption that dropout from therapy is a negative outcome is disrespectful to the agency of customers and seems to entrench a lack of value in the self-determination by the person to decide the healthiest outcomes for themselves. It is important to remember that dropout from therapy is not necessarily a treatment failure or bad outcome.

Depending on what definition is used, someone may be described as a dropout if they do not complete the whole programme or attend a certain number of sessions. However, their improvement in their mental health may have been sufficient from the person's perspective, therefore they are making choices that are appropriate for the way in which they want to live. Equally, it is reasonable to argue that a customer choosing to terminate therapy early is making a rational, positive, or constructive choice about their time, cost, and wellbeing when for whatever reason their customer experience is poor. This is where Swift et al.'s (2012) cost/benefit analysis of therapy has some use. The idea that termination is measured by whether there has been a significant positive shift in the clinical diagnosis conflicts with the lived experience view that customers determine the appropriate time to terminate treatment and that choosing to live with health issues, mental health or

otherwise, is a legitimate and often rational choice. “Some people reconstruct a good life for themselves by making space for both madness and sanity. Other people reconstruct a good life by leaving their madness behind” (O’Hagan, 2015, p. 125). Therefore, it may be useful for the ongoing discussion about an appropriate definition of dropout to put the customer at the centre of the thinking. Rather than dropout being a failing on the customer’s part, it may be possible to consider a definition of dropout which is determined in collaboration with customers and taking into account the opportunities for improvement within a wide range of variables that influence the customer experience.

This study used IPA methodology, taking an idiographic approach to the customer experience of people who choose to stop going to therapy, after attending between one to three sessions, seeking to understand how this might influence a person’s likelihood of going to therapy in the future, and recommending therapy to others. The alignment between customer experience constructs and the use of IPA as the methodology was particularly helpful for this research, especially when considering novel experiences and lived experiences (Gillard et al., 2021; LaSalle & Britton, 2003). IPA’s focus on the individual, their sense-making of particular situations and the meaning people assigned to the situations along with its attention to the detail of the experience provided (Smith, 2015; Smith & Fieldsend, 2021) resulted in rich data which amplified the customer at the heart of the therapy experience. Six participants were interviewed, and transcriptions reviewed using IPA methodology to arrive at four themes, and seven subthemes. Five of the six participants described unsatisfactory experiences, while one participant described a satisfactory experience. The aim of the study is to arrive at themes contributing to a broader knowledge set, and which lead to future research and possible actions which may reduce dropout.

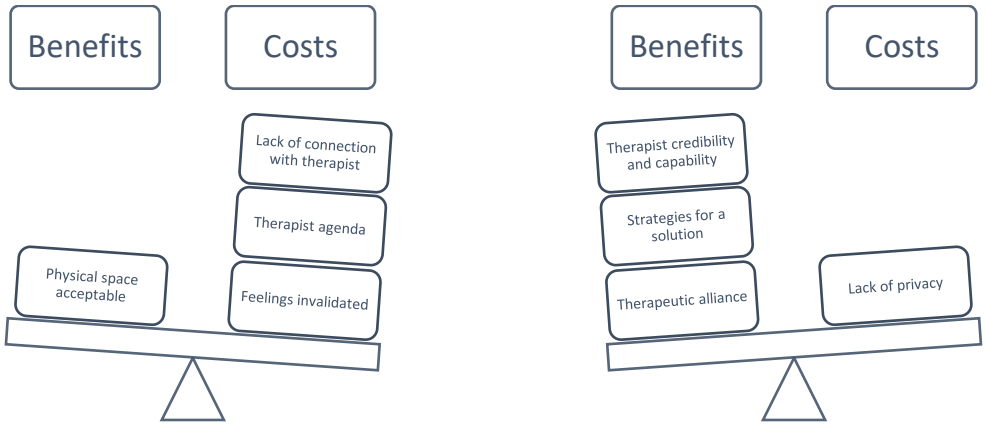
The four themes arising from the participant interviews provide insight into their customer experiences of attending therapy. In the pre-experience stage, participants were concordant in their view that the stigma associated with mental health has changed over time, but that it still exists and plays out for people in the community and workplaces. In the pre-purchase stage, participants were getting themselves practically and emotionally ready for therapy, and process and expectations were key subthemes. Participants valued an easy process to

find and make a booking with their therapist. Their expectations of what would occur in therapy were located around, first, getting a solution to the issues and second, having someone independent to talk to. In the purchase stage, participants talked in some detail about what happened in-session and this was obviously meaningful and memorable to them, resulting in four subthemes. The physical space reinforced either comfort or discomfort, with seemingly minor details contributing in an impactful way to their experience. In terms of emotional and physical feelings about the experience, these were associated with their willingness to engage and be vulnerable with their therapist and what actions they took. The therapist's behaviours, including practical details such as timeliness, but also interpersonal style, therapeutic approach, and alliance, as well as conflict attention, were all factors of importance to the participants. In addition, progress, or lack of, was a factor. Termination occurred in a way which was in alignment with their therapy experience. The participant with a positive therapy experience described an exemplar termination approach by the therapist while the individuals with unsatisfactory therapy experiences terminated their therapy abruptly and with little or no discussion. Finally, in post-purchase, participants were hopeful and positive in their views about mental health, therapy, and therapists, irrespective of whether they had a satisfactory or unsatisfactory experience. They felt that depending on what their mental health needs are, their sense that they had the strength to attend therapy and the therapist capability were factors which would need to be in place to arrange therapy in the future. They would all recommend therapy to others, but with caveats to that recommendation, which is that match with the therapist, or finding the person that is right for you, and right timing are critical. It is helpful to stay aware that the four themes, structured around Bueno et al.'s (2019) four customer experience stages, are useful for the purpose of a framework and for clarity but that they are not experienced in isolation of each other. For example, individuals who used their work experience of referring others to therapy or hearing whānau members talk about therapy parlayed this into their pre-purchase decisions about accessing a therapist. Similarly, the pre-purchase decision of which therapist to choose played out in their expectations of what would happen in-session, sometimes to their surprise in the purchase stage. Finally, post-purchase views are influenced by their experiences at all the preceding stages. This is somewhat congruent with Swift and Greenberg's (2015) cost-benefit model, in which it is a combination of variables that lead to a dropout decision. Figure 1 is a simple

conceptualisation based on their model (Swift & Greenberg, 2015, p. 30), in which dropout is more likely where the costs outweigh the benefits and less likely where the benefits outweigh the costs. Example benefits and costs come from the participant interviews.

Figure 1

Examples of Customer Assessment of Benefits and Costs of Going to Therapy



There are a wide range of findings from the studies on dropout considered in the literature review, many of them contradictory. There is little to be found in the customer characteristics that will reliably predict dropout. In addition, this focus of the research on customer characteristics seems based in an assumption that it is customers who are at fault of dropping out, often due to factors that they cannot control, such as their demographics or mental health disorders. It may be more prudent to consider any consistent findings in the extant research as signposts for further research, rather than as a clear road to decreasing dropout rates. Future research may bring other perspectives to light by considering, using a commercial perspective, what it is that therapy is selling, whether that meets customer expectations, why customers might choose to stop buying it and how the service could be adapted to better fit with the customer experience expectations.

The next section discusses the main themes developed from this study's interviews and connect these with findings in the literature review. The purpose of this section is to bring the various sources of information together and identify implications to be considered in the industry or by therapists and for future possible research.

