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# A Review That Psychotherapy Outcomes Aren't Always Positive

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**Abstract**

The results of psychotherapy are not always seen as beneficial. 40-60% of patients do not meet the criteria for recovery (Fisher and Durham, 1999; Gyani et al., 2013; HSCIS, 2018) and 5% to 8.2% of patients have a negative outcome, ie, their mental state is unfavorable Health is worse at the end of treatment than at the beginning of treatment (Barkham et al., 2001; Hansen et al., 2002). Estimates are subject to variance due to differences in measurement and population. However, there is an important distinction to be made between an ineffective treatment and a dangerous treatment. Clinical deterioration can result from a wide variety of causes unrelated to treatment, and failure to receive help from treatment does not necessarily mean it is harmful. It is common for therapy to have unintended consequences, and although these effects do not last long, some therapists believe that going through difficult emotions is necessary for effective treatment (Schermuly-Haupt et al., 2018). On the Negative Effects Questionnaire, Rozental et al. (2019) discovered that 50.9% of 564 patients who took part in low-intensity CBT reported some degree of poor experience while receiving treatment (NEQ). On the other hand, in a study of 14,587 British patients receiving psychotherapy through the National Health Service, five percent of reported "persistent negative consequences" of the treatment (Crawford et al., 2016). Although this is a low percentage, it is a considerable number of patients who claim that the treatment is

harming them, at least in some respects. Empirical research on patient safety that looks directly at the factors that cause harm and how to avoid it is not yet well established, although the more general issue of adverse outcomes has been studied at length.

**Keywords:** *Clinical Psychology, Psychotherapy, Results of Psychotherapy, Negative Results of Psychotherapy, Cause-Effect Relationship in Clinical Psychology*

## 1. Introduction

Research in this direction is difficult because the damage that would be defined as long-term adverse outcomes produced directly by treatment is extremely rare and cannot be manipulated experimentally. Randomized controlled trials in psychotherapy can check adverse events occurring during treatment and have the potential to usefully report impairment rates as well as overall weighted mean differences (Parry et al., 2016). However, none of these methods can directly investigate the causes of the damage. Another approach is to use qualitative data, where patients report their experience in terms of treatment-related adverse processes and outcomes. In support of this, an article (Rozental et al. 2018) written by a group of selected psychotherapy researchers working in this industry noted that despite increasing knowledge of the negative consequences of psychotherapy, there is still a great deal of psychotherapy.

## 2. Unresolved Concerns

qualitative methodologies have been suggested by most experts as a solution to this problem. Although individual qualitative studies are sometimes quite small and unique, enough qualitative research has been published to allow for a narrative synthesis of their findings. In addition, there are several patient testimony resources available online as well as in the gray literature . Current methods for meta-analysis and thematic synthesis of qualitative data supply a comprehensive description of a phenomenon, as well as an assessment of the impact of study technique on outcomes (Thomas & Harden, 2008; Timulak, 2009). However, they may not by themselves



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supply a testable process model of processes in which patient experience is linked to negative long-term outcomes.

To address this issue directly, we have adopted the task analysis approach used in psychotherapy research (Rice and Greenberg, 1984) to construct and further develop such a model. Rice and Greenberg (1984) came up with the idea of using task analysis in psychotherapy research as an intensive observational approach to conduct psychotherapy process research. This method is context sensitive and focused on detecting and documenting major change events. An interactive sequence between a patient and a therapist was used to characterize an event. This series had a starting point, a working process, and a conclusion point. In many cases, the individual receiving psychotherapy was seen as an active participant working towards the goal of solving the current problem. Because finding major change events requires both theoretical insight and practical ability, this task should be left to the clinician-scientists rather than being performed by naive audiences. The first stage of the process is called the discovery stage, and the second stage is called the verification stage. After making the researchers' cognitive map as clear as possible and describing the task environment and the broader context of intervention, a rational model of the process being studied is created in the exploration phase.

