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What Can Qualitative Research Tell Us about Service User Perspectives of CBT for Psychosis? A Synthesis of Current Evidence

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Background: Although recommended in national treatment guidelines, there is much that is still unknown about CBT for psychosis (CBTp) in terms of the process and experience of the therapy. One way to investigate these gaps in knowledge is to explore service users' experiences through qualitative research. **Aims:** To consolidate existing qualitative explorations of CBTp from a service user perspective. **Method:** Qualitative synthesis and comparison with previous research findings. **Results:** Two analytical themes were created from initial descriptive themes common to multiple studies: "The ingredients in the process of therapy" and "What is the process of therapy?" **Conclusions:** Qualitative synthesis is a useful method for generating new insights from multiple qualitative studies. Service user perspectives on CBTp corroborate existing research and may also offer more novel findings regarding the ingredients and process of therapy. However, qualitative studies are limited in number and do not always maximize the prominence of service user experience.

Keywords: CBT, qualitative methods, psychosis, service users, therapy, synthesis, third wave, systematic reviews, psychological therapies.

Introduction

Despite the endorsement of Cognitive Behaviour Therapy for psychosis (CBTp) within NICE guidance, there are still gaps in our understanding of this therapy (Dudley, Brabban and Turkington, 2009). Exploring these gaps is complicated by the variance within the therapy, including models, techniques, and settings, but researchers, for example, Morrison and Barratt (2010), are beginning to clarify the components of CBTp. Despite its emphasis on collaboration, the service user voice remains quiet within explorations of the experience of CBTp. However, qualitative research into service user experiences has been acknowledged as an important addition to the evidence base for CBTp (Thornicroft, Rose, Huxley, Dale and

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Wykes, 2002), because of peoples' expert knowledge about what works for them individually. In addition, qualitative research can be seen to be responsive to the needs of prospective recipients of CBTp, e.g. people who are offered CBTp may be more interested in the experience of therapy recipients than results from quantitative trials.

A relatively new approach within review methodology is the synthesis of findings from multiple qualitative studies. Qualitative synthesis refers to the "bringing together" of findings on one topic or area of interest in order to identify and compare the main concepts, but with the purpose of re-interpreting findings and generating new insights (Dixon-Woods et al., 2006).

Method

In order to generate a comprehensive sample of papers for analysis, a systematic search was conducted in August 2009 and repeated in December 2009. Thematic analysis was chosen as the method for synthesizing the findings in the current paper due to its prior use in evaluating what qualitative research can tell us about a particular topic (Noyes and Popay, 2007). The data analyzed consisted of all text presented in the results section of each study as the current paper is concerned only with the qualitative findings themselves (i.e. the service user perspective) as opposed to context or author interpretations. Braun and Clarke's (2006) six steps guided the thematic analysis and led to the creation of two analytical themes.

Findings

Eight studies were included in the final analysis. Details of the included papers are presented in Table 1. Two analytical themes were identified during the analysis: (i) the ingredients in the process of therapy; and (ii) what is the process of therapy?

The ingredients in the process of therapy

Despite the varied models within the included studies, many common ingredients of therapy were reported. The first ingredient of therapy appeared to be an increased understanding of the onset of psychosis (theme identified in 5/8 studies). Several participants described learning about the stress-diathesis model of psychosis, and the influence of social exclusion and low mood: "starting with my er my behaviour in the past, my feelings, how outside events that could have caused me stress" (Messari and Hallam, 2003, p. 177). Interestingly, however, not all participants reported wholly positive consequences of increased understanding, e.g. the introduction of the stress-diathesis model of psychosis led one participant to state: "I blame my daughter a bit, and I know that's a terrible thing to do. If I hadn't have had her, I might not have [the voices]" (Goodliffe, Hayward, Brown, Turton and Dannahy, 2010, p. 450).

The increased understanding of onset of psychosis was related to the increased understanding of coping strategies (identified in 7/8 studies). Participants across most studies described learning about how ineffective coping strategies may contribute to them feeling more unwell, and also about alternative coping strategies; for example, "Letting go helps, you avoid getting into some ritual that goes on longer than the actual thought or image itself" (Abba, Chadwick and Stevenson, 2007, p. 83).

