

# ‘Someone on my level’: A Meta-Ethnographic Review of Therapeutic Relationships in Cognitive Behavioural Therapy for Psychosis

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## Abstract

**Objectives:** Cognitive Behavioural Therapy for Psychosis (CBTp) demonstrates variable and at times mild to moderate effect sizes; thus, its therapeutic processes are important to explore. Establishing a secure therapeutic relationship is one such key process where barriers may exist, including those related to psychotic symptoms and associated stigma. This review synthesizes the available qualitative research pertaining to the experience of the therapeutic relationship from the perspective of those experiencing psychosis.

**Methods:** A systematic review was undertaken using PRISMA guidelines. Search terms included variants of ‘psychosis’, ‘therapy’ and ‘qualitative’. PsycInfo, CINAHL, EmBase, MedLine and Web of Science were searched, and reference lists were hand-scanned. Yardley’s quality appraisal tool was utilized and Noblit and Hare’s seven-stage process for conducting a meta-ethnographic review. A line-of-argument synthesis is presented.

**Results:** Fourteen papers were identified using inclusion and exclusion criteria. Twelve papers were deemed to have satisfactory quality. The line-of-argument synthesis used attachment theory to propose four semi-distinct stages to establishing a therapeutic relationship: beginning; safety, hope and trust; the practicalities of therapy; and branching out. Findings suggest that the therapist’s persona and use of CBTp techniques such as collaboration and shared agency over the process were important in establishing for the patient a sense of self as normal, equal and worthwhile.

**Conclusions:** Attachment security may be an important strand of CBTp and warrants further research and clinical investigation as a process and an outcome. Future research can benefit from increased transparency regarding researcher positionality as a potential source of bias.

## KEYWORDS

attachment theory, Cognitive Behavioural Therapy for Psychosis, psychosis, therapeutic relationship, therapy process

## 1 | INTRODUCTION

Cognitive Behavioural Therapy for Psychosis (CBTp) has historically demonstrated variable and at times limited effect sizes in producing a range of outcomes in psychosis (Jones et al., 2018; Laws et al., 2018; Mehl et al., 2015). Recent trends in CBTp research have focussed on symptom-specific approaches to identifying and addressing maintenance factors, such as addressing the role of worry processes and sleep in delusional beliefs (Freeman et al., 2015; Lincoln & Peters, 2019), the role of trauma in both hallucinations and delusions (Folk et al., 2019; Larkin & Read, 2008) and the role of attachment in voice hearing and paranoia (Berry et al., 2008; Gumley et al., 2014). A recent meta-analysis reported improvements in CBTp for addressing delusions over time, suggesting that the shift towards symptom-focussed CBTp approaches offers improved focus and efficacy in addressing specific difficulties compared to broader packages (Sitko et al., 2020). As such, the processes underlying the efficacy of CBTp are important to explore further.

One strand of research enquiry is considering the role of attachment in psychosis, which may have twofold importance as a developmental risk and/or maintenance factor in psychotic experiences and as a determinant for the development of a secure therapeutic relationship (Berry et al., 2019). Quantitative research has long suggested that the development of a secure therapeutic relationship is a predictor of positive therapeutic outcomes (Ardito & Rabellino, 2011), with research replicating this finding in therapy for psychosis (Browne et al., 2019; Priebe et al., 2011). However, the experience of psychosis is known to relate to potential difficulties engaging in therapy, such as paranoia impairing one's ability to relate to a therapist and hallucinations negatively impacting active engagement (Allott et al., 2018; Gottlieb et al., 2011). Research has also found elevated rates of insecure attachment in people experiencing psychosis (Bucci et al., 2017; Gumley et al., 2014), and this is known to limit the development of a secure therapeutic relationship (Berry et al., 2015; Mikulincer & Shaver, 2012). Further research has considered that insecure attachment styles may contribute to negative underlying beliefs, such as a basic mistrust of others (Berry & Bucci, 2015; Debbané et al., 2016), and maladaptive coping strategies such as avoidance or dissociation (Berry et al., 2017), which may in part maintain distressing voice hearing and paranoia. Some studies show associations between insecure attachment styles and worse positive symptoms (Bucci et al., 2017). Emotion regulation difficulties, one of the consequences of insecure attachment styles, have been linked to poorer quality therapeutic relationships in people experiencing psychosis (Mehl et al., 2020). Prior research therefore suggests that attachment style may play a role in both the development of a secure therapeutic relationship and overall symptom severity, which may in turn influence therapy engagement and overall outcome (Berry et al., 2019). The present review synthesizes the existing qualitative research regarding what people experiencing psychosis find important in establishing a therapeutic relationship. A theoretical abstraction of the themes identified from the data is presented.

### Key Practitioner Message

- Individuals experiencing psychosis may present to therapy with insecurities manifesting in an initial negative experience of therapy and the therapist.
- Core therapeutic competencies and CBT techniques can instill a sense of safety and trust.
- Attachment theory may provide a framework to consider and address the relational elements of CBTp, including how one experiences oneself and the therapist in the therapy context.

### 1.1 | Aims and research question

The present systematic review synthesizes the available qualitative literature pertaining to the following research question: what is important in the experience of a therapeutic relationship for people presenting with psychosis? It focusses specifically on CBTp and Cognitive Behavioural Therapy (CBT) interventions for co-morbidities within a psychosis population. As the review aimed to offer an abstract understanding of a healthcare phenomenon, meta-ethnography was deemed the appropriate synthesis methodology (Noblit & Hare, 1988). It offers an overarching account grounded in the available data and an emergent line-of-argument synthesis to inform practitioners and researchers working in this field. Relevant theory was

**TABLE 1** A table summarizing the seven-stage process of meta-ethnography (Noblit & Hare, 1988)

Stage	Description
Getting started	Identifying research question
Deciding what is relevant to the initial interest	Developing search strategies for inclusion/exclusion of data to answer the question and identifying relevant data
Reading the studies	Repeated reading of accounts and noting interpretive themes and constructs
Determining how they are related	'Putting together' the studies. Listing key metaphors (themes), phrases, ideas, or concepts used in studies and juxtaposing them
Translating the studies into one another	Comparing the themes, concepts and interactions of the studies whilst maintaining the central themes in the original studies
Synthesizing translations	Synthesizing the themes and interactions in one of three ways; they may be directly comparable as reciprocal translations; they may be in opposition to one another; or together they may represent a new line of argument.
Expressing the synthesis	Producing a written synthesis as one of many possible forms.

considered in light of the emergent themes, rather than being preimposed. The review also appraised the quality of the body of literature.

## 2 | METHODS

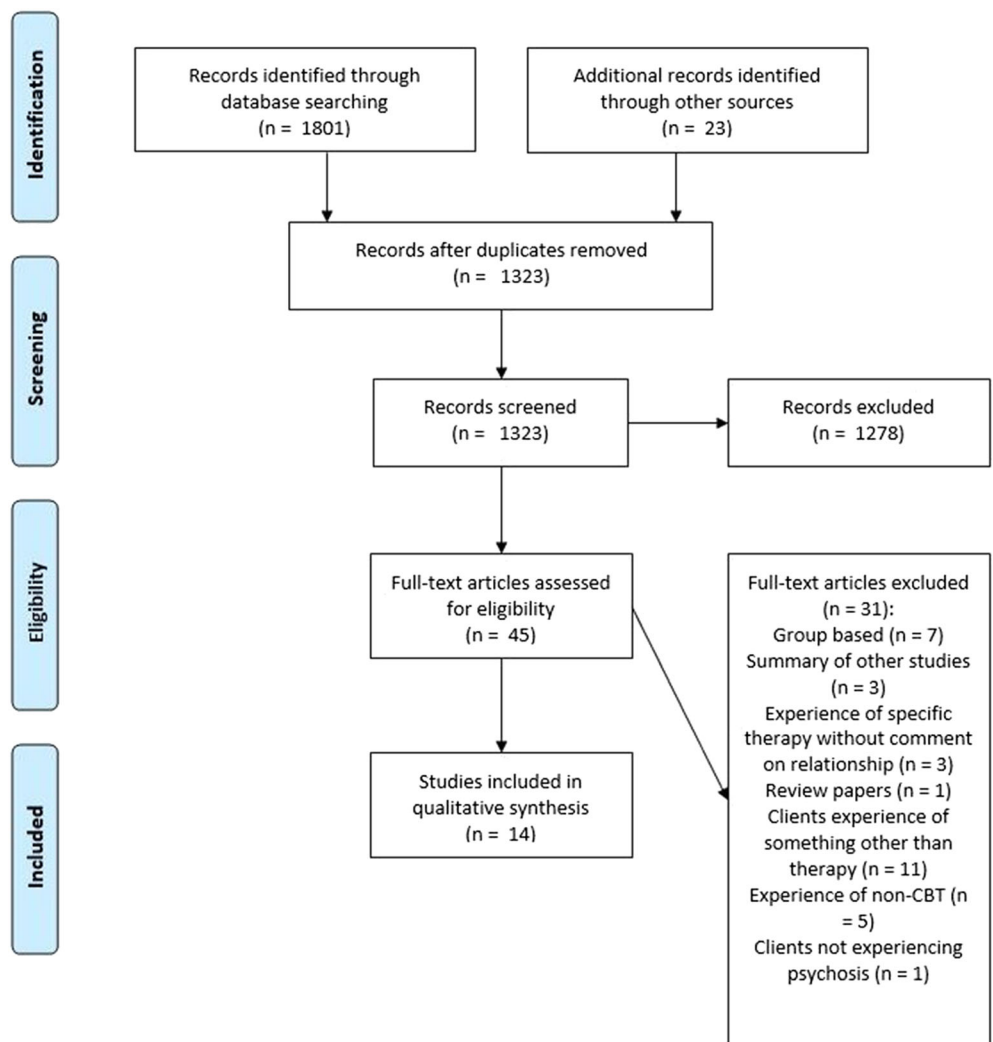
Noblit and Hare's (1988) guidance for conducting meta-ethnography studies was followed and reporting adhered to published guidance (France et al., 2019). The process is summarized in the below table (see Table 1).