This is done after the exploration phase is complete. A rational model is a hypothetical possible task performance that brings together researchers' understanding of how the process develops and presents it in a logical format. The next step is empirical task analysis based on a detailed observation of the actual psychotherapy process. This is followed by a kind of qualitative content analysis that describes a series of events that develop over time. Once the first empirical model is outlined, it is compared to the rational model and used to confirm, change, or even invalidate the rational model. This process is repeated until the first empirical model is outlined. Subsequently, the revised model is subjected to an iterative empirical -rational comparison process with a new sample. This continues until there are no further explorations to be made (model saturation).

final rational -empirical model is completed, the exploration phase is completed. In the validation phase, a survey is conducted to decide to what extent the rational-experimental model accurately describes the task solution. Ideally, as a last step, but less often, the process should also be

evaluated to decide how accurately it predicts the outcome of the treatment. In this research, we deviate from the main purpose of task analysis by focusing on the analysis of the text rather than the literal therapeutic process. However, it is necessary to preserve the logic underlying the discovery phase of analytical technique.

## 3. Ineffective or Harmful Treatment

The course of ineffective or harmful treatment is the subject of this research; events occurring in the patient's life are the primary focus of research; however, therapist factors are also considered because of how important they are to the work environment . Researchers' cognitive mapping and identification of inadequate treatment both contribute to the establishment of the rational model, followed by empirical observation of the process described in (a) qualitative research and (b) patient testimony. Then, after using rational- empirical comparisons to develop two independent models by iterative selection of the best cases , we compare these models with each other and, as a last step, with the joint rational-empirical model. Finally, we make a systematic comparison of the newly developed model with the results of an independent qualitative study to partially confirm our findings.

Based on a systematic narrative synthesis of evidence on negative experiences and effects of psychotherapy from (a) qualitative research findings and (b) patients' testimonies, the aims of this study are to derive a model of process factors that potentially lead to negative or harmful effects. therapy from the patient's point of view . This model will be derived using task analytical methods.

## 4. Rational Model

The Rational model consists of eight Domains, all marked with a strong font and linked to a negative outcome. The first chapter, titled "Contextual factors", has a total of six different topics related to the therapeutic setting (Referral and access to service, Organizational factors, Socio-economic factors, Political factors, Lack of information, and Effects of drugs). The model then considers a second Domain, called "Pre-therapy variables", "Poor pre-treatment contract", "Past

treatment experiences", "Customers' empowerment attitude", "Service focuses on symptoms rather than treatment".

, the qualities that clients and therapists add to the therapeutic relationship were also considered. These included client aspects such as personality (Demography, Lack of Understanding, Fear, Helplessness, and Last Chance Feeling) as well as clinician elements such as trust, financial interest, attitudes, and the therapist 's personality. These domains had an impact on Relationship processes (Negative relationship patterns, Negative countertransference, Poor harmony between the client and the therapist , Power, So-called alliance and ignoring client preferences), Therapist behaviors (Therapist mistakes, Therapist's persecutory style, Misapplication, Inappropriate).

These procedures and actions had an impact on how treatment was ultimately terminated (Unprepared, Breaking the Terminal alliance, Short-term therapies creating a "wormbox", Client left high and dry and No Maintenance dose) A link between each of these Domains and n has.

of psychological therapies has been to decide whether they can reduce or cutting emotional pain (Boisvert, 2010). Meanwhile, there is a significant gap in our understanding of the nature and frequency of potential adverse effects, which is a direct result of deficiencies in clinical studies (Nutt & Sharpe, 2008). Investigations of adverse effects focused almost exclusively on so-called alternative or extreme psychotherapies, such as rebirth and reclaimed memory techniques, while less attention was paid to adverse effects that could be associated with evidence-based care. For example, techniques of rebirth and recovered memory are thought-provoking (Barlow, 2010). However, recent research shows that a considerable number of patients continue to suffer from impairment and adverse events despite receiving validated and properly administered psychological treatments (Berk & Parker, 2009). According to Foulkes (2010), any intervention that has the potential to reduce mental illness carries the risk of negative consequences. This risk is inherent in the intervention. Similarly, Castonguay, Boswell, Constantino, Goldfried, and Hill (2010) suggest that clinicians should accept the possibility of unintentional adverse effects in one or more patients during psychological treatment, and that clinicians as well as researchers should be aware of conditions that may have a negative impact on the therapeutic process and treatment outcome. should be more conscious of how to check and manage it.