The third ingredient of therapy appeared to be the process of considering alternative explanations (identified in 6/8 studies). This appeared to be related to both increasing

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Table 1. Characteristics of studies included in qualitative synthesis

List of included studies	Methodology	Sampling method	Data collection method	CBTp model	Therapy method	Therapy status	Therapy duration	Population	*N*	Sex	**Age (years)**	**Ethnicity**	**Presenting problems (participants)**	**Duration of problems**
Abba et al. (2007)	Grounded theory	Purposive	Focus groups	Mindfulness group (Chadwick et al., 2005)	Group	Unknown	Unknown	Adult participants who had completed Mindfulness group around hearing voices	16	6 male	22–58	Unknown	All experienced paranoia, and depression and anxiety, plus hearing voices (11), 'other' hallucinations (5)	3–10 years for current episode
Dunn et al. (2002)	Grounded theory	Purposive	Group interviews	CBTp (unknown model)	Individual	Some ongoing	11–30 sessions (mean = 16.6)	Adult participants identified as "completers" or "non-completers" of homework in CBTp	10	12 male	31–52 (mean = 37.5)	Unknown	All 'had experienced distressing hallucinations and/or delusions'	6–15 years (mean = 10.1)
Goodliffe et al. (2010)	Grounded theory	Opportunity	Semi-structured individual interviews	Group person-based cognitive therapy (Chadwick et al., 2006, 2000)	Group	Completed	Mean = 7.3 sessions (8 session maximum)	Adult participants who had completed Person-Based Cognitive Therapy groups	18	6 male	30–59	16 White British, 1 White European, 1 Latin American	All experienced 'medication resistant voices'	'At least 2 years'
Hayward and Fuller (2010)	Interpretive Phe-nomenological Analysis	Purposive	Semi-structured individual interviews	Relating Therapy (Hayward et al., 2009)	Individual	Completed	Unknown	Adults who had received Relating Therapy as part of previous pilot study	3	1 male	20–49	3 White British	All experienced "distressing voices'	Less than 5 – more than 10 years
McGowan et al. (2005)	Grounded theory	Purposive	Semi-structured individual interviews	CBTp (Chadwick et al., 1996 or Fowler et al., 1995)	Individual	Some ongoing	6- more than 70 sessions	Inpatient and outpatient adults identified as "progressors" and "non-progressors" in CBTp	8	4 male	26–44	Unknown	Auditory hallucinations (3), with disturbing memories (1), with grandiose delusions (1), persecutory and grandiose delusions (1), persecutory only (2)	3 – 20 years (not known for all)

Table 1. Continued.

List of included studies	Methodology	Sampling method	Data collection method	CBTp model	Therapy method	Therapy status	Therapy duration	Population	*N*	Sex	**Age (years)**	**Ethnicity**	**Presenting problems (participants)**	**Duration of problems**
Messari and Hallam (2003)	Discourse analysis	Opportunity	Semi-structured individual interviews	CBTp (Nelson, 1997)	Individual	Mainly ongoing	11-more than 70 sessions	Inpatient and outpatient adults receiving/ received CBTp	5	4 male	28–49	2 White British, 1 White Irish, I Afro-Caribbean, 1 Black African	Delusions and alcohol abuse or social anxiety (2), delusions only (2), hearing voices (1), medication compliance (1)	10–28 years
Morberg Pain et al. (2008)	Content analysis	Opportunity	Semi-structured individual interviews	CBTp (unknown "common" model)	Individual	All ongoing	5–18 sessions (mean = 10)	Inpatient and outpatient participants interviewed 2 weeks after being given a case formulation in CBTp	13	8 male	21–52 (mean = 21.2)	Unknown	Distressing voices and paranoid beliefs (4), voices only (5), paranoia only (4)	2- 15 years (mean = 10.4)
Newton et al. (2007)	Interpretive Phenomenological Analysis	Purposive	Group semi-structured interviews	Group CBTp (Wykes et al., 1999)	Group	Completed	Up to 7 sessions	Young people (inpatient and outpatient) who completed CBTp group for auditory hallucinations	8	3 male	17–18	"varied"	All experiencing 'distressing auditory hallucinations'	5 months-4 years

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understanding of the onset and coping with psychosis. The complexity of this process is highlighted by participants across four studies who recognized doubts about their original explanations of psychosis, but did not completely discount them: "I've got doubts or slight doubts about the ideas that I have, but I don't think that er . . . that those doubts would get any bigger" (Messari and Hallam, 2003, p. 179), or instead turned to seemingly similar explanations: "by a process of . . . elimination . . . I eliminated Santa and said it was telepathy" (McGowan, Lavendar and Garety, 2005, p. 519).

In addition, normalization of psychosis appeared to constitute another ingredient of therapy occurring within the context of both group and individual therapy. Normalization was associated with increased understanding about the onset of psychosis for some participants; "[the therapist] understands that it's, it's been built up understandably from a lot of evidence . . . and so that makes me feel a bit better about having, having these beliefs" (Messari and Hallam, 2003, p. 179).

What is the process of therapy?