### 2.1 | Deciding what is relevant

#### 2.1.1 | Search strategy and process

The first author conducted a systematic review across five databases (PsycInfo, CINAHL, EmBase, MedLine and Web of Science) using variations of the search terms 'psychosis' (including variants of key

symptoms, including 'hallucinations' OR 'delusions' OR 'negative symptoms' OR 'thought disorder') and 'therapy' (including variants of CBT and 'relationship') and 'qualitative' (including variants of methodologies and key phrases, including 'interview' OR 'experience' OR 'attitudes'). Searches were conducted in each database individually using both MeSH terms for the key phrases for each database and keywords searches (see exact search terms per database available in the supporting information, which is available upon request). The search was conducted with support from an Expert Librarian. Web of Science was used to conduct searches for similar papers for all key identified references and review papers, and reference lists were scanned. Searches were also conducted in Google Scholar and ProQuest Dissertation Database to find unpublished and grey literature. Hand reference list searches were also conducted and electronic searches of relevant publications (Behavioural and Cognitive Psychotherapy; Psychosis; Psychology and Psychotherapy; Clinical Psychology and Psychotherapy; and Early Intervention in Psychiatry). Additionally, the seven most cited authors in the field were emailed to inquire about any additional or upcoming publications that had been missed. The PRISMA diagram can be found below (see Figure 1). The



**FIGURE 1** PRISMA diagram summarizing the results of the systematic search

search was conducted in December 2019 and repeated in October 2020; no new papers were identified.

was checked for inclusion by the second and third authors with a good overall agreement, and final study selection was considered between the first three authors.

## 2.1.2 | Study screening and selection

Studies were screened according to the following inclusion and exclusion criteria; studies were included if they used any qualitative methodology to directly report the lived experience of CBTP; the sample had to be experiencing psychosis and be talking about their experience of the therapeutic relationship in therapy; and studies had to directly report the lived experience of the service user. Studies were excluded if they only used questionnaires for data collection or made no reference to the therapeutic relationship. For credibility purposes, a random 20% of the pool of papers ( $n = 3$ )

## 2.2 | Reading the studies

### 2.2.1 | Data extraction

Table 2 summarizes the data extraction, translation and synthesis processes which occurred concurrently. Key terms and issues pertaining to meta-ethnography are described.

A data extraction tool from Munro et al.'s (2007) meta-ethnography was used in line with guidance from the Cochrane Handbook of Systematic Reviews (Noyes et al., 2019). First-order

**TABLE 2** Table describing the translation process of the meta-ethnography and credibility checking tools utilized

Phase of translation process	Description of process	Credibility checking
1) Data extraction and quality appraisal	<ul style="list-style-type: none"> <li>• A paper was read in full twice.</li> <li>• Data extraction and quality appraisal tools were completed.</li> <li>• Paper was read in full again, and key first and second-order concepts from the entire paper relating to the therapeutic relationship were highlighted in NVivo.</li> <li>• Third-order interpretations were noted alongside the codes.</li> <li>• Repeated for each paper</li> <li>• Decision made with both supervisors to group all the papers together due to conceptual overlaps</li> </ul>	<ul style="list-style-type: none"> <li>• Five papers in total were co-coded, one each by the two supervisors and three individually by peer doctoral trainees to monitor consistency in identifying relevant themes, data extraction and quality appraisal.</li> <li>• Bracketing interview and reflective diary were used to note potential bias in third-order interpretations.</li> </ul>
2) Translating meanings within papers	<ul style="list-style-type: none"> <li>• Codes were listed in a table</li> <li>• Higher level thematic units of meaning were given to each code to reflect its overarching meaning; for example, a first-order code about the importance of therapist's body language was given 'therapist's approach'.</li> <li>• Higher level units of meaning were grouped based on reciprocal or refutational elements.</li> <li>• A summary of overarching themes and codes was produced.</li> <li>• Process repeated for each paper</li> </ul>	<ul style="list-style-type: none"> <li>• Re-iterative approach of referring to the original data once higher-level units of meaning were ascribed to consider 'best fit'</li> <li>• Ongoing use of supervision to review the translation process</li> <li>• Continued use of reflective diary to monitor research bias and risk of reducing the original meanings</li> </ul>
3) Synthesizing translations across papers	<ul style="list-style-type: none"> <li>• A table containing all of the papers themes was produced.</li> <li>• Related themes were grouped into super-ordinate categories, maintaining reference to the original data and meanings from the original codes.</li> <li>• A re-iterative process to consider the original codes and data, reciprocal and refutational elements within themes and a 'best fit'.</li> </ul>	<ul style="list-style-type: none"> <li>• Both supervisors read one random individual paper each to track development of translations across the entire process.</li> </ul>
4) Expressing the synthesis	<ul style="list-style-type: none"> <li>• A visual concept map was produced to reflect how the translations fit together.</li> </ul>	<ul style="list-style-type: none"> <li>• A table mapping original quotes and codes was completed and monitored by both supervisors.</li> </ul>

concepts were defined as direct quotes from participants; second-order concepts were interpretations made by the primary researchers; and third-order concepts were the lead researcher's overall interpretation of the first and second-order codes and form the final synthesis (Noblit & Hare, 1988).

## 2.2.2 | Quality appraisal

Yardley's four-criterion quality appraisal tool (Yardley, 2000, 2017) was used. This spans four areas: sensitivity to context; commitment and rigour; coherence and transparency; and impact and importance. A 4-point rating system was utilized to consider inter-rater reliability: criteria absent (0), less than half criteria present but limited in overall depth or description (1), more than half the criteria present and satisfactory depth to description enabling replicability (2) to all criteria present and of detailed description (3). Narrative summaries of the strengths and weaknesses of each paper were created and summarized. The second and third authors rated a total of 20% of the studies, and peer doctoral students additionally rated a further different 20% of the studies to allow consistency of ratings to be monitored; there was good overall agreement. Papers were deemed of 'satisfactory' quality with an average overall rating of two across all four domains and 'limited' if there were ratings of one in any of the domains. Low-quality papers were not excluded to preserve inclusion of the user experience; however, relative weaknesses were considered in relation to conclusions drawn.

## 2.3 | How are the studies related?

### 2.3.1 | Process for determining relationships between studies

Studies were analysed together. Different treatment targets, settings and evaluation methods were not deemed divergent or substantial enough to analyse the papers in groups. Additionally, the coded data appeared to reflect similar phenomena and was therefore considered as a whole.

## 2.4 | Translating the studies

### 2.4.1 | Process for translating studies

In meta-ethnography, translation is defined as the process of a researcher inferring meaning from the participant's account of the experience (Noblit & Hare, 1988). Meta-ethnography refers to either reciprocal translations—concepts or data largely agreeing with each other—and refutational translations—differing or disagreeing concepts. A line-of-argument synthesis refers to an overarching argument summarizing the entire dataset.

## 2.5 | Synthesizing translations and expressing the synthesis

### 2.5.1 | Synthesis process

Supporting information is available upon request regarding the synthesis process. A visual concept map was drawn to express the line-of-argument synthesis (see Figure 2), and the papers referencing each overarching theme were tracked to enable an auditable process overseen by the research team.

## 2.6 | Reflexivity statement

The lead author is a white, British male completing doctoral training in Clinical Psychology. Having spent 3 years working in an Early Intervention in Psychosis service prior to doctoral training, he developed interests in user engagement in mental health care where barriers seemed to exist and how services responded to this. He has theoretical interests in relational and attachment-based approaches to mental health. A bracketing interview was conducted to identify key personal and professional sources of resonance and potential bias, which was monitored by the research team throughout the analytic process.

## 3 | RESULTS

### 3.1 | Outcome of systematic search

The PRISMA diagram below summarizes the results of the systematic search (see Figure 1). The systematic search found 1,323 articles. Following title and abstract screening, 1,278 were removed. Forty-five papers were then screened in full using the inclusion and exclusion criteria, resulting in 14 papers being included in the study.

### 3.2 | Characteristics of included studies

Full study characteristics can be found in Table 3.