In addition, the question of whether psychological therapies can lead to undesirable results and how serious these consequences can have been the subject of much debate, and they argue that they should be more conscious about how to check and manage situations that may occur (Boisvert, 2010; Rozental et al ., 2014 ). ). It is widely believed that the Cambridge-Somerville crime prevention study (Powers & Witmer, 1951) supplies the first empirical evidence of adverse effects . However, the question of whether psychological treatments can produce adverse effects did not become known until Bergin (1966), who reviewed a series of outcome studies.

Bergin (1996) suggested that in addition to patients who receive help from psychological treatments, there are also patients who do not benefit at all from these treatments, and that only a small proportion of patients deteriorate because of these treatments. He called this phenomenon the distortion effect. Several recent outcome studies have supplied evidence that between 5 and 10 percent of all patients receiving psychological treatment experience worsening in their condition , although this finding has been criticized by May (1971) and Rachman (1973) . difficulty Hannan et al., 2005; Hatfield, McCullough, Frantz, & Krieger, 2010; Heins et al., 2010; Lambert et al., 2002).

However, it is also possible that deterioration is not the only negative effect that may occur (Boisvert & Faust, 2002). Strupp and Hadley (1976) conducted a study to decide how several influential clinicians and researchers perceived negative effects. They then presented a tripartite model in which adverse effects should be evaluated from the perspective of the patient, clinician, and community. This model suggests that mental distress and personal well-being are largely dependent on the eye of the beholder (Strupp, Hadley, & Gomes-Schwartz, 1977). Rather than using the term disruption effect as a definition, Strupp and Hadley (1976) proposed the concept of adverse effects. They hypothesized that this concept encompasses more than just deterioration and includes such things as new symptoms , misuse of psychological treatments, and the assumption of unrealistic tasks and goals.

## 5. Negative Result

Using the phrase "adverse outcome", Mays and Franks (1980) offered a remarkably similar idea: a significant decline in one or more areas of the patient's functioning between the start of psychotherapy and the end of treatment (and between treatment termination). For controls, for an equivalent period), it is considered to have a Negative Result if it persists for a significant period after treatment has been dropped. This contrasts with a Positive Outcome, which means an improvement in functionality after therapy is ended. Because the term "Adverse Outcome" is not limited to adverse changes caused by therapy , use of the term does not imply that the therapist manages the undesirable change. Thus, poor outcome included not only impairment but also various negative outcomes, although researchers did not assume that these adverse effects were necessarily due to psychological therapies in themselves (Mays & Franks, 1985). For example, it is possible that some patients will experience adverse effects because of events that occur in their normal lives, and that some patients may get worse if they did not receive any help. Both scenarios are plausible (Mays & Franks, 1980). It is difficult to distinguish which aspects of an ongoing psychiatric illness are the result of psychological therapies and which aspects are a natural part of the person's experience of mental suffering due to the natural difficulties that go with mental pain (Richman & Wilson, 1980). In addition, unresponsiveness, withdrawal, interpersonal difficulties, addiction, and social stigma have been defined as negative effects that may prevent or prevent the patient from receiving help from psychological treatments (Crown, 1983; Foa & Emmelkamp, 1983; Dimidjian & Hollon, 2010). It is therefore difficult to decide exactly what constitutes adverse effects; however, some recommendations have recently been made on how to check and report adverse effects (Peterson, Roache, Raj, & Young-McCaughan, 2013). Linden (2013) presented a comprehensive checklist that categorizes adverse effects into several distinct categories, such as events and reactions unrelated to the treatments used, unresponsiveness, and worsening of the disease.

