User experiences of CBT for anxiety and depression: A qualitative systematic review and meta-synthesis

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Abstract

Cognitive behavioural therapy (CBT) is an evidence-based treatment for anxiety and depression. It is important to determine the positive and negative aspects of CBT from the perspective of service users. However, there has been a lack of qualitative exploration into service user experiences of the therapy. This review aimed to address this gap by examining participants' experiences of CBT for anxiety and depression. Databases were searched and data were synthesised thematically. CBT was well-received by participants, though barriers to engagement were identified. CBT was often perceived as too difficult or demanding, as well as interventions being short and therefore superficial. Clinician qualities of being trustworthy, non-judgemental, and understanding appear to be significant contributors to client engagement and recovery. Findings support the delivery of in-depth clinician led CBT for anxiety and depression, as well as highlighting the need to review CBT delivery to better support service users.

Key words: CBT, meta-synthesis, qualitative, lived experience, anxiety, depression

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Statements and Declarations

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Introduction

Anxiety and depression are two of the most common mental health problems experienced by adults. Global prevalence of depression is estimated to be around 3.2% whereas the prevalence of anxiety disorders approaches almost 5% (Santomauro et al., 2021). Anxiety and depression may share similar symptoms that include difficulty sleeping, psychomotor agitation and retardation, fatigue, difficulty concentrating, and indecisiveness (Zbozinek et al., 2012). They also share similar underlying mechanisms which can include maladaptive emotion regulation, repetitive negative thinking, and experiential avoidance (Kladnitski et al., 2020).

Due to the high prevalence rate and impact on those affected by these mental health problems, it is crucial to identify effective interventions as well as barriers associated with anxiety and depression. Cognitive behavioural therapy (CBT) is a psychological treatment with strong evidence base (Angelakis et al., 2022; David et al., 2018). CBT is effective in the treatment of depression (Lepping et al., 2020; National Institute for Clinical Excellence, 2022), and anxiety (Kaczkurkin & Foa, 2015; National Institute of Clinical Excellence, 2020). The core theoretical principle of CBT is based upon an interrelated relationship between behaviour, thoughts, and feelings. CBT aims to break these links through identifying and challenging negative thoughts and beliefs, which in turn can affect behaviour and feelings – both physical and emotional.

Previous research has heavily focused on empirically supporting the clinical effectiveness of cognitive behavioural interventions (Hoffman et al., 2012). In comparison, less emphasis has been given historically on exploring the views and perspectives on, and the acceptability of, these psychological treatments (Harper & Thompson, 2011). However, in recent years there has been an increase in research focusing on the journey and recovery of those receiving therapy. This is important not only to better understand and amplify service user perspectives and experiences, but also to consider implications for practice to better support recipients of CBT. One such example, Barnes et al. (2013) explored the experiences of people who discontinued CBT. Inside sessions, several barriers were identified including participants feeling that the cause of their low mood was not being directly addressed, difficulties relating to the therapist, and how the therapeutic process itself was painful. Homework was identified as a major difficulty outside of sessions which participants found distressing both practically and emotionally. A qualitative meta-synthesis by McPherson et al. (2020) explored experiences of therapy for depression. Several areas for improvement were identified, such as the importance of users being more involved in the therapeutic process, including the individualisation of therapy. However, this study did not have a focus on any one type of therapy. Similar findings were identified in earlier study by Knowles et al.

(2014), in which it was concluded that computerised therapy could be improved through personalisation of its content to better support individual users.

Given that people experiencing depression and/or anxiety may not respond to treatment or can relapse following treatment (David et al., 2018), it is urgent to determine the positive and negative aspects associated with the delivery of CBT from a service user perspective. By doing so, we will be able to identify and overcome barriers towards effective treatment and facilitate long-term positive outcomes. Increased service user satisfaction could also lead to better treatment uptake and acceptability, which will ultimately contribute to higher treatment success rates. Furthermore, a better understanding of service users' needs may invoke discussions amongst mental health practitioners about best practice in the delivery of CBT. The primary objective of this review was to synthesise the existing qualitative evidence base of users' experiences of clinician delivered one-to-one CBT for anxiety and/or depression. Qualitative data were explored to generate themes regarding service users' views and thoughts of receiving CBT to manage symptoms of depression and/or anxiety with an aim to improve treatment effectiveness and acceptability.

Methods

Protocol and registration

This study was registered with PROSPERO (International prospective register of systematic reviews; crd.york.ac.uk/prospero/), registration number: CRD42021259012) and reported in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines (Page et al., 2021). Ethical approval was not required for this study as there was no direct participant contact. The meta-synthesis involved the use of data derived from published studies for which ethical approval had already been obtained by the relevant authors.

Inclusion and exclusion criteria

This review explored data on the reports of lived experiences of people who had received CBT to treat anxiety, depression, and/or both. The studies included had to be qualitative or mixed-methods, including questionnaire, interview, and case study designs; published in peer-reviewed journals; and focusing on the experiences of adult service users/patients/participants who had taken part in synchronous clinician led second-wave CBT interventions for anxiety and/or depression. Second-wave CBT is typically focussed on presenting problems,

utilising behavioural strategies to reduce symptoms and address ‘dysfunctional beliefs’, whereas third-wave therapies use such strategies to target meta-cognitive processes, with more of an emphasis on mindfulness and acceptance techniques (Brown et al., 2011). Studies which used purely quantitative methodologies; studies focusing on digital delivery (e.g. mental health apps); or on other evidence-based psychological treatments outside of second-wave CBT were not included. Articles not written in English also were excluded. Full inclusion and exclusion criteria are presented in Online Resource 1.