### 3.3 | Quality appraisal

Twelve papers were rated as having satisfactory quality overall based on the information provided, although the majority of these had sample sizes of below 10 ( $n = 6$ ). Two papers were deemed to have limited quality, one of these (Halpin et al., 2016) had the lowest overall rating of sensitivity to context having provided limited description of the sample and recruitment strategy and having a sample size of only three. Notable further issues in the two limited quality papers were absence of user involvement, limited reports of data saturation, limited credibility checking beyond the supervisor or immediate

**TABLE 3** A table summarizing the characteristics of the included studies

Paper	Country	Study aims	Sampling approach	Participants	Data collection method	Data analysis method
Awenat et al. (2017)	UK—North West of England	Investigate user perceptions of acceptability and impact of cognitive behaviour therapy targetting suicidal thoughts and behaviours	Recruited as part of an RCT, total pool of 24 participants, inclusion criteria in line with RCT criteria, recruited until data saturation reached	8, 2 males and 6 females All white British Age 17–46 Range of 7–24 sessions completed	Semi-structured interview	Inductive Critical Realist approach using Thematic Analysis following Braun and Clarke (2006)
Birchwood et al. (2018)	UK—North West and South West of England	Explore user perceptions of 9-month cognitive therapy for command hallucinations trial	Recruited as part of a multi-site RCT, used random sampling approach, inclusion criteria in line with RCT, recruited until data saturation reached	25, 15 males and 10 females Ages 18–67 68% white British 3 Caribbean 1 African 1 Irish 1 Other-Black Diagnoses: 36% unspec psychosis, 56% schizophrenia, 8% scizhoffective	Semi-structured interview	Grounded theory
Bjornestad et al. (2018)	Norway	Explore what people whom have recovered from psychosis found helpful in psychotherapy	Recruited at 2-, 5- and 10-year follow-up from larger naturalistic study of FEP detection and treatment, inclusion in line with prior study and self-selecting, recruited until data saturation reached	20, 10 males and 10 females Ages 17–58 Range of sessions 2–416, 76 average	Semi-structured interview	Semantic team-based thematic analysis using phenomenological approach
Dilks et al. (2013)	UK	Explore processes in psychotherapy for psychosis	Naturalistic opportunity sampling—recruited psychologists in local services with suitable clients on their caseloads	6, 2 males and 4 females Ages 33–37 2 White British, 1 White European, 1 Nigerian, 1 Black British, 1 Black African Range of years in service 3–25	Semi-structured interview plus analysis of two therapy tapes per dyad	Critical realist approach, grounded theory
Halpin et al. (2016)	Australia	Explore experience of case formulation in CBT intervention for symptoms of PTSD	Naturalistic opportunity sampling—recruited as part of trial in existing FEP teams to pilot trauma intervention for people aged 15–25	3, gender not reported. Ages 19, 19 and 21 Also included their three therapists	Semi-structured interview	Interpretive phenomenological analysis (Smith, Flowers, & Larkin, 2009)

**TABLE 3** (Continued)

Paper	Country	Study aims	Sampling approach	Participants	Data collection method	Data analysis method
Hazell et al. (2017)	UK—South of England	Explore experience of a guided self-help CBT intervention for hearing voices and identify potential barriers and facilitators to implementation	Self-selecting—people who hear voices across NHS services and third-sector organizations	21, 47% male and 42% female Mean age 42, SD 11.12 Number of years hearing voices mean 17, SD 14 Also 201 clinicians via online survey	Three focus groups using topic guides	Thematic analysis (Braun & Clarke, 2006)
Kilbride et al. (2013)	UK—North West of England	Explore perceptions of CBTp from a user-led perspective	Self-selecting opportunity sample—recruited people who have had CBTp in the last 12 months from EIP and CMHT	9, 5 females and 4 males Ages 21–65, mean 26 8 White British 1 Black British	Semi-structured interview	Interpretive phenomenological analysis
Lawlor et al. (2015)	UK	Explore how paranoia presents in the therapeutic relationship and how it is resolved	Purposive sampling of therapists delivering CBTp who had suitable clients on their caseloads	8, all males All White British Ages 31–41, mean age 35.9	Semi-structured interview	Thematic analysis (Braun & Clarke, 2006)
McGowan et al. (2005)	UK	Expand understanding of user experiences of CBTp and processes of good and bad outcomes of therapy	Purposive sampling of therapists with suitable clients on their caseloads, grouped clients by therapists' views of clients having progressed in therapy or not	8, 4 males and 4 females Ages 26–42 Sessions range 12 sessions-year weekly sessions	Semi-structured interview	Grounded theory
Messari and Hallam (2003)	UK	Explore users' understanding and experience of CBTp	Self-selecting opportunity sample—lead clinician identified suitable clients from all who had received CBTp on inpatient ward	5, 4 males and 1 female Ages 28–49 2 White British, 1 White Irish, 1 Black African 1 Afro Caribbean 4 inpatient 1 outpatient Treatment duration 3–18 months of weekly sessions	Semi-structured interview	Discourse analysis
Slater and Painter (2016)	UK	To use collaborative group game design to explore user experiences of CBTp in a	Purposive sampling – Lead clinician on forensic ward identified all clients who had received CBTp	10 males Ages 32–50, mean 41 All forensic inpatient Average length of stay 7 years	Collaborative group game design - initial questionnaire with prompt questions, then group sessions	Thematic analysis, visual and descriptive representation of data created in the game design

(Continues)



**TABLE 3** (Continued)

Paper	Country	Study aims	Sampling approach	Participants	Data collection method	Data analysis method
		forensic setting and evaluate its use as a methodology	who would be appropriate to be invited to take part	Also included their five therapists at various stages of CBTp training	with clients and therapists to design game together, then feedback on the process using interviews	
Tong et al. (2019)	Australia	To explore the experiences of a trauma-informed intervention for people experiencing a first episode of psychosis	Naturalistic purposive sampling—recruited as part of service piloting trauma-informed intervention	11, 9 females and 2 males Ages 18–27	Semi-structured interview	Interpretive phenomenological analysis
Waller et al. (2015)	UK—South East of England	To explore the experience of and barriers to implementation of a low intensity CBT intervention for people experiencing psychosis	Purposive sampling—all who had taken part in trial of LICBT invited to take part	17, no further details provided	Semi-structured interview	Thematic analysis (Braun & Clarke, 2006)
Wood et al. (2016)	UK	To explore user experiences of a CT for self-stigma intervention	Purposive self-selecting sample—recruited as part of a larger RCT, inclusion in line with RCT, including moderate difficulties on self-reported measure of self-stigma	8, 6 males and 2 females Ages 19–55 mean 39 Range of sessions 3–13, average 10	Semi-structured interview	Thematic analysis

Abbreviations: CBT, Cognitive Behavioural Therapy; CBTp, Cognitive Behavioural Therapy for Psychosis; CMHT, community mental health team; CT, cognitive therapy; FEP, first episode psychosis; LICBT, low intensity cognitive behavioural therapy; PTSD, post-traumatic stress disorder; RCT, randomized controlled trial; SD, standard deviation.

research team and limited reported consideration of researcher reflexivity (Halpin et al., 2016; Waller et al., 2015).

As a whole, the majority of papers reported limited user involvement, with five not reporting any (Dilks et al., 2013; Halpin et al., 2016; Hazell et al., 2017; Messari & Hallam, 2003; Waller et al., 2015) and a further five limited; one used a pilot interview, others checked themes with participants or consulted people with lived experience regarding research design (Awenat et al., 2017; Birchwood et al., 2018; Lawlor et al., 2015; McGowan et al., 2005; Tong et al., 2019). One study was user led (Kilbride et al., 2013). Further recurrent issues included not reporting researcher reflexivity; four papers did not report any researcher reflexivity (Birchwood

et al., 2018; Lawlor et al., 2015; Waller et al., 2015; Wood et al., 2016), and a further four reported only limited details of researcher positionality or use of supervision (Bjornestad et al., 2018; Halpin et al., 2016; McGowan et al., 2005; Slater & Painter, 2016). These omissions may be due to limited space in publishing rather than the absence of consideration. Messari and Hallam's (2003) and Kilbride et al.'s (2013) papers had particular strengths regarding reflexivity, both including a reflexive statement positioning the epistemological and theoretical stance of the researcher. Other recurrent limitations included studies not giving clear rationales for methodological choices or epistemological positions, interview schedules or analytical processes. However, all 10 of the papers rated as of



satisfactory quality reported multiple methods of supervision and quality checking, clear methods for achieving data saturation and equal distribution of quotes, which bolsters validity and credibility.

### 3.3.1 | Outcome of synthesis

The second-order translations were organized into four themes reflecting the meanings ascribed to the therapeutic relationship throughout the process of therapy; beginning; safety, hope and trust; practicalities; and branching out. Two additional themes reflected *facilitators* and *barriers* to relating. Themes will be outlined before the line-of-argument synthesis is presented. Direct quotes are presented in italics and parentheses and are presented verbatim, such as maintaining original use of supplementary meanings within brackets [] and .... As client details were not often presented with the original quotes, these are not included.

### 3.3.2 | Beginning

This theme described experiences prior to and when beginning therapy and establishing an initial rapport. Eight papers referred to this theme.