In addition, Parker, Fletcher, Berk, and Paterson (2013) designed a questionnaire to investigate the presence of side effects in patients receiving psychological treatment. Dimidjian and Hollon (2010) suggested that clinicians and researchers should apply both quantitative and qualitative methods to study the occurrence and characteristics of adverse effects. Nestoriuc and Rief (2012) also proposed an inventory to assess adverse changes in various habitats . Additionally, Nestoriuc and

Rief (2012) proposed an inventory to assess adverse changes in various habitats . Therefore, it is reasonable to predict that the study of adverse outcomes in clinical trials will become more common and may help prevent patients from experiencing worsening and adverse events despite receiving evidence-based treatment (Barlow, 2010). Despite the current attention given by researchers to the negative effects of psychological therapies , it is possible that practitioners are not aware of or have not accelerated the debate about how to check and report the negative effects of psychological treatments (Castonguay et al., 2010). Little research has been done on how physicians feel and perceive adverse effects in their clinical practice; however, there are some indications that doctors may not realize that some patients are in poor condition and are experiencing adverse events (Boisvert & Faust, 2003). In a study by Strupp and Hadley (1976), they surveyed a total of 150 researchers and clinicians on adverse effects. It is an important problem in psychological treatments.

## 6. Therapist Effect

The therapist effect was determined to be the part of the total unexplained variation in clinical outcome attributable to the therapist level (partition coefficient of variance [VPC]). The MCMC estimation was used to calculate the confidence intervals for 95% . Most studies, including multilevel models, are based on statistical assumptions. One of these assumptions is that the residues are homoscedastic and normally distributed. To meet these assumptions, it was necessary to model the level 1 outcome variance as a function of non-risk severity. Two different approaches were used to decide the significance of each control variable, interaction and random effect. To begin, the reduction in the 2*log likelihood score, which indicates how well the model fits the data, must be greater than the matching chi-square critical value. Second, the Z-score of the coefficient had to be higher than the critical number (1.96) to have 95% confidence in the results.

The order of evaluating the models is below.

First, a blank model was used to examine the effects of random intersections. Second, each of the control variables was evaluated. Where the control variables were significant when linear

coefficients were included, polynomial terms were also examined to see if they significantly improved the overall fit of the model. Third, it was necessary to look at each significant control variable through the lens of a random slope test. The fourth test looked at possible interactions between important control variables.

## 7. Patients' Post-therapy Severity Score

The patients ' post- therapy severity score, pre-therapy risk-free scores, pre-therapy risk scores, age, number of sessions attended, and percentage of sessions attended were continuous variables. There were variables classified as patient's job status (working, other role, and non-working), frequency of treatment (more than weekly, weekly, less than weekly, and frequency not defined), and clinical categorical. Prior to the main analysis, employment status categories were derived from a wider range of first categories using Wald tests and examination of coefficients. These categories of employment status are not working (includes getting benefits, being unemployed, and retiring), other role (includes part-time student, full-time student, domestic worker, and others) and working (part-time employment and full-time employment) ).

In the context of expert model analysis, Wald tests were used to make comparisons between categories and combine those whose coefficients were not significantly different from each other. Data analysis was done with IBM SPSS Statistics and MLwiN. (Rasbash, Charlton, Browne, Healy, & Cameron, 2016).

The clinical situation from which the data is drawn is the third and final element and is related to the second factor. The therapists' effects are estimated using the mean values of the case mix factors included in the study as well as the typical patient from the sample. Consequently, it is possible to expect that the influence of therapists may vary between several types of therapeutic settings that are diverse patient demographics. It has been discovered that the effects of therapists vary depending on the severity of the patient in each setting (Saxon & Barkham 2012), and the same phenomenon is likely to occur in therapeutic settings. Therapist effects since Baldwin and Imel (2013) 7 studies serving patients from different social situations presenting with different

clusters of psychiatric disorders. Review questions considering the factors mentioned above, the present narrative and empirical work brings Baldwin and Imel's review up to date and makes some necessary corrections (2013).