Stage One Pre-experience – Theme: Negative connotations still exist

The pre-experience stage considers the "consumer predisposition" (Bueno et al., 2019, p. 793), that is the views that consumers hold before they engage with, or even consider engaging with the service. Bueno et al. (2019) note that this stage is often not researched in commercial customer experience studies because the companies undertaking the research perceive these as variables over which they have no control. In this study, the interview explored the beliefs and assumptions that participants held or heard around them about mental health, therapy, and therapists prior to arriving at the view that they intended to see a therapist. This is essentially exploring the participants' mental health literacy, help-seeking behaviours and views on stigma.

In relation to mental health literacy, Choudhry et al.'s (2016) four-part framework is useful to consider the range of understanding articulated by the research participants. Firstly, participants described health symptoms to be both emotional and behavioural terms and secondly, they talked about physical and emotional mental distress more than behavioural, specifically outlined life stressors, trauma and coping for mental distress, and gave examples of where they had seen normalising or underestimation of mental distress. Thirdly, in terms of the causes, participants acknowledged various psychosocial and environmental factors. Finally, when it came to treatment and help-seeking behaviour, participants described a range of views that they held or they observed in others during the pre-experience stage, which encompasses their life prior to the time they had determined they wanted to go and talk to someone. These views ranged from "had to go" (Joanne) or "harden up" and "not to be silly" (Sandra) through to a practical view about buying specialist skills and help.

> … right from the beginning, I've always been a great believer that there are times where expert help is needed (Michelle)

Participants also noted that views, their own and others, have changed over the time since they were in the pre-experience stage. In terms of stigma, both the research (Flett et al., 2020; Morris, 2001) and the participants agreed that the level of stigma around mental health has decreased over time and that "psychotherapy has gone mainstream" (Duncan,

2010, p. 26). All participants were clear however that stigma still exists and affects people's willingness to discuss their mental distress and the way in which these issues are treated. This view too is supported by studies of help-seeking and dropout behaviour (Britt et al., 2015). The participants who had an unsatisfactory experience discussed their mental distress with one or two people in their whānau but seemed reluctant to discuss this, in any real detail, with a broader social network. They explained this as a "non-event… nothing to share" (Nicole), "no one had been through it" (Joanne) or "I don't think it's just general social conversation" (Michelle). When they have told others, it has been a conscious choice "I was prepared to put it out there" (Ashley) perhaps reflecting the stigma that still exists in a broader group and society which makes people reluctant to disclose. Certainly, there was not the sense that participants would talk about their therapy experience in the same way that they would talk about going to see another health professional, such as a dentist or physiotherapist. Personal experiences of mental health and therapy still appear to be a sensitive topic for discussion. Having said that, nearly all individuals said that they had encouraged others to utilise mental health services when those individuals had raised concerns about their wellbeing, suggesting that the stigma has shifted to a point where people are supportive, rather than dismissive or shaming as might have happened in previous times. But maybe the stigma has only shifted sufficiently that we feel able to support others but not yet confident enough to necessarily be entirely open about our own mental distress. This group particularly noted in the workplace that mental health is discussed much more openly than it was in previous years, but that it can still be problematic from an employment perspective. This idea that mental health continues to have a stigma in our community and has the potential to negatively impact on a person's employment, along with other key life needs such as housing and relationships, was supported in recent research in Aotearoa New Zealand (Ministry of Health, 2015).

Another aspect of predisposition which is important for therapy and impacts on dropout are traits. In particular, research has found a relationship between dropout and traits such as motivation, psychological mindedness, and others along with avoidance behaviours. As is typical in IPA research, participant traits were not measured or tested (Balmain et al., 2021; Marotti et al., 2020; Spragg & Cahill, 2015). However, participants spoke in psychological terms about being interested in understanding themselves, people and behaviour, and keen

to learn more. These aspects may talk to a level of motivation and psychological mindedness but did not mitigate sufficiently to protect against poor customer experiences across several other factors.

In order to establish a satisfactory customer experience and mitigate for potential dropout, it is important that therapists consider the predisposition of the person sitting in front of them. Duncan and Miller (2004) describe this as the client's theory of change or their understanding of the problem, causes and potential solutions. Therapists who understand the mental health literacy levels with which customers arrive, their preferences based on those predispositions and to test those through the programme are likely to help retain people in therapy (Windle et al., 2020). This may be done through discussion and exploration with the person about how these things might influence what they expect and want to have happen in therapy, their attendance or decision to end therapy. Companies may not explore customer predisposition, but in therapy this construct may be at the heart of the therapy experience, rather than peripheral to it. In addition, of course, therapists should be testing their own views relating to help-seeking behaviours and stigma regularly in supervision, to avoid inadvertently creating an unsatisfactory therapy experience.

Stage Two Pre-purchase – Theme: Anticipation

Subtheme: Process

This pre-purchase stage includes the steps of the participants deciding that therapy might help, deciding to source therapy options and contacting a therapist (Elliot, et al., 2015). In customer experience research, topics that are typically considered in the pre-purchase stage include price, means and ease of accessing and communicating with the service, reputation of the supplier or industry, advertising, and brand (Bueno et al., 2019). In this study, price did not appear to be a consideration for the participants. Three were able to receive their therapy free, as it was paid for through their employer. For the other three, the topic of price only came up for Ashley, almost as an aside.

> …I probably turned up blindly. And… that could have been like $170 later of turning up blindly and hoping that something came out of the session, which for some people, that's a lot of money. So, but I was prepared to do that. Other people may not have been. (Ashley)

This likely reflects the financial situation of the participants, rather than a broader implication, although the findings in the research suggest that barriers other than cost may be more relevant for customers. While research has found cost to be a barrier to treatment (Mohr et al., 2006; Penn et al., 2004), research in Aotearoa New Zealand has not found that to be such a key factor, assumingly because of the public health system (Kulshrestha and Shahid, 2022; Oakley Browne et al., 2006). In contrast, research in Aotearoa New Zealand has shown that accessibility and timeliness are common barriers to participating in therapy (Gibb & Cunningham, 2018). In this study, all of the participants found it easy to source and book with the therapist they saw, using differing channels, and had no issues in terms of timeliness. In terms of their communications with their selected therapists, most of the participants found this to be as expected. Michelle's experience of her therapist sending her an email which caused her to question her mental health however contributed greatly to her poor therapy experience, decision to terminate and then subsequent decision not to use that company again for other purposes. Like any other provider selling a service, it is important to be cognisant of the fact that customers are measuring and judging the therapy service at every stage, even when not personally interacting, and these connections impact their view of the experience and willingness to continue.

With regard to communication, reviewing the barriers to therapy summarised in Choudhry et al. (2016) provides a useful list when thinking about the likely questions potential customers will have. These include stigma, lack of knowledge and awareness about mental health problems and treatment, cost, legal and language barriers, ethnicity, and concerns about prejudice. For example, therapists could include relevant and simple information about each of these topics on their websites making it easy for potential customers to find the answers. This answering of questions before they are even raised also helps customers to feel that this therapist understands their needs, and could contribute to later connection and therapeutic alliance. Communication channels include technology of course. Given the

intensifying interest in and use of service robots and AI in the broader service sector, therapists should consider its place in their business. This is likely to change quickly as organisations generally are struggling to identify how they operationalise these technologies and use these to reinforce their customer experience (Altinay & Arici, 2022).

