

Service-User Satisfaction with CBT for Psychosis

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Abstract. Service user satisfaction with Cognitive Behavioural Therapy (CBT) for psychosis was examined with the Satisfaction with Therapy Questionnaire (STQ; Beck, Wright, Newman and Liese, 1993). Sixty-five service-users completed the STQ at the end of therapy, and 40 3-month post therapy. Overall, the majority of service-users were satisfied with therapy. Satisfaction was unaffected by service-user demographics or service issues, and remained stable over the 3-month follow-up. Belief in the extent to which CBT skills/knowledge had been gained predicted overall satisfaction at the end of therapy, while there was a near-significant effect for belief about the usefulness of homework(s) to predict overall satisfaction at 3-month follow-up. These results suggest that (i) CBT for psychosis is an acceptable intervention to service-users, regardless of their demographic characteristics or service issues; (ii) the specific aspects of CBT, not the non-specific attributes of therapy, predict overall satisfaction; (iii) homework setting may be important in ensuring ongoing satisfaction post-therapy.

Keywords: Cognitive-behavioural therapy, psychosis, service-user satisfaction.

Introduction

Psychosis is a chronic and debilitating disorder, with many individuals continuing to experience residual positive symptoms (e.g. delusions and hallucinations), causing distress and disability despite advances in pharmacological treatments. Research has now accumulated demonstrating the efficacy of cognitive behavioural therapy (CBT) for psychosis (Zimmermann, Favrod, Trieu and Pomini, 2005), culminating in the UK NICE (National Institute of Clinical Excellence) Guidelines (2003) recommending the wide-spread availability of CBT. Initial evaluations of service-user satisfaction with CBT for psychosis appear favourable, whether in a research (Kuipers et al., 1997) or routine clinical service context (Messari and Hallam, 2003). Sensky et al. (2000) also found a non-significant trend towards more satisfaction with CBT than a “befriending” intervention, and Durham et al. (2003) found “definite satisfaction” was higher for CBT than “treatment as usual”. Therefore, CBT for

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psychosis appears to be an acceptable intervention, although the factors underlying service-user satisfaction remain unclear. They may include non-specific therapist attributes; the quality of therapeutic relationship, service-user expectations and demographics; service issues such as waiting times, locality of services, research or service context; or specific aspects of CBT such as collaboration, skills gained and usefulness of “homeworks”.

This study examines service-users’ satisfaction with CBT for psychosis, in a NHS national specialist service – Psychological Intervention Clinic for Outpatients with Psychosis (PICuP).

Method

Service setting

PICuP is a national tertiary service established in 1999, based at the Maudsley Hospital, South London & Maudsley NHS Trust. PICuP offers CBT for individuals with distressing delusions and hallucinations, or with emotional disturbances in the context of a history of psychosis. Therapy lasts approximately 6 months, with either weekly or fortnightly sessions. Therapists ($n = 34$) were qualified CBT therapists, clinical psychologists, or trainee clinical psychologists, operating under supervision. During this study PICuP operated as both a research trial and routine clinical service.

Participants

Response rates are shown in Table 1. Seventy-nine people completed the Satisfaction with Therapy Questionnaire (STQ; Beck et al., 1993), 39 at the end of therapy only, 14 at 3-month follow-up only, and 26 at both time points. The sample size at the end of therapy therefore was 65, with 40 at follow-up. Service-users were significantly more likely to complete the STQ if they were in the research trial [$X^2(1) = 5.54, p = .019$], had received therapy after a waiting-list control delay of 9 months [$X^2(1) = 7.20, p = .007$] or were female [$X^2(1) = 6.11, p = .013$]. There was no significant difference in STQ completion rates by referral location [$X^2(1) = 1.73, p = .188$], ethnicity [$X^2(1) = 2.01, p = .157$] or age at referral [$t(97) = 1.13, p = .263$]. Forty-six (58%) were referred from the local NHS Trust. The average age of service-users at referral was 36.6 years ($SD = 10.2$, range 20–61). Forty (51%) were male and 32 (40%) were female (missing = 7, 9%). Of those with available ethnicity data from case notes (missing = 29, 37%), 40% were White ($n = 32$) whilst 18 (23%) were from other ethnic backgrounds (e.g. Black or Asian).