It offers both a practical and pragmatic framework for considering the effects of the therapist by clinical circumstances; this may be varying degrees of patient severity and the various conditions presented by patients. This framework is consistent with the original observation of the differential effect of patient severity by Ricks (1974) and observations reported by Barkham et al. (2017) note that patient severity can be an important determinant to the extent to which therapist effects are present. ("A systematic review of therapist effects: A critical narrative update ...") Ricks was the first investigator to see the differential effect of patient severity. So, the primary purpose of the review is to describe the individual and joint size of ICCs previously showed in publications or online from clinical trials and practice-based research over the time from 2012 to 2016. And considering Baldwin and Izmel's (2013) call for larger studies as well as studies specifically designed to explore the effects of therapists , we report the extent to which these two recommendations have been met so far. Method Determination of Existence of Studies A comprehensive search of the published literature was conducted by searching the titles and abstracts of three online databases (PsycINFO, PubMed, and Web of Science) and limiting the dates to five years , January 2012 to December 2016. This included the first publications on the internet that were published during this time and then printed and distributed in 2017. The start date was chosen for continuity from Baldwin and Imel's (2013) review and repeated the search terms: "Therapist effects" or " therapist outcome" or "therapists differential effects" or (therapist and "intraclass correlation") or (therapist) and "multilevel" or "hierarchical linear modeling" or "mixed models") or "effective therapist" or "ineffective therapist" or "therapist variance". ("A systematic review of therapist effects: A critical narrative update ...")

## 8. Systematic Reviews

method as Baldwin and Imel . The reference lists of the obtained studies were further searched to find other studies that may have been overlooked because of the restriction of search keywords as



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described above. Procedures based on preferred reporting items were applied for systematic reviews (PRISMA). Following initial discovery of the study (n = 2132), duplicates were eliminated, and 1566 studies were evaluated for meeting inclusion criteria . After obtaining and analyzing the full texts of the 47 studies that emerged, further exclusions were made, resulting in a reduction in the number of studies to 21. Twenty studies were selected for inclusion in the review, one of which was a meta-analysis. had previously been ignored. Review the selection criteria . The effects of therapy have been studied since the work of Baldwin and Imel (2013) .

Eight studies were accepted for inclusion if they met the following criteria :

a) *They were published in a peer-reviewed journal.*
b) *therapist effects in a clinical population.*
c) *They were released in hard copy or early online between January 2012 and December 2016.*
d) *Study samples were adults.*
e) *Written in English ; and*
f) *were experimental studies that examined quantitative treatment outcomes and focused on therapist effects as the main aim of the study.*

suggestion that therapist effects studies should be structured primarily as studies of therapist effects rather than having therapist effects as a secondary goal formed the basis of this last criterion (Baldwin & Imel 2013). Consistent with the recommendations made by Wampold (2005) for therapist effects, the exclusion criteria were the opposite of the inclusion criteria or placed a heavy emphasis on process factors (such as coexistence or commitment) or patient dropout rates. Evaluation of quality the quality of each study was assessed using a customized version of the checklist used by Downs and Black (1998) . Statistical (Adelson & Owen 2012), power (Schiefele et al. 2017), and reporting recommendations (Baldwin & Imel 2013) were used for therapist impact studies as inspirations for changes . To be more specific , the power question was changed to include sampling recommendations for patients as well as therapists. Often, therapists' sample size is considered the single most crucial factor in the reliability of therapist effects (e.g., Adelson & Owen 2012). According to Maas and Hox (2005), an unbiased impact assessment requires the

participation of at least 100 therapists ; however, results obtained from a sample of only 50 therapists will be considered sufficient. Schiefele et al. (2017) suggested collecting data from a sample of 1200 patients, which could be performed with a variety of different therapist and patient pairings. The number of therapists available and the primary purpose of the research may be primary factors influencing the required ratio of patients per therapist. As a result, there is no single unanimous value for the number of therapists or patients.