In terms of reputation of the supplier or industry, the participants were largely unconcerned about the particular person they saw. The participants mainly saw the therapists as experts with training, tools and experience and as a group generally had a positive view of the value of therapy. For Hannah however, the experience she had with the therapist irreparably damaged both the person's brand whereby she no longer referred employees to this therapist, but also more broadly has led her to have a negative voice, action, and view about counsellors. Reputation can be built or damaged through personal experience, as in Michelle and Hannah's experiences, but can also be affected by others' experiences. None of these participants saw using public health services as a viable option. They were not critical of the skillset in the public sector, in likelihood their views reflected the accepted truth of the pressure on public health, which is supported by the research (Paterson et al., 2018) and the resources they had access to which are not necessarily available to everyone. In contrast, of the three participants who did not use an employer-funded therapist, they had questions about the quality of EAP. Even Michelle and Hannah, who utilised employer-funded therapists and at the time facilitated those services in their workplace, crucially had concerns about how EAP services are contracted by some employers. Given the ubiquity of EAP as an employee benefit in large businesses in Aotearoa New Zealand, the ambivalent view held by these well-educated individuals with well-established careers was interesting. However, this did reflect the findings of other research in which seeking help through the workplace can be viewed as unsafe due to stigma (van der Rijt et al., 2013) and that there are mixed views and experiences in relation to EAP specifically (Elder et al., 2018). It does suggest that further work could be undertaken to test employee perceptions and understanding of EAP, their customer experience and makes changes to deliver more effective therapy, if needed (Joseph et al., 2018).

Finally, in terms of process, when it comes to advertising and brand, this is low-key in Aotearoa New Zealand with little advertising and few "famous" therapists to access.

Websites which advertise therapists tend to rely on being factual and informative rather than influential. Although this is changing in Aotearoa New Zealand as private psychotherapy continues to grow in size and with more media and social media engagement with psychologists, in particular, as commentators on wellbeing and world events (see Heath, 2022; Nimmo, 2023). At the same time, there has been the growth of 'broadcast therapy' where a form of therapy occurs on radio, television, or social media (Brown, 2018) effectively creating 'celebrity' or influencer psychologists who will have a well-recognised brand. This may impact on potential customers' expectations about mental health, therapy, and therapists. In the commercial sphere, as customer experience has become more emphasised in the service offering and central to the business' success, customer expectations have also continued to grow (Grainer et al., 2013). As people become more familiar with psychotherapy, there's no reason why their customer expectations will not expand here also. It is worth considering if there are different approaches that might impact on the customer experience. For example, two of the participants said that they would have found it useful to have a short phone call with the therapist at the pre-purchase stage prior to investing in therapy (Barrett et al., 2008). This was largely to test for connection, a sense that this was someone who had an appreciation for their concerns and that there was someone there for them. Nicole talked about a satisfactory experience where she was asked to provide detailed information before meeting with the therapist. She had mixed feelings about the work required, but overall saw it as positive "therapy before the therapy." Research has found that the person who delivers the therapy may contribute five to nine times more to the treatment outcome than the actual therapy that is delivered (Miller et al., 2013). Even at this pre-purchase stage, there are actions therapist can take to accommodate customer preferences and grow therapeutic alliance, both of which seem to mitigate for dropout (Cooper et al., 2016; Sharf et al., 2010; Swift et al., 2018; Windle et al., 2020). Building these connections before people even get in the room would seem to be particularly impactful, given the proportion of people who stop after one session (Connolly Gibbons et al., 2011) giving the therapist very little time to influence the customer perception before they decide whether they want to come back.

Subtheme: Expectations

In terms of expectations, two key themes emerged from the interviews – a solution and someone to talk to. First, in terms of a solution, participants were both looking for a fix to their concerns and tools which they could implement. To be clear however, this was not about being told what to do. For example, Joanne's unsatisfactory experience involved a therapist who was "rushing me to this solution" whereas her satisfactory experience "she didn't give me answers at all. It was actually a two-way discussion." Associated conversely with this, a lack of progress was noted by some as a key frustration. In research, this topic of solutions is most similar to measurement of treatment outcomes. Typically, customers have been found to expect therapy to be quick, (Swift & Callahan, 2011) and dropout rates to increase where the timeframes are not clearly expressed (Swift & Greenberg, 2012). Similarly, a lack of progress means that customers are more likely to dropout (Schindler et al., 2013). A fix per se is somewhat problematic as credible therapists would not seek to 'solve' their customer's challenges however it is important to know that this is what customers are looking for. In some regards, better management of customer expectations would be helpful here. This could be done through more information on the therapist's website or other communications channels, such as social media, pre-purchase phone calls or information gathering. In addition, there is an opportunity to grow mental health literacy generally through making more accessible information available through industry communications channels. This requires skilled communication of course, in order to make it more attractive for customers to move to the purchase stage and for the communications not to create a barrier of impenetrability or hopelessness to someone seeking help. At the purchase stage, it is useful to explore those expectations, what success looks like for the customer, to talk directly to those and agree the areas of focus. Therapists would do well to be upfront at the first session about the treatment approach, likely number of sessions, to check customer views on that and look to work in a collaborative manner that works for both therapist and customer. None of these ideas are new (Duncan et al., 2010; Lambert, 2013; Swift & Greenberg, 2015) and yet for many customers, it appears that these do not happen in their experience (Bowie et al., 2016).

Second, with regard to the pre-purchase expectation that they would find someone to talk to, participants in this study were all looking for someone they could connect with. At the pre-purchase stage, the issue is about how therapists can present information or provide access so that customers can make an effective purchase decision; that is, decide who is the right therapist for them. Given the difficulty in accessing therapists (Oakley Browne et al., 2006), it could be argued that this question is irrelevant, people will take who they can get. However, lack of connection is a key reason why people dropout (Bohart & Wade, 2013; Roe et al., 2006) and contributes to inefficient use of the resources available (Khazaie et al., 2016), increased customer acquisition costs and to potential damage to therapist self-efficacy (Piselli et al., 2011). Therefore, it is worth establishing a more robust way in which potential customers can determine the right therapist for them, at the pre-purchase stage before any parties incur real costs. The most common way of providing insight into the therapist is on a website. However, this is not sufficient to help a potential customer understand whether a connection can be developed. As Nicole noted, her therapist did not "misrepresent" themselves on their profile but even so, she "just didn't feel a connection to that individual."

The customer's predisposition will also impact on their expectations for therapy, including therapy roles, characteristics of the therapist and treatment types, and whether they are even prepared to start (Swift et al., 2011). Participants in this study, when asked what would need to be true to undertake therapy in the future, noted two factors related to preferences; that is, the particular skills and capabilities of the therapist and the connection and reciprocated experience with the therapist. It is worth investigating how therapists can provide more information or engagement at the pre-purchase stage so that customers can make informed decisions about the right therapist for them (Bohart & Wade, 2013). It is worth this additional effort because where customer preferences are met, dropout decreases and outcomes improve (Swift et al., 2018).

Stage Three Purchase – Theme: The details matter

One of the underlying constructs of customer experience is the idea that the experience stands out from the customer's day to day experience (Kim & So, 2022). That was certainly

true for the participants in this study. The event was memorable to them all and they were fluent and descriptive in recalling their experience. Becker and Jaakkola (2020) noted the five most used customer experience dimensions are cognitive, affective, physical, sensorial, and social anticipation and responses. Again, all participants could articulate quite detailed aspects of these dimensions with ease and with little prompting from the interviewer. An important point on this theme is that it was the details, plural not singular, that mattered and contributed to the decision to end therapy. For example, Ashley who had a positive customer experience, was in an office that she appreciated – this plays to the physical and sensorial dimensions. In addition, her cognitive state, being "hungry for information," was met through the tools the therapist provided her with. Her affective and social dimensions were met through the sense of being emotionally supported and her experience that the therapist was "interested in understanding my needs." The only potentially negative moment, that is, the sign-in sheet, seems to have been offset by all of the other dimensions being experienced in such a satisfactory manner. This suggests that these customer experience dimensions layer on top of each other and are compounding in their impact. Customers can tolerate the occasional offkey notes but the overall experience, taking all the dimensions into account, will contribute to their view of whether this is a customer experience they wish to continue or stop.