Materials

The Satisfaction with Therapy Questionnaire (STQ; Beck et al., 1993) is a short 20-item self-completion instrument, with good face validity covering (i) service-users’ expectations of and their perceptions of their actual progress made during therapy; (ii) their beliefs in the extent to which they gained CBT skills and knowledge; (iii) their perceptions of the usefulness of homework tasks set; (iv) ratings of their therapist’s attributes and related satisfaction; and (v) overall satisfaction with therapy. Items are scored on a Likert scale ranging from 1 to 5 (higher = more positive, 3 = neutral).

Table 1. Response rates

	<i>n</i>	<i>%</i>
Total number of service-users referred to PICuP*#	265	
Total number of service-users referred who started therapy*	149	56
Total number of service-users who dropped out of therapy (<5 sessions) (% of those who started therapy)*	42	28
–Research	19	13
(experimental group)	(10)	(7)
(control group)	(9)	(6)
–Service	23	15
Total number of service-users referred who completed therapy*	107	40
Total number of service-users who completed the STQ* (% of those who completed therapy)	79	74
–Research (% of total sample who completed the STQ)	43	54
(experimental group)	(21)	(27)
(control group)	(22)	(28)
–Service (% of total sample who completed the STQ)	36	46
Total number of STQs at end of therapy* (% of those who completed therapy)	65	61
Total number of STQs at 3-month follow-up* (% of those who completed therapy, although only service-users who were in the research trial were followed-up at 3 months)	40	37

*Up to December 2004

#Not all referred service-users began therapy (i.e. may not have attended initial assessments, may have been more appropriate to see in local team, may have not been offered therapy due to mental state etc. or may have not attended initial therapy appointment).

Procedure

The STQ was distributed by the trial research assistants and self-completed by service-users at the end of therapy (for both service and research trial service-users), and after a 3-month follow-up period (for research trial participants only). Service-users were informed their responses were confidential and would not be shared with their therapist.

Statistical analysis

This study reports both descriptive and analytic statistical analyses. Parametric statistical procedures are used as appropriate and Bonferroni corrections were applied to multiple univariate analyses. Binomial logistic regression analyses used a Forward Stepwise (Likelihood Ratio) method due to multi-collinearity between the independent variables.

Results

Overall, the majority of service-users were satisfied with CBT for psychosis. At the end of therapy, 77% were satisfied or very satisfied, rising to 80% by 3-month follow-up. Individual STQ item results are shown in Table 2. Mean ratings were high (>3) on all items, at both time points. Individual items were grouped to form five specific areas, displayed in Table 3,

Table 2. Individual item results of Satisfaction with Therapy Questionnaire (STQ)