*I became frightened of everyone, thinking anybody who was around me was part of some sort of great scheme about me. At first, this included [my therapist].*

*I was being very guarded about what I said, how I acted and did things .... I just said what had to be said but I did not open up.*

*I had to suss (him) out to see if he was trustworthy ... checking out ... how well (he) dealt with the stuff that I brought up initially. (Lawlor et al., 2015, p. 493), Clients 3, 6 and 7.*

The beginning of therapy was largely characterized by fear, dread and hypervigilance to the perceived threat of the therapist not being trustworthy. Some papers highlighted specific worries, such as therapy making one's voices worse, the therapist being part of wider worries of persecution and doubt that therapy would help. Some papers reflected a sense that being in therapy 'made me think I'm sick'. Voices and paranoid ideas in relation to the therapist and uncertainty around the therapist's role or hope for change were commonly reported across papers.

### 3.3.3 | Safety, hope and trust

This theme reflects the next phase of therapy, establishing a sense of safety in the relationship. This was highlighted by most papers as

crucial for setting the stage for treatment and in fostering a sense of trust and hope. Twelve papers contributed to this theme. All 12 papers expressed that a positive, secure relationship was deemed important by participants.

*He took me seriously. I felt he had a caring way about him. ... With looks, body language, with what he said. ... He showed that he was present. It was not like a distant look or "let us just get this over with, with her, give her a prescription or something." It seemed to me that he was really into his job, that he enjoyed his job. Bjornestad et al. (2018), p. 4)*

Therapists' approach to participants was deemed important, with numerous studies reflecting a felt sense that therapists were genuinely present, caring and interested in them. Verbal and non-verbal body language, warmth and apparent willingness to emotionally invest were all commonly reported. The majority of papers referenced safety and trust developing from the collaborative relationship, shared agenda setting and therapists' demonstrated willingness to go at participants' pace. This appeared to instill a sense of control over the therapy process.

Therapists' transparency regarding the rules around confidentiality and therapeutic techniques, as well as a willingness to have open and honest conversations about difficulties in therapy were important moments for some:

*(I was) really opening up about it and saying I did not think I could trust her ... we had a whole session about it and ... at the end of it I felt really good. I felt I had found someone who understood me.*

*If I said something to (my therapist) ... I'd get paranoid about what would happen to the information ... I spoke to him about it and (it) helped me with my trust. (Lawlor et al., 2015, p. 497), Client 7 and Client 2.*

Papers considered broader literature that therapists' openness and genuine concern can address various presenting concerns, including overcoming ambivalence to process trauma, addressing perceived burdensomeness in suicidality, challenging voice content that was otherwise impeding engagement and alleviating internalized self-stigma. Six papers described that therapists conveying a verbal understanding of the development of the participants' problems established trust. This included reflecting back on their processes for gathering evidence or making links between past experiences and current difficulties. Various papers referred to how participants came to experience their therapist once the initial fear and ambivalence faded, likening it to a friendship and an equal relationship:

*like a bigger sibling ... quietly listening to you and looking out for you (Tong et al., 2019, p. 1240).*

*it's as though they are responding to the human being that's in his own dilemma* (Messari & Hallam, 2003, p. 179).

### 3.3.4 | The practicalities of therapy

This theme describes individual's experience of therapeutic tasks and techniques. Twelve papers endorsed this theme. Dilks et al.'s (2013) grounded theory paper proposed a model of therapeutic processes:

*The central therapy activity identified was conceptually summarized as a process of building bridges to observational perspectives. This was defined as a jointly negotiated process, enacted in the conversation between psychologist and client, based on the psychologist repeatedly demonstrating the activities involved in observing, or standing back from, experience during the course of conversation with the client. The psychologist appeared to be continually lending alternative observational perspectives and the client borrowing these to re-examine distressing experiences and current concerns, thereby opening up new possibilities for the client's functioning in the social world. Essentially, the psychologist seemed to be providing an observational scaffold to facilitate the client in considering their experiences and concerns from different perspectives* (Dilks et al., 2013, p. 216).

Four papers (Awenat et al., 2017, p. 42; Bjornestad et al., 2018, p. 4; Dilks et al., 2013, p. 216; McGowan et al., 2005, p. 523) detailed therapy as a space of repeated conversations offering new perspectives as an important process of change. Various papers highlighted therapy as perhaps the only space where this could happen in the context of one's beliefs being understood and validated but also sensitively challenged. One paper, notably one of limited quality with a sample size of three, highlighted that case formulation was experienced to one participant as 'dismissive' if too focussed on fostering insight into links with the past (Halpin et al., 2016, p. 5).

Participants highlighted the importance of a focus on validating here-and-now feelings. The majority of papers highlighted that psychoeducation was experienced as validating, normalizing and mobilizing change. A maintained focus on goal-directed behaviour and positively framed interventions, '*really nurtured what was healthy*' (Bjornestad et al., 2018, p. 5), was deemed important by participants across these papers. Although one participant referred to the process of addressing their trauma in therapy using the phrase '*slow and laborious*' (Tong et al., 2019, p. 1240), the majority of papers reflected that therapists' slower, person-centred pace in delivering interventions was important. Using real-life examples, therapist's use of self via disclosure or emotional display and completing behavioural tasks together were positively experienced by participants as signs of feeling understood and being in partnership. Numerous papers

captured what Bjornestad et al.'s (2018, p. 5) paper termed '*early applied sensitive pressure*', involving therapist attuning to the needs and capabilities of the participant and adapting particular techniques, such as not repeating techniques one was finding challenging, applying more pressure for behavioural change where positive gains had been made, and matching to one's emotional tone.

### 3.3.5 | Branching out

This theme referred to the latter stages of therapy and how the experience of the therapeutic relationship broadened out into other aspects of participants' lives. Twelve papers endorsed this theme.

*It restored my faith in human beings. I'm a little less guarded around people now ... if you can trust one person maybe you can extend that trust to other people.* (Lawlor et al., 2015, p. 497), Client 7.

The experience of a safe, trusting and validating therapeutic relationship where alternative relational and behavioural experiences occurred enabled participants to apply this in their real lives. This included being able to develop trust with other people, to disclose difficulties to others, to reach out to social or vocational activities, apply advice or recommendations such as strategies or access media resources. Various papers described a desire to give back, such as via peer support, sharing advice with others or helping to advise their therapist by suggesting helpful tips to share with others. Authors interpreted that the experience of a positive therapeutic relationship offered a juxtaposition or an '*antidote*' to negative ways of relating pertaining to paranoia (Lawlor et al., 2015), trauma symptoms (Tong et al., 2019), submissive relating styles associated with voice hearing (Hazell et al., 2017) or internalized self-stigma (Wood et al., 2016).

*whenever someone addresses stigma, not even saying stigma but batting a phrase or something, a statement, instead of reacting to it, think about why that stigma is there and to sort of think about why would they say that instead of just reacting to stuff [...], just to basically be more open to what people say and instead of just closing down straight away* (Wood et al., 2016, p. 245), Participant E.

### 3.3.6 | Barriers and facilitators to engagement

Eleven papers reported barriers and facilitators to engaging in a therapeutic relationship. These are summarized in the below table (see Table 4). The factors were nonlinear and largely unrelated to each other; rather, they were embedded within the experience of therapy. Third-order concepts are presented using titles reflecting the language of the original papers.

### 3.4 | Line of argument synthesis

As the third-order interpretations ascribed to each theme appeared to relate to participants' sense of self and others in relation to each 'stage' of the therapeutic relationship, attachment theory (Bowlby, 1969) was considered an appropriate theory to provide an overarching synthesis (see Figure 2). The therapeutic relationship and core CBT techniques were experienced by many participants as reflecting the self as acceptable and worthwhile:

*she makes me feel like I'm someone special, I'm worthy*  
(Dilks et al., 2013, p. 220).

It is therefore proposed that attachment security presents a cog in a machine which moves people through the therapeutic process; movement through stages may reflect shifts in one's sense of self and others. There are also opposing facilitator and barrier cogs influencing its flow, containing factors influencing the development of a secure relationship across the stages. Papers imbued the latter stages of therapy, propelled on by the relationship, with various affective and relational gains:

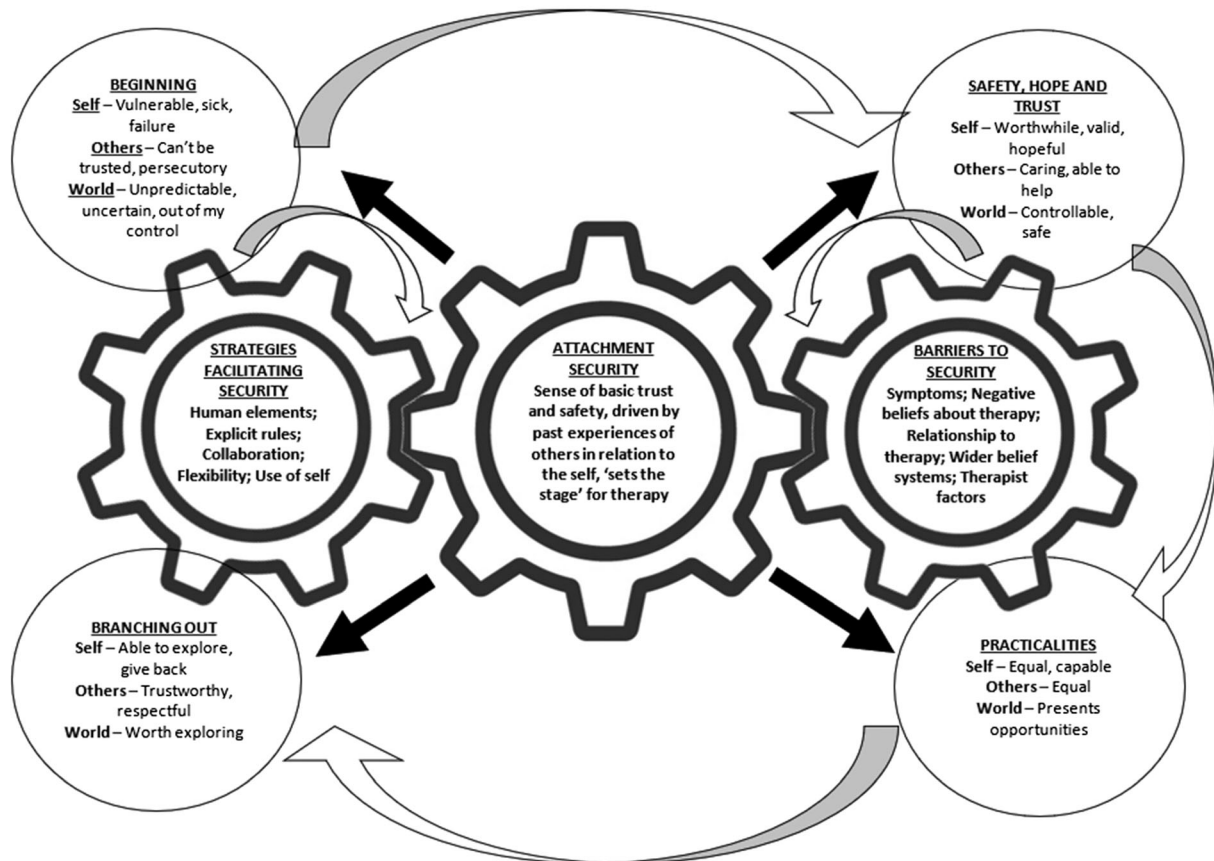
*the fog lifted a little, I had not had that experience before. I found the missing words for these thoughts and feelings.*  
(Bjornestad et al., 2018, p. 4).

This may reflect an established secure attachment relationship, whereby a child internalizes a sense of 'good enough' and safety to explore the world around them (Bowlby, 1969):

*It gave me my confidence back ... I'm more open and friendly ... I realised that not everybody is bad and I'm going to meet people that are going to harm me, but I'm also going to meet people that are good friends to me. I go out more and try to do things out of the house so I'm not always in four walls on my own.* (Awenat et al., 2017, p. 43).

## 4 | DISCUSSION

This meta-ethnography critically appraised and synthesized qualitative literature regarding what people experiencing psychosis find important in the therapeutic relationship. The quality of the papers was



**FIGURE 2** A summary of the line-of-argument synthesis incorporating attachment theory across the stages of a therapeutic relationship and proposed therapist strategies

**TABLE 4** A table summarizing the themes *facilitators* and *barriers* to relating in therapy

Barriers	Facilitators
Symptoms as barriers—generalized or specific paranoid beliefs related to therapist; avoidance of trauma or painful emotions, such as trauma or vulnerability; voice content; co-morbid physical or mental health	Flexibility—safe location; timings and duration of sessions; content personalized and applied to one's problems and experiences; and adapting process of therapy when it is not helpful
Negative beliefs about therapy—it is hard work; therapist does not take me or it seriously; therapy is too overwhelming; it will make me feel worse	Explicit rules—rules regarding confidentiality being made explicit; therapeutic behaviour being described explicitly
Wider belief systems—need to avoid negative feelings; low self-confidence or self-efficacy; emotional investment in current experiences, such as belief system defending against low self-esteem; shame and internalized self-stigma	Collaboration—shared agency over the focus; clear goals in line with one's hopes and wishes; sense of control over the pace of sessions; shared decision-making over therapy progression
Relationship to therapy—passive compliance; powerlessness; expectation to be fixed; being in therapy means I am sick or broken; transferring expectations from experiences of other professionals or people, such as 'dismissive' or non-collaborative approaches	Use of self—therapist making self-disclosures; therapist showing personality; therapist being involved in behavioural tasks or psychoeducation as part of challenging beliefs; therapist display of emotional concern, such as upset when discussing paranoia or mistrust about them
Therapist factors—therapist hopelessness for change, such as beliefs that therapy is not that effective or cognitive symptoms mean change is not likely; self-doubt or feelings of incompetence resulting in 'anti-collaborative' modes or trying to 'fix' paranoid beliefs; inflexibility to approach, such as session length, location and content	Human elements—warmth, genuineness; therapist feels like a friend or caring sibling, enables challenge; attuned to emotional state; sensitive pressure in light of unhelpful beliefs or avoidance; focusing on strengths and positive gains; therapist facilitating open and accepting conversations about beliefs, such as paranoid ideas about them or avoidance

rated, on the whole, as satisfactory; a wide range of supervision methods, analyses, approaches to credibility checks, and approaches to user involvement were described.

Studies described different aspects of the process of establishing, engaging with and experiencing benefit from a therapeutic relationship from the perspective of people experiencing psychosis. Papers also commented on various internal, external and wider sociocultural factors influencing the experience. The line-of-argument synthesis utilized attachment theory to propose a model of what people

experiencing psychosis find important at each semi-distinct 'stage' of engagement in a therapeutic relationship. Crucially, participants placed importance on how they felt about their therapist, and this was interpreted as significant for their underlying attachment beliefs. Therapists' use of self and CBT techniques were both highlighted as important in facilitating this security and a range of facilitators and barriers were identified (see Table 3). Findings will next be considered in light of existing research.

#### 4.1 | Therapeutic relationships in CBTp

The CBTp model proposes that appraisals of experiences are key in the development and maintenance of distress; they are informed by early life experiences and give rise to beliefs about oneself, others and the world (Garety et al., 2001; Morrison, 2017). The present model suggests that such appraisals have twofold importance for people who experience psychosis. First, the exploration and validation of appraisals was viewed as important to establishing hope and trust in therapy. Second, the therapeutic relationship was essentially perceived as a therapeutic tool to address unhelpful appraisals, in particular those based on insecure attachment. The presented studies suggest that this may help address specific difficulties in psychosis including paranoia, voice hearing, self-stigma and trauma. This is consistent with research considering attachment and psychosis, whereby early attachment disruption may shape beliefs that drive symptomology (Berry & Bucci, 2015; Gumley et al., 2014). The cognitive attachment model of voices (CAV; Berry et al., 2017) purports that elevated rates of insecure attachment styles in people hearing voices may drive both the development and maintenance of distress related to voices (such as via avoidant coping styles, or dissociation and trauma-based responses). The present review supports this proposition and provides hypotheses for how therapists and therapy may be viewed with anxious, avoidant or disorganized attachment-based beliefs. For example, the initial stages of therapy may be experienced through beliefs of avoiding dependence, possibly in light of earlier attachment wounds and/or on-going attachment to voices' perceived malevolence. This proposition warrants consideration of the relational experience of therapy in light of attachment beliefs, as well as how attachment beliefs likely inform the experience of psychosis, including paranoia. Therapist strategies within CBTp such as collaboration, shared goals and agenda setting, use of self, and core humanistic qualities of genuineness and openness may all be experienced as modelling a secure attachment relationship. Likewise, consideration of therapists' attachment styles, beliefs and strategies in relation to clients' styles may enable more effective strategies for engagement (Linnington, 2019). The present findings suggest that this in itself may be a change process, as well as facilitating engagement with other treatment strategies. This is salient given the limited effectiveness of CBTp in research trials; this review proposes that attachment security sets the context for therapy to occur effectively, as well as providing a key intervention strategy itself. It may be that attention afforded to attachment and relational issues directly influences treatment efficacy, which requires further research. Participant experiences

in this respect suggest that CBTp can produce quality of life improvements and reductions in distress as well as symptom reductions although these outcomes are not always reflected in research trials (Jones et al., 2018; Laws et al., 2018). Attachment as an active therapeutic process in CBTp warrants further investigation. For example, given research suggesting that relationally orientated therapies can influence positive change in attachment security (Travis et al., 2001), it would be interesting to investigate how attachment security changes over the course of CBTp and affects outcome, and underlying beliefs about oneself, others and the world. Some research has explored self-concept transformation as a process and outcome of psychotherapy for psychosis (Lysaker et al., 2003, 2015); attachment theory may offer a way to conceptualize and measure this in further research within CBTp.

The present findings are largely in line with previous reviews of user perspectives of CBTp in that the therapeutic relationship is an important aspect of therapy (Berry & Hayward, 2011; Wood et al., 2015). CBTp strategies such as collaboration may be experienced as novel aspects of therapy and go some way to alleviate the relational sequelae of psychosis, such as passivity (Messari & Hallam, 2003). However, cultural issues such as ethnic background and gender were not wholly reported or accounted for in the studies. Some research suggests that cultural beliefs inform beliefs about psychosis, therapy and mental health services more broadly (Dutta et al., 2019; Naeem et al., 2015; Rathod et al., 2010). Although cultural beliefs were identified here, it was not identified as a factor in the majority of the themes. Further research should consider cultural factors. Conversely, the included studies notably all foregrounded the voice of the participants, all people accessing therapy for psychosis. This is a novel contribution to the field. It was noted in Berry and Hayward's (2011) review that this was a limitation of the available research at the time. This suggests an improvement in the quality of the qualitative research.