In contrast, the other participants who all described an unsatisfactory customer experience largely portrayed the various dimensions negatively. For example, Nicole's experience shows how having a negative experience, even relatively minor ones, against each of the dimensions adds up to an overall unsatisfactory experience. On the cognitive, Nicole did not receive the "different ways… to think about" her situation that she was expecting from the therapist, and she felt frustrated and annoyed in the affective space. In the physical dimension, Nicole described the online meeting as fine but noted the need to sit in her car rather than be at home and Wi-Fi dropping out was occasionally an issue. As a very simple example on the sensorial dimension, Nicole laughed in her interview about her therapy session being the typical experience of the usual interruptions in online meetings, 'Can you hear me now?.' Finally on the social dimension, Nicole's experience was that her therapist was being disingenuous, and she felt that they had not really understood her unique circumstances. Taking Nicole's experience as an example, the single dimensions which might

have been quite innocuous, when added together they become an overall customer experience that was unsatisfactory and led to the decision to stop seeing this therapist. Therapists may do well to pay attention to the details of the various dimensions of the customer experience in their practice and how these link together to increase or decrease the likelihood of dropout.

Research to date on dropout has been dominated by a focus on the customer characteristics, with little in the way of conclusive findings about influenceable causes and these provide scope for exploration. “This focus upon relatively stable dispositions, traits and disorders suggests that practitioners are seeking inherent deficits in the client as explanations for treatment non-completion, rather than factors to do with the service and the client’s opinion of the service.” (McMurran et al., 2010, p. 285). This focus suggests a belief that it is failings in the customer which are causing the dropout rates. Instead, it may be more productive to demonstrate a willingness to look at self, as in the mental health industry or individual practitioners, the what, where and how of delivery, to consider how the service may contributing to a customer’s decision to stop buying what is being sold. The following subsection discusses a number of components that contributed to the overall customer experience at the purchase stage, how these connect to the extant research and implications for action.

Subtheme: Physical space

For the participants in this study, physical space seemed to matter in terms of their ability to relax and this affected their ability to engage, sense of the success of therapy and willingness to continue. Ashley described the therapist’s office in detail and the fitout reiterated her optimistic aspirations for the therapy experience. Whereas Joanne described her therapist’s space as quite clinical and contrasted it with a later experience with a different therapist, “there’s just something about a nice soft couch that you can just sort of sink into.” For Sandra, the lack of a waiting room became an entirely unsettling effect, contributed to the disconnection with the therapist and decision to terminate. The physical space may have the potential to reinforce the customer experience in a positive or negative manner and contribute to the customer’s thoughts about dropout. There has been little

research to date on the physical setting of therapy (Geotter, et al., 2015; Rost et al., 2017; Sharf et al., 2010) and most of that at a general level (Swift & Greenberg, 2012) but given these participants' experiences, there seems to be an opportunity for future research to pay attention to the detail of the physical space.

Subtheme: Feelings

This section considers negative feelings that customers experience and their connection with dropout. It links particularly to Becker and Jaakkola's (2020) affective and sensorial dimensions. In their study of the relationship between the customer experience dimensions and loyalty, (Brun et al., 2017) found that the main dimension which affected loyalty was negative affective (emotions and feelings) and that "consumers not wishing a repeat of a negative emotional experience will tend to avoid the company or service entity responsible in the future" (p. 333).

Several participants felt that their feelings were effectively invalidated when the therapist did not appear to understand and accept the participant's views. Emotional invalidation is "an experience where one's inner state (e.g., emotion) is communicated to be incorrect by another" (Hillman, et al., 2023. p. 312). Participants described unsatisfactory experiences such as 'judgy' (Sandra), "not being seen" (Joanne) or "disregarding what I was saying" (Hannah) and physical reactions of "feeling like vomiting" (Joanne) and "couldn't really sit still" (Nicole) because of their experience and emotional state. This invalidation conflicts with their pre-purchase expectations that attending therapy would provide someone to talk to who would acknowledge their experience. Hillman et al. (2023) note that emotional invalidation arouses negative emotions, with a consequent threat response. As per Brun et al. (2017) and Hillman et al.'s (2023) findings that customers will avoid a service in the future when people have a negative affect, the participants made a decision to terminate. For the participants, this sense of invalidation was a key part of their decision to stop seeing this particular therapist. Put simply, where customers have a negative emotional experience with a therapist, the risk of dropout is likely increased. For therapists, the opportunity here is to use their well-honed interpersonal skills, demonstrate validation, that is, to communicate acceptance and understanding (Greville-Harris et al., 2016) to be particularly

alert to negative affect being exhibited by the customer and to initiate a discussion for resolution where it does occur.

Subtheme: Therapist in-session behaviour

The participants' observations about the therapist's in-session behaviour and practice, for those that had an unsatisfactory experience, were grouped into ideas about the therapist having an agenda, credibility of the therapist, sense of connection and lack of progression. In the interviews, the participants did not recall the therapist seeking feedback and as a consequence adjusting their approach. Given the participants' concerns about the therapist having an agenda, it is not surprising that feedback-seeking did not happen or was not memorable for the participants. Similarly, it is not a big leap then to understand why participants would be questioning the therapist's capability and credibility and the lack of progression. The research findings on treatment feedback are clear that proactively seeking feedback results in better treatment outcomes and decreased levels of dropout (Roseborough et al., 2016). Several participants thought that the therapist would have most likely seen that they were disconnecting but, curiously, in none of these cases did the therapist raise it with them. Clearly, from the participant's perspective, there was a rupture in the relationship and yet their experience was that the therapist did nothing to address or recover the situation. It is reasonable to assume that a skilled therapist will have advanced relationship skills, being able to both spot customer conflict or discomfort and facilitate movement towards a more sustainable relationship. However, the customer experience was that this did not happen. In terms of lack of progression, Lippens and MacKenzie (2011) found the likelihood of dropout to be three times greater for those that viewed their treatment as ineffective, compared to those that viewed it as effective. Similarly, participants in this study who could not see progress in their therapy felt frustrated by this and chose to drop out.

In summary then, for the participants who had a poor experience, there was an opportunity for the therapists to have sought feedback from the participants, particularly with regard to the customer's understanding of the treatment approach, sense of solution and validation, confidence in the therapist, rating the relationship connection and satisfaction with

progress. Obviously, the promise in seeking feedback is that action will be taken and so the therapist could work actively with the customer to determine the action to take based on that feedback. There is also value in collaborating with the customer on recovering the relationship when the therapist can see that it has moved to an unhelpful space.

Subtheme: Termination

This study focussed on participants who had one to three sessions with a therapist before deciding to stop. Just as Knox et al. (2011) found in their study, the experience of those who had a positive termination from those that had a problematic termination was significantly different and lasting. Similar to Knox et al.'s participants who had a positive termination, Ashley and her therapist collaboratively agreed the ending of their interactions and she was able to remember the helpful effects from the treatment, describing it, combined with other life changes, as "I've kind of thrived really. And … the impact has been huge." She was open to participating in therapy in the future and has done so with the same therapist. In contrast, the experience of this study's participants who had a problematic termination are significantly different from Ashley's experience and match Knox et al.'s (2011) findings. Similar to their study, all of the participants in this study who had a problematic ending had an unresolved rupture with the therapist. None of the five participants told the therapist about their dissatisfaction. Just as Knox et al.'s participants had, the participants ended the interactions with the therapist abruptly and without discussion. All these participants with a problematic ending have undertaken subsequent therapy but with a different therapist. Unlike Knox et al.'s findings, participants in this study with a problematic ending did not express higher levels of fear and hesitation and, in many cases, had commenced therapy with someone else within weeks. Being proactive about planning for termination and taking action to avoid a problematic ending seem to be critical therapist responsibilities. Therapists who are proactive about the termination of therapy may find that customers are able to better engage for the full course of treatment (Swift & Greenberg, 2015).