	End of therapy mean (<i>SD</i> , range 1–5) (<i>n</i> = 65)	3-month follow-up mean (<i>SD</i> , range 1–5) (<i>n</i> = 40)
Service-users' expectations of and their perception of their actual progress in dealing with their problems in therapy		
–Part 1: Q1 - Before therapy, how much progress did you expect to make?	4.2 (0.7, 2-5)	4.4 (0.6, 3-5)
–Part 1: Q2 – During therapy, how much progress did you feel you actually made?	4.4 (0.6, 2-5)	4.4 (0.7, 2-5)
–Part 1: Q3 – In the future, how much progress do you think you will make?	4.4 (0.6, 2-5)	4.5 (0.7, 2-5)
Service-users' belief in the extent to which they gained CBT skills/knowledge		
–Part 2: Q1 – A better understanding of how my problems developed	3.5 (0.9, 1-5)	3.6 (1.1, 1-5)
–Part 2: Q2 – A better understanding of my experiences	3.7 (0.9, 1-5)	4.1 (0.7, 2-5)
–Part 2: Q3 – Techniques or methods to cope with my main problems	3.8 (0.8, 2-5)	4.0 (0.7, 2-5)
–Part 2: Q4 – Better control over my actions	3.5 (0.9, 1-5)	3.9 (0.7, 2-5)
–Part 2: Q5 – A greater ability to cope with my moods	3.7 (0.8, 2-5)	3.8 (0.8, 2-5)
–Part 2: Q6 – Techniques in defining and solving my everyday problems	3.7 (0.8, 2-5)	3.9 (0.9, 2-5)
–Part 2: Q7 – Methods or techniques for better ways of dealing with people	3.5 (0.8, 2-5)	3.8 (0.8, 2-5)
–Part 2: Q8 – Confidence in undertaking an activity to help myself	3.9 (0.8, 2-5)	3.9 (0.9, 1-5)
Service-users' beliefs about the usefulness of homework(s) set in therapy		
–Part 1: Q7 – How helpful were the tasks you did between therapy sessions?	4.1 (0.7, 2-5)	4.4 (0.7, 3-5)
Services-users' ratings of therapist attributes		
–Part 1: Q5 – How well do you think your therapist understood your problems?	4.3 (0.8, 2-5)	4.4 (0.7, 3-5)
–Part 1: Q6 – How much could you trust your therapist?	4.5 (0.8, 2-5)	4.6 (0.8, 2-5)
–Part 3: Q1 – Sympathetic and caring therapist?	4.5 (0.6, 3-5)	4.6 (0.5, 3-5)
–Part 3: Q2 – Competent therapist?	4.5 (0.7, 2-5)	4.6 (0.8, 1-5)
–Part 3: Q3 – Warm and friendly therapist?	4.6 (0.7, 2-5)	4.8 (0.4, 4-5)
–Part 4: Q4 – Supportive and encouraging therapist?	4.6 (0.6, 3-5)	4.7 (0.5, 4-5)
–Part 5: Q5 – Possible to get on with therapist?	4.4 (0.9, 1-5)	4.3 (1.2, 1-5)
Service-users' overall satisfaction with therapy		
–Part 1: Q4 – How satisfied were you with therapy?	4.0 (0.9, 2-5)	4.2 (0.9, 2-5)

Table 3. Summary results of Satisfaction with Therapy Questionnaire (STQ)