## 4.2 | Social relationships and psychosis

The role of attachment in psychosis is relevant to wider considerations of the social world of those experiencing psychosis, where symptoms, internalized self-stigma and negative self-concepts can impair the ability to relate (Brabban et al., 2017; Lim et al., 2018). Research considering attachment and psychosis has begun to inform work in various settings, including inpatient wards (Campbell et al., 2014). There is also growing research into the benefits of affirmative spaces such as the charity The Hearing Voices Network that report similar themes regarding the freedom to be oneself, connect with others and make sense of one's experiences (Payne et al., 2017). It may be that individual therapy provides one opportunity for a secure relationship to ameliorate these issues and support individuals to branch out to other positive social experiences. However, alternatives are also important to consider. The role of the self and identity has been considered in research in psychosis (Braehler & Schwannauer, 2012; Lysaker et al., 2003; Meehan & MacLachlan, 2008). Attachment theory could provide a framework for

interventions targeting such factors via clinical design and research (Gumley et al., 2014).

## 4.3 | Limitations

Meta-ethnographic syntheses vary in the number of papers included; this review of 14 papers reflects the relatively small size of the evidence base. Additionally, it is notable that not all papers specifically asked about the therapy relationship or processes related to it, suggesting that further research may be warranted. Additionally, the included papers here have a total sample size of less than 200, where sociocultural and setting factors were not always described. Future qualitative studies may benefit from larger sample sizes and clear reporting of demographic and contextual information to represent the diversity of voices heard.

The meta-ethnography synthesis was limited by its lack of user involvement and a diverse, multi-disciplinary research team. Ideally, multiple professional and personal perspectives should have been involved in the synthesis process to enrich the presented model and support credibility checking. Further, by nature of this being a qualitative review, awareness should be given to potential biases at all levels of the presented research, including original funding, study conception, researcher bias and publication biases. Although attempts were made to acknowledge and consider researcher reflexivity and credibility, it is acknowledged that the write-up and overall model will have been influenced by the researcher's position. For example, the lead author acknowledges that the final synthesis has resonance with his own experience of providing psychological therapy for people experiencing psychosis and the felt sense of growing attachment security. It is acknowledged that this is but one frame from which to consider these dynamic processes. Being qualitative in nature, the review also offers no clarity as to causation and only represents the experiences of some.

As discussed earlier, the use of a quality appraisal tool in qualitative reviews is under debate. The choice of appraisal tool represents one lens for appraising qualitative research, and, equally, the original papers may have simply been limited by journal word limits, and so what is appraised here may not be what occurred in practice. It did not seem overly apparent that removing lower quality papers would have influenced the synthesis much, given that the majority of papers endorsed each theme and there were no particular patterns regarding papers and themes. This may inform decisions made in future meta-ethnographic reviews.

## 4.4 | Implications

### 4.4.1 | Clinical implications

The findings here suggest a number of clinical implications. Attachment security as a concept could be formulated and inform intervention for people experiencing psychosis as an important factor in both therapy



engagement and outcomes. Individuals with pre-existing attachment security may engage with therapy processes more easily than insecurely attached people (Mallinckrodt & Jeong, 2015), which may have particular salience for those experiencing psychosis where symptoms and stigma pose additional barriers to treatment engagement. CBTp strategies such as collaboration, shared agency over process and flexibility may go some way to model a secure attachment relationship. CBTp treatment strategies may have limited effectiveness and may even be appraised as threatening in the absence of consideration of attachment and pre-existing relational beliefs. This resonates with wider suggestions for a focus on engagement, normalization and person-centred, relational engagement (Brabban et al., 2017).

This review also suggests that facilitating clients 'branching out' is an important aspect of clinical care, so facilitating engagement with safe, affirming social spaces may be of benefit. Hearing Voices Network groups, vocational resources and groups or activities affording social connection may maintain gains made from a positive experience of therapy (Brabban et al., 2017; Cooke, 2017). It may be that individuals need therapeutic support to make these connections and test their helpfulness.

Therapist use of self and therapist beliefs were identified as important factors. Therapists' ability to remain open, curious and genuine in the face of paranoia and attachment insecurity may be an important clinical process in therapy for psychosis. This suggests supervision considering relational and cultural issues may facilitate the development of a secure therapeutic relationship where challenges arise.

#### 4.4.2 | Research implications

Future research should continue to explore attachment security in psychosis, such as insecurity as a factor regarding engagement with and outcomes of therapy in larger trials. Researching the impact of relational therapeutic strategies in CBTp may consider whether the themes here translate to treatment efficacy, as participants' lived experiences imply. Treatment component research and studies exploring working alliance may shed further light on these issues. Therapist factors may also have relevance, given some research suggesting that therapist attachment security plays a role in the development of a secure relationship (Bucci et al., 2016).

Further qualitative research could learn from the limitations of the reviewed studies. Particular issues pertain to the sensitivity of context with limited consideration of study context, design and researcher positionality as issues of potential bias. Sample sizes and research strategies were limited, with the majority of papers ranging from 3 to 10 participants, most often from naturalistic settings or follow-up larger pilot or randomized controlled trials (RCTs). It is not clear how this and the researchers' positionality may influence the experiences people report. On the whole, however, the majority of studies were rated as being of satisfactory quality in the majority of domains. Future qualitative research in this field may benefit from clear statements of researcher positionality including theoretical and epistemological standing as both may come to bear on both what is

asked and what is found; from increasing user involvement and being user led where possible; and from considering the impact of study context, setting and sampling strategy in the study process. Additionally, qualitative research in this field could continue to explore the experience of the therapeutic relationship, such as building on more process-based angles such as Lawlor et al.'s (2015) experience of paranoia within the relationship. This would continue to facilitate our understanding of what is important in establishing attachment security in the face of insecurity and specific barriers.

The least endorsed theme here was 'beginning'. Further research exploring the initial stages of therapeutic engagement for people experiencing psychosis considering facilitators, barriers and the role of internalized self-stigma would benefit our understanding here.

## 5 | CONCLUSIONS

The following meta-ethnographic review proposed an attachment theory-informed model of the therapeutic relationship from the perspective of those experiencing psychosis. It suggests that therapists' orientation to the client as an equal, with a willingness to be open and honest, alongside CBT principles of collaboration, shared agency over the process and psychoeducation are all important principles. Participants related these experiences as positive and denoting a sense of self as safe and acceptable. Qualitative research in this field has expanded substantially and maintains a steady focus on privileging the voice of the service user. It is overall of satisfactory quality, though can continue to improve by increased transparency regarding epistemological position, user demographics, study settings and increasing user involvement at all levels. Further research and clinical practice can continue to explore the significance of attachment security in relation to the outcomes of CBTp; measuring attachment security or related self-concept beliefs as an outcome of CBTp may shed light on this issue.

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### CONFLICT OF INTEREST

There is no conflict of interest.

### DATA AVAILABILITY STATEMENT

Not applicable as no new data were generated during this review.

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### REFERENCES

Allott, K., Simmons, M., Tindall, R. M., Hamilton, B. E., & Roberts, W. (2018). Engagement at entry to an early intervention service for first