Sandra's view that, terminating the therapy would not have any impact on the therapist apart from the money, is an interesting one. The relationship between a customer and a therapist is both a commercial and a personal arrangement. Based on participants' views in

this study, customers are looking for a solution and validation, and recognise that therapy requires vulnerability and will be challenging to achieve those things. They are also paying for a service. Certainly, a number of the participants articulated quite a transactional view, that is, if this therapist did not work, they would just find another one. This view however should be seen in the context of strong emotions that the participants also expressed such as disappointment, anxiety, and frustration when the therapy experience was unsatisfactory, so maybe not quite as transactional as they on occasions presented. Therapists presumably are looking to work in a way that enhances client growth, promotes self-growth and learn about other people (McBeath, 2019), but also are making a living. This connection between the commercial and personal needs of both parties in the arrangement has some potential to create tension which will play out in the behaviours and views of both.

In this study, five out of the six participants had an unsatisfactory experience and ended therapy with that particular therapist without telling them about their dissatisfaction. This matches the information on customer complaining behaviour, in which the majority of customers do not publicly complain (Chebat et al., 2010; Panda, 2014; Voorhees et al., 2006). Ro and Mittila's (2015) theory that neglect and loyalty contribute to an absence of complaining behaviour was seen in the participant's experiences. In terms of neglect, Nicole said, "I'm not going to try and force a relationship with an individual that I don't have to" and on loyalty, Sandra said "they're an expert and … I thought if I kept going maybe things would get better or would reveal itself". This absence of complaint probably also contributes to therapist upset and confusion when customers simply disappear (Piselli et al., 2011). In a qualitative IPA study of unsatisfactory therapy experiences, only one of the 10 participants formally complained, and they did not complain because they were uncertain about whether this was a 'reasonable thing to do' or 'had no energy to fight another battle' (Bowie et al., 2016, p. 84). This matches with CCB research which finds that people determine their complaint response by considering two aspects, their capabilities to respond and the appropriate response (CCMC, 2023; Lazarus, 1991; Ro & Mattila, 2015). Participants in this study did however undertake private actions (Day & Landon, 1977) including exiting the interactions with the therapist, boycotting a particular company or therapist or negative word of mouth. It might also be assumed that the participants'

conditional recommendations to others are a form of negative word of mouth. Therapists should assume therefore that customers are unlikely to complain. Actions such as understanding and meeting customer preferences, seeking feedback and taking action in response, valuing the importance of the therapeutic alliance and being proactive on ruptures are all ways in which therapists can mitigate for customer complaints. The experiences of the participants in this study and the extant research shows that the quality of the termination counts. As the party who is most familiar with therapy, it is the role of the therapist to facilitate a positive termination experience.

Stage Four Post-purchase – Theme: (Still) Hopeful and positive

Following their experience of therapy, the emotions the participants experienced aligned with their view, negative or positive, of the customer experience. For some, this resulted in brand damage for the supplier and subsequent boycotting (Day & Landon, 1977; Istanbulluoglu et al., 2017). For some, they identified benefits or learnings that they have taken forward.

Subtheme: Yes, but…

One of the questions that this study sought to explore is what would need to be true for people to go to therapy, after having a poor customer experience. The participants in this study named four key aspects. These were first, where they are in themselves, not only from a need basis but also having the strength to deal with therapy; second, the skill and capability of the therapist in their view; third, the connection and reciprocated experience with the therapist and finally, the physical space. Before the interviews, it had been anticipated by the researcher that people who had a poor experience may be so affected by their encounters that they would be negative about therapy, as a general construct, or as a possibility for the future. That is, the assumption was there would be nothing that would prompt them to go to therapy again or it may take an extended period for the discomfort or memory to fade for them to be prepared to try again.

> I don't know what I would have done if … I'd had that second (unsatisfactory) experience first … I don't think I would have tried to a second time (Michelle)

This idea does seem to be supported by the very limited research available (Buchholz et al., 2017; Colman et al., 2014; Oliva et al., 2013). However, this was not the case for the participants. That may be due to a small sample, the views of people who would be willing to participate in research such as this being more supportive of therapy than the general population or it may be that one poor therapy experience does not seem to put people off. More research is needed here.

The participants in this study had a range of experiences from "gratefulness" (Ashley) through to "traumatic" (Joanne) and "disingenuous" (Nicole). Despite the range of experiences, they were all in agreement that they would recommend therapy to others. However, with some caveats – "you just have to find the person that's right for you" (Nicole) or "it has to be at the right time for that individual" (Joanne). In commercial organisations, NPS is used to understand customer loyalty and brand value. In this study, NPS was used to understand not the participants' loyalty to a particular therapist but as a means of exploring a type of loyalty to therapy generally. It was used to understand how they might influence others' views of mental health, therapy, and therapists. Future research might test whether, like these participants, people will go to therapy again and they will continue to recommend therapy to others, irrespective of a poor experience. This triumph of hope over experience seems to be due to a broader societal agreement that it is important to look after mental health (Duncan, 2010; Flett et al., 2020), that is, need driven rather than supplier led. In NPS terms, a customer's likelihood of recommending a service to others is correlated with growth (Reichheld, 2003) and all the participants said they would recommend therapy, most gave examples of how they have done so. Therefore, it suggests that there will be continuing growth of demand in the industry irrespective of the customer experience people are receiving.

Given the ongoing likelihood of growth in demand, it is possible for the issue of customer experience to be dismissed by the therapy industry. However, companies and industries who are accepting of poor customer experience tend to be those which are disrupted by

competitors keen to tap into a missed opportunity. For example, a service such as Better Help (www.betterhelp.com) enables customers to be 'matched' to a therapist, move easily between therapists, offers a more immediate communications capability and a different model for fees. People living in Aotearoa New Zealand are no longer limited to sourcing their therapy from their community or even their country. Similarly, the use of artificial intelligence is likely to significantly influence the mental health industry, as it is disrupting many other industries (Omarov et al., 2023). These examples are not to suggest that the services through these channels are better. Rather, simply they are examples of businesses who have identified opportunities to provide services in ways in which traditional therapy models do not. They will undoubtedly incorporate customer service and experience as key variables for their models. Therapists who are unaware of and unresponsive to the changing shape of the offering in their industry run the risk of not meeting customer expectations and therefore being, rightly or wrongly, viewed as lacking capability and credibility, having significant turnover which is effectively an increase in resource demand and ultimately having to compete on price. Worst of all, the customers' mental health issues may potentially not improve or regress due to an unsatisfactory therapy experience.

Contributions

It is important to note that because of the nature of this study and the homogeneity of the participants, the findings of this study cannot be generalised to a wider population. However, it may offer some ideas for actions to test impact on dropout rates. In particular, much of the extant research takes a clinical or therapist perspective, with limited research available which is focussed on the customer experience. The research findings in many areas are equivocal providing little clear direction. In line with broader commercial research on customer experience, new and fruitful insights may be revealed through future research which is more focussed on the voice of the customer.