	Mean rating (1-5)	Significance tests						
		Age	Sex	Ethnicity	Referral location (in SLAM NHS Trust vs. other NHS Trust)	Waiting list (control group) vs. immediate therapy (experimental group)	Research trial vs. service	End of therapy/–3-month follow-up
Service-users' expectations of and their perception of their actual progress in dealing with their problems in therapy								
–end of therapy	4.3	$r = -0.320$, $p = .014^*$	$t(56) = -1.139$, $p = .260$	$t(34) = -0.391$, $p = .698$	$t(56) = -0.834$, $p = .408$	$t(34) = 0.587$, $p = .561$	$t(63) = -0.341$, $p = .734$	$t(24) = 0.153$, $p = .879$
–3-month follow-up	4.4	$r = -0.115$, $p = .478$	$t(38) = 0.414$, $p = .681$	$t(36) = 1.437$, $p = .159$	$t(38) = -1.148$, $p = .258$	$t(31) = 1.147$, $p = .260$	$t(38) = -0.938$, $p = .354$	
Service-users' belief in the extent to which they gained CBT skills/knowledge								
–end of therapy	3.7	$r = -0.110$, $p = .411$	$t(56) = -0.372$, $p = .712$	$t(34) = -0.354$, $p = .726$	$t(56) = -1.096$, $p = .278$	$t(34) = 0.706$, $p = .485$	$t(62) = 0.124$, $p = .901$	$t(24) = 0.259$, $p = .798$
–3-month follow-up	3.9	$r = 0.17$, $p = .918$	$t(24) = -0.676$, $p = .503$	$t(35) = 0.148$, $p = .883$	$t(37) = -0.026$, $p = .979$	$t(30) = -0.166$, $p = .869$	$t(37) = -1.642$, $p = .109$	
Service-users' beliefs about the usefulness of homework(s) set in therapy								
–end of therapy	4.1	$r = 0.060$, $p = .659$	$U = -0.511$, $p = .609$	$U = -0.405$, $p = .685$	$U = -1.505$, $p = .132$	$U = -0.367$, $p = .714$	$U = -0.339$, $p = .734$	$Z = -0.728$, $p = .467$
–3-month follow-up	4.4	$r = 0.093$, $p = .569$	$U = -1.361$, $p = .174$	$U = -0.104$, $p = .917$	$U = -1.201$, $p = .230$	$U = -0.218$, $p = .827$	$U = -1.212$, $p = .225$	
Service-users' ratings of therapist attributes								
–end of therapy	4.5	$r = -0.104$, $p = .439$	$t(56) = 0.102$, $p = .919$	$t(34) = -0.229$, $p = .821$	$t(56) = -1.563$, $p = .124$	$t(34) = 0.864$, $p = .394$	$t(41.5) = 1.654$, $p = .106$	$t(25) = 2.033$, $p = .053$
–3-month follow-up	4.6	$r = -0.017$, $p = .917$	$t(38) = -1.249$, $p = .219$	$t(36) = -0.657$, $p = .515$	$t(38) = 0.139$, $p = .890$	$t(31) = 0.493$, $p = .625$	$t(38) = -2.153$, $p = .038^*$	
Service-users' overall satisfaction with therapy								
–end of therapy	4.0	$r = -0.103$, $p = .440$	$U = -0.513$, $p = .608$	$U = 0.000$, $p = 1.000$	$U = 0.000$, $p = 1.000$	$U = -0.256$, $p = .798$	$U = -0.148$, $p = .882$	$Z = -1.155$, $p = .248$
–3-month follow-up	4.2	$r = 0.103$, $p = .526$	$U = -0.770$, $p = .441$	$U = -0.908$, $p = .364$	$U = -0.908$, $p = .364$	$U = -0.593$, $p = .553$	$U = -1.852$, $p = .064$	

*Not significant after Bonferroni Correction ($p < .05/6$ tests per row = 0.008 or 5 tests in final column $p < .05/5 = 0.01$)

along with statistical analyses of each area difference between end of therapy and 3-month follow-up, service user demographics and service issues. Mean satisfaction scores were high (>3) in all areas, at both time points. The highest ratings were for therapist attributes, the lowest for CBT skills and knowledge gained, for both time points. No significant differences were found in any of the statistical analyses.

Binomial logistic regression analyses were performed to identify which areas predicted service-users' overall satisfaction with therapy, one model at the end of therapy and another at 3-month follow-up. Overall satisfaction ratings were recoded into either "satisfied with therapy" (ratings of "satisfied" or "very satisfied") or "not satisfied with therapy" (ratings of "very dissatisfied" or "dissatisfied"). "Indifferent" ratings were excluded. At the end of therapy ($n = 52$), the logistic regression equation was significantly different from zero [$X^2(1) = 15.024, p < .001$] and accounted for 54% of the variance. However, the only significant regression coefficient predicting service-users' overall satisfaction with therapy was the total rating of the extent to which they believed they had gained specific CBT skills and knowledge in therapy [Wald(1) = 6.185, $\beta = 0.580, p = .013$]. At 3-month follow-up ($n = 34$), the logistic regression equation was significantly different from zero [$X^2(1) = 5.457, p = .019$] and accounted for 41% of the variance. There was a near-significant effect for perception of the helpfulness of homework tasks set [Wald(1) = 3.670, $\beta = 2.760, p = .055$]; none of the other regression coefficients was significant.