- episode psychosis: An exploratory study of young people and caregivers. *Psychosis*, 10(3), 175–186. <https://doi.org/10.1080/17522439.2018.1502341>
- Ardito, R. B., & Rabellino, D. (2011). Therapeutic Alliance and outcome of psychotherapy: Historical excursus, measurements, and prospects for research. *Frontiers in Psychology*, 2. <https://doi.org/10.3389/fpsyg.2011.00270>
- Awenat, Y. F., Shaw-Nunez, E., Kelly, J., Law, H., Ahmed, S., Welford, M., Tarrier, N., & Gooding, P. A. (2017). A qualitative analysis of the experiences of people with psychosis of a novel cognitive behavioural therapy targeting suicidality. *Psychosis: Psychological, Social and Integrative Approaches*, 9(1), 38–47. <https://doi.org/10.1080/17522439.2016.1198827>
- Berry, C., & Hayward, M. (2011). What can qualitative research tell us about service user perspectives of CBT for psychosis? A synthesis of current evidence. *Behavioural and Cognitive Psychotherapy*, 39(4), 487–494. <https://doi.org/10.1017/S1352465811000154>
- Berry, K., Barrowclough, C., & Wearden, A. (2008). Attachment theory: A framework for understanding symptoms and interpersonal relationships in psychosis. *Behaviour Research and Therapy*, 46(12), 1275–1282. <https://doi.org/10.1016/j.brat.2008.08.009>
- Berry, K., & Bucci, S. (2015). What does attachment theory tell us about working with distressing voices? *Psychosis*, 8, 60–71. <https://doi.org/10.1080/17522439.2015.1070370>
- Berry, K., Bucci, S., & Danquah, A. N. (2019). *Attachment theory and psychosis: Current perspectives and future directions*. UK: Routledge. <https://doi.org/10.4324/9781315665573>
- Berry, K., Gregg, L., Hartwell, R., Haddock, G., Fitzsimmons, M., & Barrowclough, C. (2015). Therapist-client relationships in a psychological therapy trial for psychosis and substance misuse. *Drug and Alcohol Dependence*, 152, 170–176. <https://doi.org/10.1016/j.drugalcdep.2015.04.006>
- Berry, K., Varese, F., & Bucci, S. (2017). Cognitive attachment model of voices: Evidence base and future implications. *Frontiers in Psychiatry*, 8, 111. <https://doi.org/10.3389/fpsyg.2017.00111>
- Birchwood, M., Mohan, L., Meaden, A., Tarrier, N., Lewis, S., Wykes, T., Davies, L. M., Dunn, G., Peters, E., & Michail, M. (2018). The COMMAND trial of cognitive therapy for harmful compliance with command hallucinations (CTCH): A qualitative study of acceptability and tolerability in the UK. *BMJ Open*, 8(6), e021657. <https://doi.org/10.1136/bmjopen-2018-021657>
- Bjornestad, J., Veseth, M., Davidson, L., Joa, I., Johannessen, J. O., Larsen, T. K., Melle, I., & Hegelstad, W. T. (2018). Psychotherapy in psychosis: Experiences of fully recovered service users. *Frontiers in Psychology*, 9, 1675. <https://doi.org/10.3389/fpsyg.2018.01675>
- Bowlby, J. (1969). *Attachment and loss: Attachment*. USA: Basic Books.
- Brabban, A., Byrne, R., Longden, E., & Morrison, A. P. (2017). The importance of human relationships, ethics and recovery-orientated values in the delivery of CBT for people with psychosis. *Psychosis*, 9(2), 157–166. <https://doi.org/10.1080/17522439.2016.1259648>
- Braehler, C., & Schwannauer, M. (2012). Recovering an emerging self: Exploring reflective function in recovery from adolescent-onset psychosis. *Psychology & Psychotherapy: Theory, Research & Practice*, 85(1), 48–67. <https://doi.org/10.1111/j.2044-8341.2011.02018.x>
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77–101. <https://doi.org/10.1191/1478088706qp0630a>
- Browne, J., Mueser, K. T., Meyer-Kalos, P., Gottlieb, J. D., Estroff, S. E., & Penn, D. L. (2019). The therapeutic alliance in individual resiliency training for first episode psychosis: Relationship with treatment outcomes and therapy participation. *Journal of Consulting and Clinical Psychology*, 87(8), 734–744. <https://doi.org/10.1037/ccp0000418>
- Bucci, S., Emsley, R., & Berry, K. (2017). Attachment in psychosis: A latent profile analysis of attachment styles and association with symptoms in a large psychosis cohort. *Psychiatry Research*, 247, 243–249. <https://doi.org/10.1016/j.psychres.2016.11.036>
- Bucci, S., Seymour-Hyde, A., Harris, A., & Berry, K. (2016). Client and therapist attachment styles and working Alliance. *Clinical Psychology & Psychotherapy*, 23(2), 155–165. <https://doi.org/10.1002/cpp.1944>
- Campbell, R., Allan, S., & Sims, P. (2014). Service attachment: The relative contributions of ward climate perceptions and attachment anxiety and avoidance in male inpatients with psychosis. *Criminal Behaviour and Mental Health*, 24(1), 49–59. <https://doi.org/10.1002/cbm.1880>
- Cooke, A. (2017). *Understanding psychosis and schizophrenia*. UK: British Psychological Society, Division of Clinical Psychology.
- Debbané, M., Salaminios, G., Luyten, P., Badoud, D., Armando, M., Solida Tozzi, A., Fonagy, P., & Brent, B. K. (2016). Attachment, neurobiology, and mentalizing along the psychosis continuum. *Frontiers in Human Neuroscience*, 10, 406. <https://doi.org/10.3389/fnhum.2016.00406>
- Dilks, S., Tasker, F., & Wren, B. (2013). Conceptualizing the therapist's role in therapy in psychosis. *Psychology & Psychotherapy: Theory, Research & Practice*, 86(3), 315–333. <https://doi.org/10.1111/j.2044-8341.2011.02061.x>
- Dutta, M., Spoorthy, M. S., Patel, S., & Agarwala, N. (2019). Factors responsible for delay in treatment seeking in patients with psychosis: A qualitative study. *Indian Journal of Psychiatry*, 61(1), 53–59. [https://doi.org/10.4103/psychiatry.IndianJPsychiatry\\_234\\_17](https://doi.org/10.4103/psychiatry.IndianJPsychiatry_234_17)
- Folk, J., Tully, L. M., Blacker, D. M., Liles, B. D., Bolden, K. A., Tryon, V., Botello, R., & Niendam, T. A. (2019). Uncharted waters: Treating trauma symptoms in the context of early psychosis. *Journal of Clinical Medicine*, 8(9), 1456. <https://doi.org/10.3390/jcm8091456>
- France, E. F., Cunningham, M., Ring, N., Uny, I., Duncan, E. A. S., Jepson, R. G., Maxwell, M., Roberts, R. J., Turley, R. L., Booth, A., Britten, N., Flemming, K., Gallagher, I., Garside, R., Hannes, K., Lewin, S., Noblit, G. W., Pope, C., Thomas, J., ... Noyes, J. (2019). Improving reporting of meta-ethnography: The eMERGe reporting guidance. *BMC Medical Research Methodology*, 19(1), 25. <https://doi.org/10.1186/s12874-018-0600-0>
- Freeman, D., Dunn, G., Startup, H., Pugh, K., Cordwell, J., Cernis, E., Wingham, G., Shirvell, K., & Kingdon, D. (2015). Effects of cognitive behaviour therapy for worry on persecutory delusions in patients with psychosis (WIT): A parallel, single blind, randomised controlled trial with a mediation analysis. *Lancet Psychiatry*, 2(4), 305–313. [https://doi.org/10.1016/S2215-0366\(15\)00039-5](https://doi.org/10.1016/S2215-0366(15)00039-5)
- Garety, P. A., Kuipers, E., Fowler, D., Freeman, D., & Bebbington, P. E. (2001). A cognitive model of the positive symptoms of psychosis. *Psychological Medicine*, 31(2), 189–195. <https://doi.org/10.1017/s003291701003312>
- Gottlieb, J. D., Mueser, K. T., Rosenberg, S. D., Xie, H., & Wolfe, R. S. (2011). Psychotic depression, posttraumatic stress disorder, and engagement in cognitive-behavioral therapy within an outpatient sample of adults with serious mental illness. *Comprehensive Psychiatry*, 52(1), 41–49. <https://doi.org/10.1016/j.comppsyg.2010.04.012>
- Gumley, A. I., Taylor, H. E. F., Schwannauer, M., & MacBeth, A. (2014). A systematic review of attachment and psychosis: Measurement, construct validity and outcomes. *Acta Psychiatrica Scandinavica*, 129(4), 257–274. <https://doi.org/10.1111/acps.12172>
- Halpin, E., Kugathasan, V., Hulbert, C., Alvarez-Jimenez, M., & Bendall, S. (2016). Case formulation in young people with post-traumatic stress disorder and first-episode psychosis. *Journal of Clinical Medicine*, 5(11), 106. <https://doi.org/10.3390/jcm5110106>
- Hazell, C. M., Strauss, C., Cavanagh, K., & Hayward, M. (2017). Barriers to disseminating brief CBT for voices from a lived experience and clinician perspective. *PLoS One*, 12(6), e0178715. <https://doi.org/10.1371/journal.pone.0178715>
- Jones, C., Hacker, D., Meaden, A., Cormac, I., Irving, C. B., Xia, J., Zhao, S., Shi, C., & Chen, J. (2018). Cognitive behavioural therapy plus standard care versus standard care plus other psychosocial treatments for