This study makes several contributions for therapists who wish to improve the therapy experience of their customers and minimise the dropout rate. Considering the literature review and the results of the participant interviews, the decision to dropout does not appear to have a single key cause. It is the combination of a few key moments which

influence the customer experience and their decision to end therapy. The following lists actions that therapists may take at each of the customer experience stages:

i. Pre-experience
    a. Seek to understand each customer's mental health predispositions such as literacy, beliefs, assumptions, traits, help-seeking behaviours, and levels of stigma and how these play out in their preferences for therapy.
    b. Explore and challenge one's own predisposition through supervision and ongoing training in order to deliver the most impactful service possible.

ii. Pre-purchase
    a. Every interaction counts, even before the customer fully engages. Therapists might review, update, and invest in communication and booking channels and revisit messaging quality.
    b. Therapists should stay aware of changing therapy offering models in the broader global industry. In addition, therapists should test and implement innovations and adaptations in their practice, which might better match and anticipate changing customer expectations.
    c. EAP providers may want to consider the general understanding, by employees in the companies they contract to, of their service and whether they understand the customer expectations, are meeting those and how to communicate the offering more effectively.

iii. Purchase
    a. Keep in mind that it is the cumulative effect of multiple dimensions which impact on the customer's likelihood to engage and continue. For example, taking the five dimensions from Becker and Jaakkola (2020), quickly assessing the customer experience against each of these and calculating the overall customer experience on a regular basis may provide a useful prompt to conversations or actions which contribute to a more productive therapy experience and decrease the likelihood of dropout.
    b. Review the physical space for face-to-face meetings and how this might reinforce or undermine a customer's perception of the therapist, their ability to

connect and even affect their decision to dropout. It is important to not assume that what works for therapist will work in the customer's best interest.

c. Seek to understand what success would look like from an individual customer's perspective; that is, ask them, manage expectations, and adjust the therapy offering to meet those expectations as much as is feasible.
d. Refresh knowledge and revisit practice on connection, customer feedback and relationship recovery and ensure these are implemented with customers.
e. Be sensitive to the dynamic in the room and take responsibility for initiating the discussion about how the interactions are going from the customer perspective.
f. Proactively raise and manage the topic of termination with customers from the start of the therapy interactions.

iv. Post-purchase

a. It seems likely that the majority of dissatisfied customers will not complain directly. Initiating an exit interview or post-therapy survey process, using an independent provider means customers are more likely to be forthcoming in their views, and take action on the feedback. Many therapists may argue that this is cost-prohibitive. However, considered from another perspective, doing so mitigates for the very real cost of customer harm from an unsatisfactory experience in therapy.

Chapter Six: CONCLUSION

The customer experience of people who stop going to therapy is a complex one, made up of multiple stages and dimensions. It is also not always a negative outcome for the individual. Some customers will end 'early' having had a very satisfying experience and positive termination. However, some customers will also dropout unilaterally, not having had any discussion with the therapist. Even for these individuals, dropout is not necessarily a poor decision. In fact, it may be the optimal choice given an unsatisfactory situation. This study found variables across the stages and dimensions made a difference to the customer experience. At the pre-experience stage, stigma still exists and this influences both the customer and therapist predisposition, which then influences later stages. At the pre-purchase stage, the process of engaging in therapy and expectations are a part of the customer experience before the customer has even engaged with the therapist. The purchase stage is a memorable experience for customers who are hyper-aware of the details, jig-sawing these together to create a complete picture – satisfactory or unsatisfactory. Critical details were the physical settings, the customer's affective and sensorial dimensions, therapist in-session behaviours and the quality of the termination. Finally at the post-purchase stage, it was found that irrespective of their customer experience, people would go to therapy again in the future, although this did not match the findings in the limited literature available. In addition, participants in this study would recommend therapy to others, with some conditions. Given that it is a growing industry, having gone mainstream, this gives the industry the space to think strategically about what a great customer experience looks like. The study provides ideas for future research options and suggestions about areas that therapists may wish to adjust and test to understand the impact on customer experience in their practice.

The multitude of dropout definitions and the lack of clear findings in the research about the causes of dropout, gives little guidance to therapists about the practical actions they could take to mitigate for dropout. Furthermore, the focus of the dropout definitions on therapeutic outcomes misses the point that therapy exists to serve the customer, to support their mental wellbeing and that customers are able to determine if they have a satisfactory experience. With a shift in focus to one which is more customer led, based on the voice of

the customer for example, it may be that this would bring a fresh perspective and shed a different light on the causes of dropout from therapy.

Reflections

Qualitative research acknowledges the interpersonal nature of the work which is shaped by both the participants and the researcher (Camic, 2021). IPA research asks participants to reflect on their experiences and identify how these have influenced their memories, emotions, and actions. An IPA researcher who respects the value of such reflection will also undertake a similar process in the unique event of undertaking the research, both to acknowledge the generosity of the participants but also to demonstrate the awareness of the researcher's potential impact on the research. As such, the researcher's profile is presented for transparency as Pākehā, cis female, having worked for over twenty years in human resources in Aotearoa New Zealand, Australia, and UK companies. The researcher leans towards a critical realist approach to the research, as described in Smith (2010) 'what people believe to be real is significantly shaped not only by objective reality but also by their sociocultural contexts' (p. 122).

A part of IPA is 'bracketing' (Ahern, 1999) in which the researcher consciously seeks to bracket their own preconceived views through self-reflection. Alase (2017, p. 10) proposes that these researcher self-reflections should be a "step-by-step detailed and descriptive journey" outlining the process and learnings along the way. The researcher undertook this activity from the time of developing the research proposal through to completion of the thesis. This section summaries the key findings of those self-reflections.

In the planning stage, the researcher acknowledged that the motivation for the topic had come from her surprise that so many people were having an unsatisfactory therapy experience. As recommended in Smith and Nizza (2022), the researcher arranged for a friend to interview her using the semi-structured interview template that was also used for the participants, prior to commencing the data collection process. The purpose of this was for the researcher to identify her views and opinions on the research question, to be aware of these and attempt to bracket them during the data analysis process.

In the data collection stage, once participants were confirmed, the researcher became conscious that the participants were similar in gender and educational level and in discussion with them, came to understand that they were all knowledge workers, with similar career and family situations. This is to be expected somewhat given that participants were recruited through the researcher's networks on LinkedIn. This became particularly important in the analysis stage that the researcher was finding the sweet spot between allowing the participants' views to be presented as spoken and not assuming automatically that she knew what they were implicitly saying but also to undertake the double hermeneutic of interpreting their interpretations. The researcher did this by rereading the transcripts multiple times and challenging herself to find multiple sources to support her interpretations and paying particular attention to disconfirming statements by the participants. As is typical in IPA research, there was not a hypothesis developed prior to the commencement of the study. However, the researcher had assumed that people who had a poor experience of therapy would be less likely to attend therapy again and would be unlikely to recommend therapy to others. This was not at all found in the interviews, in fact, the opposite was the experience of the participants. Another unexpected outcome of the interviews was discovering that none of the participants had told the therapist of their dissatisfaction. This led to a review of and the section on customer complaining behaviour and an entirely new insight for the study.

In the writing stage, the researcher's assumptions that the health sector is often not motivated by the customer experience was reinforced by the quantity of literature which takes a therapist view, customer characteristic or therapeutic outcome perspective and the relative dearth of literature based on the customer perspective. The researcher acknowledges the value of the multiple perspectives, but it is acknowledged that her belief and experience that 'companies are better to ask customers what they want to buy and then build services based on that' underpins this study.

Limitations

Much of the research considered in the literature review on dropout is based on randomised controlled trials, which have scope controls in place that do not replicate a

more typical psychotherapy practice. This can limit the generalisability of the research to a real-world setting. Additionally, the extant research is limited in its diversity of subjects, possibly more women than men (Springer & Bedi, 2021), and largely focussed on customer characteristics with little research available on influenceable factors such as the therapist contribution to dropout, customer perceptions and beliefs (McMurran et al., 2010). A key limitation in the literature review of this study is the use of articles only available in English, which tends to a western-centric view, which is also the upbringing and experience of the researcher.