In addition, these patients no longer require active treatment (Fava, Rafanelli, & Tomba, 2012). Over -reliance on symptoms , which is part of the diagnostic criteria for mental disorders (such as major depressive disorder and generalized anxiety disorder) , does not reflect a wide range of variables that influence clinical manifestations. These variables are low mood and restless mood (Fava, Cosci, & Sonino, 2017), psychological well-being (Fava & Bech, 2016 (Tyrer, Tyrer, & Guo, 2016). Probability of Getting a Response from Richardson & Doster (2014), stressed that an evidence-based decision-making process should include:

1. *Major risk of poor outcomes from an index disorder Not receiving treatment, which is important for deciding whether treatment is beneficial.*
2. *Responsiveness to treatment choice (important to confirm whether remission has been achieved),*
3. *Vulnerability to the adverse effects of treatment, which is important to confirm whether the treatment is supplying benefits.*

In the field of psychopharmacology, Richardson and Doster (2014) highlighted the likelihood of a patient responding favorably to a particular drug treatment and predetermined clinical features. The dictation of response is extremely important; however, in recent years, overemphasis has been placed on the treatment of the typical patient , leading to decreased interest in these aspects of the field (Bech, 2016; Fava, 2017; Richardson & Doster, 2014). While it is essential for therapeutic purposes to have the most comprehensive picture possible of a drug's effects, the degree of response a patient exhibits can be assessed based on several factors (Bech, 2016).

In addition, it is now widespread practice in clinical trials to measure the number of participants who achieved response or remission after a pharmacological and/or psychotherapeutic trial,

compared to certain cut-off points of rating scales. This is done to compare the results of the trial with the expectations set before the trial started (Guidi et al., 2018). Remission can be expressed as a categorical variable (such as "present" or "absent") or as a comparative category (such as "not improved", "slightly improved", "moderately improved" or "largely improved").

Remission can be expressed as an existing or absent variable (Bech, 1990). The use of this research technique has its drawbacks and makes it more difficult to translate the study's findings into reality. For example, an improvement compared to certain cut-off points of the rating scales may not reflect a true clinical improvement of the patient as perceived by the patient or saw by the clinician. This is because rating scales use diverse types of data to decide when a point has been reached. Similarly, although adequate criteria are not available for all mental health conditions and clinicians and researchers in clinical psychiatry often confuse treatment response for complete recovery, many studies deal with relapse and relapse as primary outcome measures. This is because many clinicians and researchers in clinical psychiatry believe that relapse and relapse are the same thing (Bech, 1990; Fava, 1996).

A treatment that is on average helpful in the average patient may be ineffective (i.e., no different from placebo) in some patients or even harmful (i.e., worse than placebo) in another in credible subgroup differentiation clinical trials. For example, an antidepressant may help on average in the average patient (Horwitz, Hayes-Conroy, & Singer, 2017; Horwitz, Singer, Makuch, & Viscoli, 1996). In this context, clinometric can supply a correct method of measuring how well a patient is responding to a treatment. This method is based on staging an assessment of the longitudinal development of mental disorders as well as their longitudinal return (Cosci & Fava, 2013). Compared to conventional diagnostic practice , staging differs in that it not only decides how far a disorder has progressed at a given time, but also decides where a person is currently along the path that a person is constantly on.

symptoms and signs and residual symptoms that differ from the acute clinical phase , are defined by the staging process (eg, persistent symptoms and signs despite significant remission or improvement). To be more specific , Stage 1 is the prodromal phase, which refers to the time that occurs between the onset of prodromal symptoms and the onset of the characteristic signs of a

fully developed disease. Stage 1 occurs before the onset of symptoms that are characteristic of a full-blown disease (Cosci and Fava, 2013). After the acute phase (Stage 2) it may be difficult to decide whether there is partial or complete remission, and attenuated symptoms called residual symptoms may be seen. These symptoms are caused by partial persistence of the disorder or exacerbation of a pre-existing abnormal personality trait. Mental illness has been prevalent in this stage (stage 4) for a long time. (Cosci & Fava, 2013). It suggests a link between prodromal symptoms and residual symptoms. Detre and Jarecki (1971) presented a hypothesis that they called the flashback phenomenon . This model states that the disease gradually recapitulates as it heals, but in the reverse order.