The process of therapy was reported to include a change in attitude, power, and self-concept. The change in attitude appeared to consist of a movement from "all or nothing" thinking towards an attitude characterized by acceptance (identified in 4/8 studies). Initially, participants across many studies reported an "all or nothing" attitude, i.e. a belief in which psychosis must be eradicated in order to lead a positive or enjoyable life. One participant said of his voices: "Either I goes, or they go, and I think that it's going to be me" (Newton, Larkin, Melhuish and Wykes, 2007, p. 141). However, many participants appeared to move towards accepting their experiences of psychosis, both in thought and behaviour: "To me my normal state of affairs is I'm moving all the time, I'm running away, I'm scared; this mindfulness thing . . . it's the first time where I stop moving" (Abba et al., 2007, p. 82). Acceptance was associated with positive consequences, such as an increased ability to cope, and an appreciation of the experiences themselves: "I don't want to get rid of them, I don't feel like they should ever really die or anything" (Hayward and Fuller, 2010, p. 369).

Acceptance of psychotic experiences appeared to be associated with a change in participants' power in relation to their psychotic experiences (identified in 5/8 studies). Participants across multiple studies initially presented themselves as disempowered; "[The voices] allowed me to come to these groups and the reason for that was that they could laugh at me and what I was doing here. . . I should be grateful to them for allowing me to come" (Goodliffe et al., 2010, p. 451). Traditional CBTp techniques, such as logical reasoning, were associated with a perceived decrease in voice power. Third wave techniques also facilitated a reduction in perceived voice power, for example, mindful observation of voices showed them to be: ". . . just a load of hot air and bluster" (Abba et al., 2007, p. 84). In the Relating Therapy study, participants associated this reduction in power with reciprocal gain: "the more power I get, the less he has" (Hayward and Fuller, 2010, p. 369). Several studies noted that participants did not necessarily experience an actual reduction in the frequency or distressing content of psychotic experiences, but instead gained an increased ability to cope and an increased perception of personal power.

The changes in attitude and in the perception of power appear to be associated with a reconceptualization of the self as distinct from psychosis (identified in 3/8 studies). Several

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participants described presenting with a sense of being defined by their psychotic experiences, for example: "I'm schizophrenic, that's it basically" (Goodliffe et al., 2010, p. 452). However, during the course of therapy, participants across three studies began to consider themselves as a person who has particular experiences, rather than "being" the experiences themselves: "I am not the illness. I am a person with a certain illness" (Goodliffe et al., 2010, p. 455).

Discussion

The current findings appear to corroborate the importance of the following CBTp components as delineated by Morrison and Barratt (2010) using an expert clinician Delphi exercise: increasing understandings of onset and coping with psychotic experiences; the use of normalization to reduce stigma; and the consideration of alternative explanations for psychotic symptoms. However, Morrison and Barratt (2010) did not explicitly refer to the possibility that service users may simultaneously embrace seemingly contradictory explanations for their experiences, e.g. "I am ill" but also "my experiences are real", as found in the current paper. This finding corroborates suggestions that service users may have a "double awareness of delusions" (Chadwick, Birchwood and Trower, 1996), and hold beliefs with varying degrees of conviction during the course of therapy (Nelson, 1997). Finally, within the Morrison and Barratt (2010) list, there was no elucidation of the association between therapy components, whereas the current synthesis suggests that this is something that can be explored using qualitative research, e.g. increasing understanding of the origins of psychotic experiences seems to have an effect on other processes such as coping and normalization.

The current paper is limited by the lack of consensus regarding methods for synthesizing qualitative research. The disparate nature of the included papers with regard to mechanisms and methodology also complicated the process of analyzing the presented findings. In addition, there was often a lack of transparency regarding how much the findings "went beyond" the data in the studies reviewed, i.e. the extent to which author interpretations were presented as findings. Furthermore, in studies where therapists were also interviewed, therapist perspectives tended to dominate what was presented as "findings".

The main finding of the current paper is that the service user voice is quiet and even when it is present in qualitative research, it may still be somewhat dominated by professional perspectives. For example, in the paper by McGowan et al. (2005), which purports to concern "users' and clinician views", 74% of the quotes are taken from therapists' accounts, and 26% from service users (i.e. when each verbatim quote equals 1 unit). This is despite the inclusion of eight service users, compared to four therapist participants. In order to truly prioritize the service user voice, it is recommended that future qualitative research concerning CBTp be service user-led, thereby ensuring that the service user voice has prominence in all aspects of the data analysis, interpretation and reporting. In addition, the inclusion of an exit interview in all therapy trials would provide the researchers with service user perspectives on the outcomes and process of CBTp, and publication of these findings would expand this currently limited literature base. Furthermore, when reporting qualitative findings, it is recommended that authors try to ensure that some proportional standards are met. For example, in papers purporting to concern the views of service users and therapists, an approximately even divide between quotes from both perspectives would be recommended.

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Declaration of interest

The first author declares no interest. The second author is currently exploring the development of third wave variants of CBTp. These explorations are motivated by a desire for the benefits of CBTp to be maximized.

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