In terms of the current study, participants were self-selected, which subjects the sample to potential bias. Participants were not representative of the broader population and all interviews were undertaken in English. In addition, the group were homogeneous in terms of gender (identified as women) and education levels (post-secondary). Both demographic factors have been found to be more likely to engage with mental health professionals (Wellcome, 2021). Given the participants who had unsatisfactory customer experiences also had subsequent therapy, research with a group with more diverse characteristics may possibly result in different findings. In the selection and interview process, there was no differentiation in therapist; that is whether participants had met with a counsellor, psychotherapist, or psychiatrist. Hannah, who is a registered psychologist, expressed a view that counsellors and psychologists provide quite different services and limiting the research to a particular professional field may have resulted in different outcomes.

Qualitative research is sometimes challenged on its validity in ways in which quantitative research is not, because of the dominance over time of quantitative methods in research. There are actions, such as triangulation and seeking participant feedback, which could be taken in future qualitative research on this topic which may talk to the question of validity. Undertaking a form of triangulation might provide further insight and enrich the understanding of the customer experience through exploring and overlaying the different perspectives. Although conversely this does run the risk of down-weighting or even invalidating the view of the customers. Another option is to seek participant feedback, in which the researcher asks the participants to consider and comment on the analysis prior to completion (Silverman, 1993). This provides the means of both testing that the researcher

has understood the participants but also provides a different perspective for consideration, potentially mitigating for researcher biases. The decision was taken in this study that participants had already contributed enough of their time and energy, therefore it was not appropriate to ask for more.

Future research

Future research on the customer experience of people who stop going to therapy has value. At its most pragmatic, it would minimise resource wastage and acquisition costs due to customers cancelling at short notice or simply not turning up. Even more value can be found in research which provides insights into the various aspects of customer experience and how mental health provisions might be adjusted to meet that experience need and expectations. In relation to this study, future research might consider having a sample more representative of the population, a quantitative study might use a typical NPS to understand more about customer loyalty and recommendation behaviour and studying the impact of changes where therapists or practices do implement any of the suggested actions in the contributions section would be helpful.

More generally on the topic of dropout, shifting the current research focus from one which is focused on customer characteristics or therapeutic outcomes to one which seeks to better understand the customer experience would be helpful. It would provide the opportunity to take a different perspective on this topic, providing entirely new insights and more fruitful solutions to the causes and consequences of dropout.

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APPENDICES

Appendix A: Participant Information Sheet

School of Psychology
Te Kura Hinengaro Tangata

Exploring the Customer Experience of People who Stop Going to Therapy
Participant Information Sheet

Information for Participants
Thank you for showing an interest in this study. Please read everything below before deciding if you want to take part. Sara Broadhurst is doing the research for her Master's thesis and will be supervised by Dr Matthew Shepherd, Associate Professor and clinical psychologist in the School of Psychology.

Research Description
The aim of the research is to better understand the views of people who go and see a therapist (psychologist or counsellor) once or twice and then decide to stop going, using "customer experience" models.

Why is this research important?
This is intended to contribute to theories around why people stop going to therapy.
There is quite a lot of research available about the things that might cause someone to stop going to therapy before the programme is finished and many therapists use tools to measure progress during treatment. Sara hopes that this research will add value to the other research by taking a slightly different approach - which is seeing you as a customer who has made an active choice to no longer take or buy a service from the therapist.

Who can take part in this study?
Inclusion to participate in this study will be based on a number of factors:
Participants must have **chosen** to go to therapy with a psychologist or counsellor registered in Aotearoa New Zealand. If someone is *required* to see a therapist (such as by work or the courts), they will not be able to participate in this research;

1. Participants must have **chosen** to terminate therapy after one or two sessions;
2. Participants must be 18 years or older; and
3. Participants must have no personal relationship with the researcher.

How do I volunteer to participate in this study?
To volunteer to participate in this study, please email Sara on sara.at.massey@gmail.com to advise that you meet the criteria above and are interested in participating.
Sara will send you a link to an online consent form and demographic questionnaire. In total, it should take you approximately five minutes to complete those documents and email them back. Once completed, Sara will contact you to let you know about the next steps.

What will I be asked to do if I am selected for the study?
You will be asked to participate in an interview with Sara, which will take 60-90 minutes. This can be done online (via Zoom, Teams, or other online meeting channel) or face-to-face, based on your preference. You are welcome to bring whānau or other people with you to the interview. If the meeting is face-to-face, Sara will discuss a contribution by Massey University to your travel costs with you. The interview will be recorded, using

text transcripts if online or voice recording if face-to-face. You will receive a copy of the recording after the interview.
Sara will not be asking you about what led to you meet with a therapist, the focus of the interview will be on your customer experience. However, you might find these resources which support people with their mental health and wellbeing useful.

What happens with what I tell you?

Your privacy and confidentiality of your information is very important to us. Only the researcher will know your name or other identifying information such as the consent form details, phone number and email. This information will be held separately from the demographic information and interview records. All information will be password protected.
Your demographic data and views will be summarised into themes and will not be able to be used to identify you. Your specific agreement will be requested before any quotes from the interview are used in the report. Once the thesis has been examined and accepted all documentation will be given to the supervisor and held for at least six years before disposal, as per the Massey University Code of Responsible Research Conduct, section 6.10. You can find more information here. The findings of the thesis may be used in other research but only at the aggregated level.

Participants Rights

You are under no obligation to accept this invitation. If you decide to participate, you have the right to:

- decline to answer any particular question;
- withdraw from the study at any time before the 1st of September 2023;
- ask any questions about the study at any time during participation;
- provide information on the understanding that your name will not be used unless you give permission to the researcher;
- ask for the recorder (transcript or voice) to be turned off at any time during the interview. Only the section that is recorded will be used in the research; and
- be given access to a summary of the research findings when it is concluded.

Project Contacts

Please do not hesitate to contact the researcher and/or supervisor for any questions related to the research project.

Researcher

Sara Broadhurst
Email: [redacted]
Phone: [redacted]

Researcher Supervisor

Doctor Matthew Shepherd
Email: M.Shepherd1@massey.ac.nz
Phone: 09 213 6094

Compulsory Statements

This project has been reviewed and approved by the Massey University Human Ethics Ohu Matatika 2, Application OM2 23/34. If you have any concerns about the conduct of this research, please contact Associate Professor Fiona Te Momo, Chair, Massey University Human Ethics Ohu Matatika 2, email humanethics2@massey.ac.nz.
If you have any concerns about the conduct of this research that you wish to raise with someone other than the researcher(s), please contact Prof Craig Johnson, Director of Research Ethics:
Phone: 06 356 9099 x 85271
Email: humanethics@massey.ac.nz.

Thank you for your consideration of participation in this study.

Appendix B: Written Consent Form

MASSEY UNIVERSITY
TE KUNENGA KI PŪREHUROA
UNIVERSITY OF NEW ZEALAND

School of Psychology
Te Kura Hinengaro Tangata

Exploring the Customer Experience of People who Stop Going to Therapy
Participant Consent Form

Individual Participant Consent Form

I have read, or have had read to me in my first language, and I understand the Information Sheet **attached**.

I have had the details of the study explained to me, any questions I have had been answered to my satisfaction, and I understand that I may ask further questions at any time.

I have been given sufficient time to consider whether to participate in this study and I understand participation is voluntary and that I may withdraw from the study at any time until the 1st of September 2023.