A total of 39 (49%) service-users wrote additional comments on the STQ, which were generally positive. Twenty-eight percent commented that therapy taught them "coping strategies" to help manage their distressing symptoms and/or daily problems, 23% reported finding "talking to someone" particularly helpful. A further 18% reported therapy had boosted their "self-confidence" and/or "improved their mood", three (8%) thought it had given them a "better understanding of their experiences" and another three that it had taught them ways of "monitoring their thoughts" and "breaking free from negative circular thinking patterns". Other comments were that therapy helped foster realistic expectations and improved concentration, although one service-user felt that CBT was too quick to provide an alternative explanation for and deny their religious experiences and beliefs. Five (13%) requested additional or future booster sessions, in order to maintain and consolidate therapeutic gains.

Discussion

The results of this study indicate that, overall, service-users were satisfied with therapy, with levels of satisfaction remaining stable at 3-month follow-up, and unaffected by demographic characteristics, or differences in service issues. These findings are promising given that higher levels of patient satisfaction are associated with clinical improvement (Baradell, 1995), and are likely to be associated with better engagement and lower attrition rates, increasing the cost effectiveness of CBT for psychosis.

Ratings were also high for the four specific areas of satisfaction, stayed stable over time and were unaffected by service-users' demographics or service issues. Ratings were highest for therapist attributes, suggesting that both the collaborative stance taken in CBT, and being able to "talk to someone" is valued. This is an important result for psychological approaches to psychosis as this population can be difficult to engage, and previously dissatisfied with mental health professionals.

Satisfaction ratings for the extent to which service-users believed they had gained CBT skills and knowledge were slightly lower than for other areas (possibly as not all service-users would have rated themselves as having acquired all skills, as some may not be relevant), although the specific effects of CBT were the *only* significant predictor of overall satisfaction at the end of therapy. This finding contradicts suggestions that CBT for psychosis is equivalent to other general psychological approaches, and that its successful outcomes and individual satisfaction are merely a consequence of “attention or non-specific effects” (Curtis, 1999). The qualitative comments also suggested that service-users thought therapy had taught them “coping strategies”, both general aspects (i.e. increasing self-efficacy, addressing low mood) and specific aspects of addressing psychosis (i.e. individual formulation, techniques to reduce residual positive symptoms).

At 3-month follow-up the perceived usefulness of homeworks was a near significant predictor of overall satisfaction. This result is concordant with the self-help ethos of CBT, tentatively suggesting that continued satisfaction with therapy may relate to how much practice of CBT skills occurs between sessions to develop behavioural and cognitive change to last beyond the end of therapy. However, due to the small sample size in the regression analysis, further research is needed before firm conclusions can be made about the role of homework. There are a number of limitations to this study. It was exploratory in nature, and entirely based on self-report. (Objective measures of individual outcome will be analysed in a separate study). It is likely that there is some sample bias as only 40% of referrals completed therapy, commonly due to non-attendance at initial assessment, inappropriate referrals, relapses of acute psychotic illness, or service-users refusing therapy. However, 72% of those who started therapy ended up completing, and 74% of those who completed therapy returned their STQ, proportions similar to previous reports (Durham et al., 2003), which may reflect difficulties in engaging this clinical population. Service-users who completed the STQ are likely to have felt most positive about their experience of CBT, thereby potentially artificially inflating the satisfaction levels. The small sample size also results in a lack of statistical power, particularly at 3-month follow-up, rendering any conclusions tentative. Further research is clearly needed to address these limitations. Finally, since PICuP is a national, specialist service, the level of expertise may be higher than in local services, thereby limiting the generalizability of these findings. However, the majority of PICuP therapists were not experts in CBT for psychosis, working in PICuP in order to develop their skills, although they all received fortnightly group supervision facilitated by an expert (EP or EK), which may not occur in a routine clinical context. Nevertheless, the finding that the majority of service-users are satisfied is similar to other CBT studies in less specialised service settings (e.g. Durham et al., 2003; Messari and Hallam, 2003).

In conclusion, this study provides evidence that service-users are satisfied with CBT for psychosis. It suggests that psychological approaches to psychosis should focus on enabling individuals to develop and practise skills and knowledge to manage and understand their emotional difficulties and psychotic experiences, in addition to fostering a positive therapeutic relationship, to maximize clinical improvements.

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