There is a possibility that some prodromal symptoms may be obscured by acute manifestations of the condition; however, these prodromal symptoms will continue to exist as residual symptoms and will eventually develop into recurrent prodromes. Indeed, the prodromal symptoms of a relapse tend to mirror those of the first episode (Cosci and Fava, 2013). According to the reversal model, there is also a temporal relationship between the development time of a disorder and the duration of the recovery phase. This relationship is since disorders tend to develop over a period. This has been proved in many ways in hospitals and clinics. For example, persistence of residual symptoms after administering an antidepressant therapy to treat a major depressive episode is a risk of relapse that should be considered by clinicians and considered as a partial response to administered antidepressant therapy. This should be considered as a partial response to the antidepressant treatment administered by clinicians (Tomba and Fava, 2012). Evaluation of Adverse Effects Evidence-based medicine places primary emphasis on the possible advantages that treatment may bring in relation to the underlying risk; however, it tends to overlook security vulnerabilities as well as responsiveness (Fava, 2017; Richardson & Doster, 2014). A reasonable therapeutic approach considers the potential advantages as well as the negative consequences that the treatment may have on the patient (Fava, 2017; Vandenbroucke & Psaty, 2008). Information from several sources can be difficult to integrate , making such a balance more difficult to achieve.

## 9. Conclusion

Psychiatric drugs have certain side effects that are only temporary and may disappear within a few weeks of starting treatment, but there is also the possibility that some potentially significant side effects will persist or appear later. Side effects of antidepressants include gastrointestinal symptoms (such as nausea, diarrhea, gastric bleeding and indigestion), hepatotoxicity, weight gain and metabolic abnormalities, cardiovascular disorders (such as heart rate, QT interval prolongation, hypertension, orthostatic hypotension), genitourinary symptoms. (Such as urinary retention and incontinence), sexual dysfunction, hyponatremia, osteoporosis and fracture risk, bleeding and central nervous system disorder (Carvalho, Sharma, Brunoni, Vieta, & Fava, 2016). After a first period characterized by decreased appetite, prolonged use of antidepressants such as Serotonin Selective Reuptake Inhibitors (SSRIs) may cause weight gain, and the increased weight does not necessarily regress upon discontinuation of the drug. The reason for this is that the increase in appetite that occurs in the first period of decreased appetite is temporary (Carvalho et al ., 2016). It has been suggested that the widespread use of antidepressants, which may occur through various channels, may be a crucial factor in the epidemic of overweight and obese people (Lee, Paz-Filho, Mastronardi, Licinio, & Wong, 2016). Similarly, the incidence of sexual side effects may be as high as 50-70% in patients using SSRIs, and these symptoms may persist even after discontinuation (Carvalho et al. 2016). This phenomenon is referred to as post-SSRI sexual dysfunction (Bala, Nguyen, & Hellstrom, 2018). The idea that individuals can improve over time, even without therapy , is one of the things that can cast doubt on the validity of outcome research studies. People seek counseling or join self-help groups because they are dissatisfied with how they are currently behaving or because they want to change such behavior. People often have the feeling that they improve after taking part in a program for a long time. However, it is conceivable that they will get better regardless of whether they take part in the program or not, and the program does not really are effective in their lives. To provide evidence that treatment has been successful, it is necessary to compare people who take part in therapy with another group of individuals who do not receive treatment. The treatment is also likely to be effective, but the type of therapy used is often irrelevant to its success. On the other hand, half of the patients were randomly given the anti-anxiety drug Paxil, while the other half were given a placebo pill that was ineffective and did not have any therapeutic agents. Because the researchers discovered that both groups improved



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over the course of eight weeks, they were only able to dispel the notion that placebo effects occurred. Instead, they decided that the group that took Paxil improved much more than the placebo group. These considerations will shed light on future research.

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