I agree/do not agree to the interview being sound recorded if in person or transcript recorded if online. (Please delete as relevant).
I wish/do not wish to have my recordings returned to me. (Please delete as relevant).
I agree to participate in this study under the conditions set out in the Information Sheet.

Declaration by Participant

I _____
[print full name] hereby consent to take part in this study.

Signature: _____ Date: _____

Appendix C: Participant Demographic Data

MASSEY UNIVERSITY
TE KUNENGA KI PŪREHUROA
UNIVERSITY OF NEW ZEALAND

School of Psychology
Te Kura Hinengaro Tangata

Exploring the Customer Experience of People who Stop Going to Therapy
Participant Demographic Data

Please put an X below in the categories which best reflect you and save this form with your consent form. Please note you are not obliged to provide this demographic information in order to participate in the research.

AGE: What is your age?

18-34	35-49	50-64	65 years +	Prefer not to say

EDUCATION: What is the highest level of education you have received?

High School	Technical or trade	University	Prefer not to say

EMPLOYMENT: Which of the following best describes your current employment status?

Employed Full-Time (30+ hours per week)	Employed Part-Time (<30 hours per week)	Not employed, looking for work	Not employed, not looking for work	Unpaid family worker	Prefer not to say

ETHNICITY: How do you identify?

Asian	European	Māori	Middle Eastern, Latin American, African	Pacific Peoples	Other	Prefer not to say

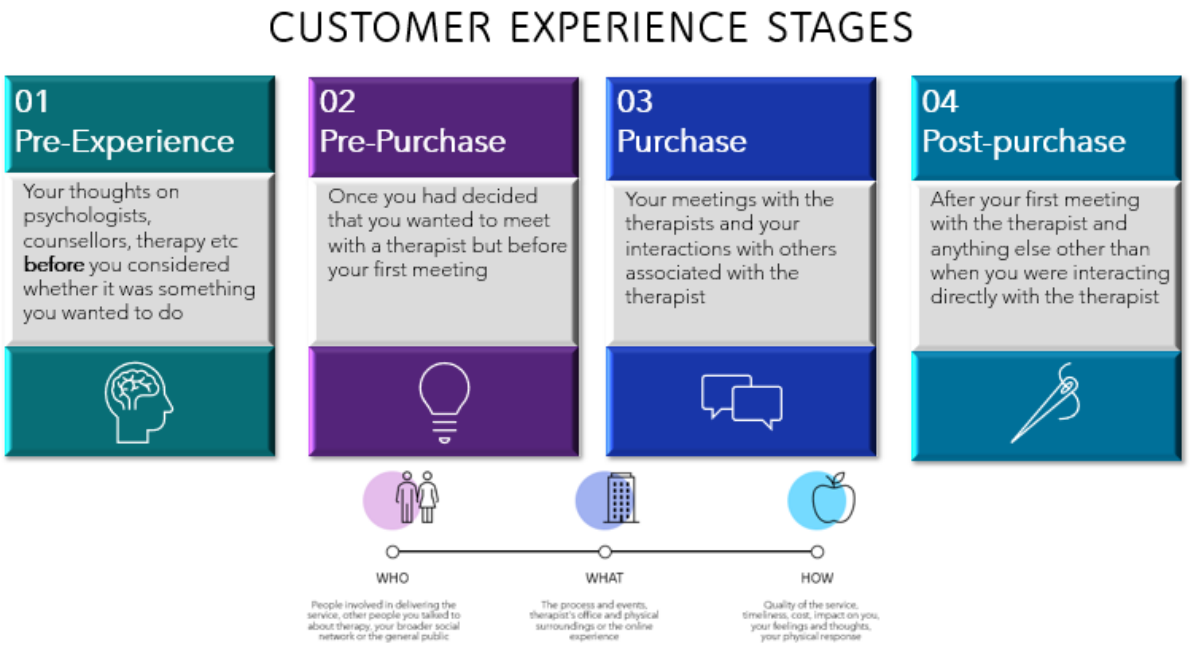
GENDER: How do you identify?

Female	Male	Another gender	Prefer not to say

RELATIONSHIP STATUS: Which of the following best describes your current relationship status?

Married/Civil union	Never married and never in a civil union	Separated/ Dissolved/ Widowed	Prefer not to say

Appendix D: Customer Experience Stages - Image shown to participants during interview



Appendix E: Interview Protocol

Detailed and specific examples

	Stage			
Dimensions	Pre-experience Your thoughts on psychologists, counsellors, therapy etc **before** you considered whether it was something you wanted to do	Pre-purchase Once you had decided that you wanted to meet with a therapist but before your first meeting	Purchase Your meetings with the therapist and your interactions with others **KNOX**	Post-purchase After your first meeting and anything else other than when you were interacting directly with the therapist – when you've thought about it, talked to others about it
PROMPT QUESTION	Before you had decided to go to a therapist, what were your thoughts about mental wellbeing, or therapy or therapists in general?	Once you had decided you wanted to see a therapist, what were the steps you took?	Can you tell me about your experience of meeting with the therapist? (see Knox questions)	When you reflect back on your experience of seeing this therapist, how would you describe it?
		Follow-up		
Cognitive	What did you think?	What did you think of the process of finding someone and booking?	What were you thinking during the experience? As expected, rational, unexpected, illogical?	When you reflect back on your experience, what do you think?
Affective	How did you feel about that?	How did you feel about that? What words come to mind?	How did you feel about that?	How did you feel about that? What words come to mind?
Physical	What sort of environment did you think that would be in?	Was it online or face to face?	What was the environment like? (Online – personal space?)	When you think back on the physical environment, how did that affect your experience?
Sensorial	What was the taste, sound, smell, feeling or look of it? What was your physical response to that?	What was the taste, sound, smell, feeling or look of it?	What was the taste, sound, smell, feeling or look of it? What was your physical response to that?	What was the taste, sound, smell, feeling or look of it that made that good for you? Could have made it better for you?
Social	What did you hear from other people about mental health?	Who else was involved?	How did you engage with them? How did they engage with you?	Who else did you talk to about your experience of going to therapy?

- Tell me about what happened?
- What did you think about that?
- What would you have liked to have happened?
- What was really good about that?
- What would be a better way of doing that?
- When you think back on it, what worked really well?
- What really didn't work so well?
- What caused that?
- Who else was involved? What difference did that make?
- What did that look like?
- What were you expecting?
- What was different from your expectations?
- When did that happen?
- Do you think it made a difference for you?
- What did you want to achieve?
- Can you give me an example?
- How did that impact you?
- What did you do to try and fix it?
- What were some alternatives?
- How did you feel about that?
- What is the impact of that on you?
- Who else did you talk to about it?
- What was your physical response to that?
- Instead of "why" (can feel confrontational), ask "tell me more about that experience of…"
- Could you give me an example of that?
- Could you say more about that?
- Are there other times that you have felt similar to/different from that?

Knox et al., (2011):

1. Please tell me about your relationship with your therapist.
2. Please tell me about your goals for this therapy, and your sense of the progress you made toward these goals.
3. Now I'd like to talk about your termination with this therapist.
    a. How did the termination occur (when, why, who initiated, how, how far in advance knew it coming, planned/unplanned, etc.)?
    b. What were your reactions to the termination (thoughts, feelings, behaviors)?
    c. How did the termination affect you? Your therapy? Your relationship with your therapist?
    d. How, if at all, did you talk about the termination itself with your therapist, including from when it was first raised through the actual termination session?
    e. How, if at all, do you wish the termination had gone differently?
    f. How did this termination experience affect your feelings about pursuing therapy in the future?

(Looking for cognitive, affective, physical, sensorial, social responses) (Becker & Jaakkola, 2020).