- people with schizophrenia. *Cochrane Database of Systematic Reviews*. <https://doi.org/10.1002/14651858.CD008712.pub3>
- Kilbride, M., Byrne, R., Price, J., Wood, L., Barratt, S., Welford, M., & Morrison, A. P. (2013). Exploring service users' perceptions of Cognitive Behavioral Therapy for psychosis: A user led study. *Behavioural and Cognitive Psychotherapy*, 41(1), 89–102. <https://doi.org/10.1017/S1352465812000495>
- Larkin, W., & Read, J. (2008). Childhood trauma and psychosis: Evidence, pathways, and implications. *Journal of Postgraduate Medicine*, 54(4), 287–293. <https://doi.org/10.4103/0022-3859.41437>
- Lawlor, C., Hall, K., & Ellett, L. (2015). Paranoia in the therapeutic relationship in Cognitive Behavioural Therapy for Psychosis. *Behavioural and Cognitive Psychotherapy*, 43(4), 490–501. <https://doi.org/10.1017/S1352465814000071>
- Laws, K. R., Darlington, N., Kondel, T. K., McKenna, P. J., & Jauhar, S. (2018). Cognitive Behavioural Therapy for schizophrenia—Outcomes for functioning, distress and quality of life: A meta-analysis. *BMC Psychiatry*, 6(1), 32. <https://doi.org/10.1186/s40359-018-0243-2>
- Lim, M. H., Gleeson, J. F. M., Alvarez-Jimenez, M., & Penn, D. L. (2018). Loneliness in psychosis: A systematic review. *Social Psychiatry and Psychiatric Epidemiology*, 53(3), 221–238. <https://doi.org/10.1007/s00127-018-1482-5>
- Lincoln, T., & Peters, E. (2019). A systematic review and discussion of symptom specific cognitive behavioural approaches to delusions and hallucinations. *Schizophrenia Research*, 203, 66–79. <https://doi.org/10.1016/j.schres.2017.12.014>
- Linnington, M. (2019). The significance of the clinician's felt experience: Using attachment theory to understand the therapist's emotional experience when working with someone with psychosis. In K. Berry, S. Bucci, & A. N. Danquah (Eds.), *Attachment theory and psychosis: Current perspectives and future directions*. UK: Routledge. <https://doi.org/10.4324/9781315665573>
- Lysaker, P. H., Kukla, M., Belanger, E., White, D. A., Buck, K. D., Luther, L., Firmin, R. L., & Leonhardt, B. (2015). Individual psychotherapy and changes in self-experience in schizophrenia: A qualitative comparison of patients in metacognitively focused and supportive psychotherapy. *Psychiatry*, 78(4), 305–316. <https://doi.org/10.1080/00332747.2015.1063916>
- Lysaker, P. H., Lancaster, R. S., & Lysaker, J. T. (2003). Narrative transformation as an outcome in the psychotherapy of schizophrenia. *Psychology & Psychotherapy: Theory, Research & Practice*, 76(3), 285–299. <https://doi.org/10.1348/14760830322362505>
- Mallinckrodt, B., & Jeong, J. (2015). Meta-analysis of client attachment to therapist: Associations with working alliance and client pretherapy attachment. *Psychotherapy*, 52(1), 134–139. <https://doi.org/10.1037/a0036890>
- McGowan, J. R., Lavender, T., & Garety, P. A. (2005). Factors in outcome of cognitive-behavioural therapy for psychosis: Users' and clinicians' views. *Psychology and Psychotherapy: Theory, Research and Practice*, 78(4), 513–529. <https://doi.org/10.1348/147608305X52559>
- Meehan, T., & MacLachlan, M. (2008). Self construction in schizophrenia: A discourse analysis. *Psychology and Psychotherapy*, 81(2), 131–142. <https://doi.org/10.1348/147608307X256777>
- Mehl, S., Hesse, K., Schmidt, A.-C., Landsberg, M. W., Soll, D., Bechdorf, A., Herrlich, J., Kircher, T., Klingberg, S., Müller, B. W., Wiedemann, G., Wittorf, A., Wölwer, W., & Wagner, M. (2020). Theory of mind, emotion recognition, delusions and the quality of the therapeutic relationship in patients with psychosis—A secondary analysis of a randomized-controlled therapy trial. *BMC Psychiatry*, 20(1), 59. <https://doi.org/10.1186/s12888-020-2482-z>
- Mehl, S., Werner, D., & Lincoln, T. M. (2015). Does Cognitive Behavior Therapy for psychosis (CBTp) show a sustainable effect on delusions? A meta-analysis. *Frontiers in Psychology*, 6. <https://doi.org/10.3389/fpsyg.2015.01450>
- Messari, S., & Hallam, R. (2003). CBT for psychosis: A qualitative analysis of clients' experiences. *British Journal of Clinical Psychology*, 42(2), 171–188. <https://doi.org/10.1348/014466503321903580>
- Mikulincer, M., & Shaver, P. R. (2012). An attachment perspective on psychopathology. *World Psychiatry*, 11(1), 11–15. <https://doi.org/10.1016/j.wpsyc.2012.01.003>
- Morrison, A. P. (2017). A manualised treatment protocol to guide delivery of evidence-based cognitive therapy for people with distressing psychosis: Learning from clinical trials. *Psychosis*, 9(3), 271–281. <https://doi.org/10.1080/17522439.2017.1295098>
- Munro, S. A., Lewin, S. A., Smith, H. J., Engel, M. E., Fretheim, A., & Volmink, J. (2007). Patient adherence to tuberculosis treatment: A systematic review of qualitative research. *PLoS Medicine*, 4(7), e238. <https://doi.org/10.1371/journal.pmed.0040238>
- Naeem, F., Saeed, S., Irfan, M., Kiran, T., Mehmood, N., Gul, M., Munshi, T., Ahmad, S., Kazmi, A., Husain, N., Farooq, S., Ayub, M., & Kingdon, D. (2015). Brief culturally adapted CBT for psychosis (CaCBTp): A randomized controlled trial from a low income country. *Schizophrenia Research*, 164(1–3), 143–148. <https://doi.org/10.1016/j.schres.2015.02.015>
- Noblit, G., & Hare, D. (1988). *Meta-ethnography: Synthesizing qualitative studies (qualitative research methods)*. Sage Publications. <https://doi.org/10.4135/9781412985000>
- Noyes, J., Booth, A., Cargo, M., Flemming, K., Harden, A., Harris, J., Garside, R., Hannes, K., Pantoja, T., & Thomas, J. (2019). Chapter 21: Qualitative evidence. In J. P. T. Higgins, J. Thomas, J. Chandler, M. Cumpston, T. Li, M. J. Page, & V. A. Welch (Eds.), *Cochrane handbook for systematic reviews of interventions version 6.0*. London: Cochrane.
- Payne, T., Allen, J., & Lavender, T. (2017). Hearing Voices Network groups: Experiences of eight voice hearers and the connection to group processes and recovery. *Psychosis*, 9(3), 205–215. <https://doi.org/10.1080/17522439.2017.1300183>
- Priebe, S., Richardson, M., Cooney, M., Adedeji, O., & McCabe, R. (2011). Does the therapeutic relationship predict outcomes of psychiatric treatment in patients with psychosis? A systematic review. *Psychotherapy and Psychosomatics*, 80(2), 70–77. <https://doi.org/10.1159/000320976>
- Rathod, S., Kingdon, D., Phiri, P., & Gobbi, M. (2010). Developing culturally sensitive cognitive behaviour therapy for psychosis for ethnic minority patients by exploration and incorporation of service users' and health professionals' views and opinions. *Behavioural and Cognitive Psychotherapy*, 38(5), 511–533. <https://doi.org/10.1017/S1352465810000378>
- Sitko, K., Bewick, B., Owens, D., & Masterson, C. (2020). Meta-analysis and meta-regression of Cognitive Behavioral Therapy for Psychosis (CBTp) across time: The effectiveness of CBTp has improved for delusions. *Schizophrenia Bulletin Open*, 1(1). <https://doi.org/10.1093/schizbullopen/sgaa023>
- Slater, J. J. G., & Painter, G. (2016). Taking steps: Using collaborative group game design to consolidate and evaluate experiences of individual chief complaint-orientated cognitive behavioural therapy for psychosis (C-Co CBTp) in conditions of high security. *The Cognitive Behaviour Therapist*, 9, e9. <https://doi.org/10.1017/S1754470X16000064>
- Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research*. UK: Sage Publishing.
- Tong, J., Simpson, K., Alvarez-Jimenez, M., & Bendall, S. (2019). Talking about trauma in therapy: Perspectives from young people with post-traumatic stress symptoms and first episode psychosis. *Early Intervention in Psychiatry*, 13(5), 1236–1244. <https://doi.org/10.1111/eip.12761>
- Travis, L. A., Bliwise, N. G., Binder, J. L., & Horne-Moyer, H. L. (2001). Changes in clients' attachment styles over the course of time-limited dynamic psychotherapy. *Psychotherapy: Theory, Research, Practice*,

- Training*, 38(2), 149–159. <https://doi.org/10.1037/0033-3204.38.2.149>
- Waller, H., Garety, P., Jolley, S., Fornells-Ambrojo, M., Kuipers, E., Onwumere, J., Woodall, A., & Craig, T. (2015). Training frontline mental health staff to deliver “low intensity” psychological therapy for psychosis: A qualitative analysis of the therapist and service user views on the therapy and its future implementation. *Behavioural and Cognitive Psychotherapy*, 43(3), 298–313. <https://doi.org/10.1017/S1352465813000908>
- Wood, L., Burke, E., & Morrison, A. (2015). Individual cognitive Behavioural therapy for psychosis (CBTp): A systematic review of qualitative literature. *Behavioural and Cognitive Psychotherapy*, 43(3), 285–297. <https://doi.org/10.1017/S1352465813000970>
- Wood, L., Burke, E. M., Byrne, R., & Morrison, A. (2016). Examining service user experiences of a cognitive therapy intervention for self-stigma in psychosis. *Psychosis*, 8(3), 238–249. <https://doi.org/10.1080/17522439.2015.1135184>
- Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology & Health*, 15(2), 215–228. <https://doi.org/10.1080/08870440008400302>
- Yardley, L. (2017). Demonstrating the validity of qualitative research. *The Journal of Positive Psychology*, 12(3), 295–296. <https://doi.org/10.1080/17439760.2016.1262624>

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