Search strategies and screening

Searches were conducted in June 2021. A combination of terms was used in the searches based on the SPIDER framework as follows: *S*ample size, *P*henomenon of *I*nterest, *D*esign, *E*valuation, and *R*esearch type (Cooke et al., 2012). No timeline restrictions were given as part of the search strategy. The search strategy is available in Online Resource 2. The databases searched were: PsycInfo, SCOPUS, Web of Science, Medline, and Embase. Detailed database searches are provided in Online Resource 3. Systematic review software Rayyan (Ouzzani et al., 2016) was used for screening. Two reviewers (BY & JT) completed each stage of screening independently and any disagreements were resolved through discussion. Studies were screened at several levels: i) title and abstract, ii) methodology, iii) full-text. Additionally, a reference list screening was conducted of the full text articles to identify relevant studies which might have been missed in the initial database searches.

Reliability and assessment

Quality of the studies was assessed using the Mixed Methods Appraisal Tool (MMAT) which is based on the following five questions (Hong et al, 2018): i) Is the approach appropriate to the research question?; ii) Are the data collection methods adequate to address the research question?; iii) Are the findings adequately derived from the data?; iv) Is the interpretation of results sufficiently substantiated by data?; and v) Is there coherence between data sources, collection, analysis, and interpretation? Quality appraisal was performed by two reviewers (BY & JT) independently, there were no disagreements on scoring. No study included in the meta-synthesis scored lower than a four out of five using this scale. Scoring of the MMAT is included in the study characteristic table as shown in Online Resource 4.

Synthesis

The included studies were thematically analysed using an essentialist and inductive method of reflexive thematic analysis as detailed by Braun and Clarke (2006). Data that were included in the thematic analysis were derived from narrative description by the authors and direct quotes from participants.

Ten of the overall 14 studies related exclusively to CBT for anxiety and/or depression or provided a distinct identifiable set of themes for services users' CBT experiences. The remaining four studies did not identify whether their overarching themes were CBT-specific or exclusive to the experiences of service users with anxiety or depression. However, only article text which specifically referenced CBT for anxiety or depression was included in the synthesis.

Articles were read through fully twice for familiarisation prior to manual coding which was completed through highlighting and colour-coding all relevant data. All relevant researcher interpretations were coded relating to experiences, perceptions, and impact of CBT, other data were not included. Codes were collated and gathered into tables assigned to initial themes. Following this, theme refinement and generation of sub-themes were completed. Synthesis was completed independently by the first author.

Results

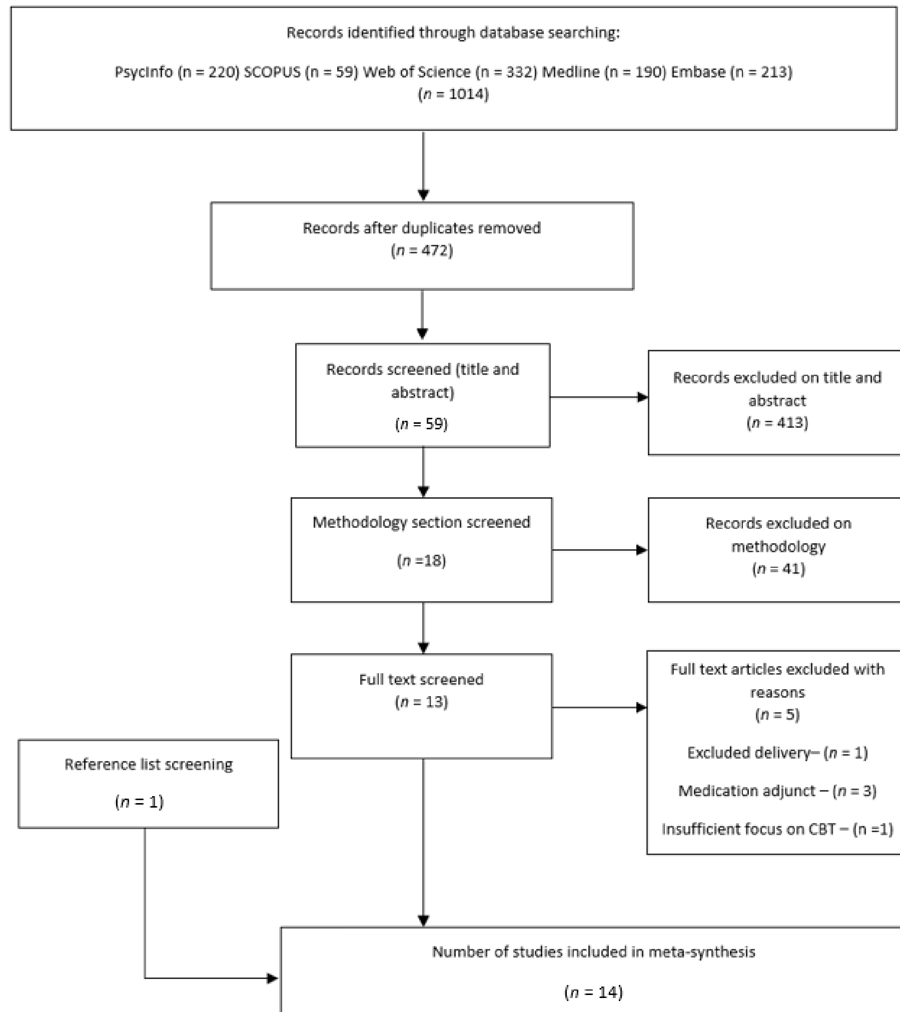
Overall,1014 studies were retrieved from database searches. Following duplicate removal, 478 papers remained. Title and abstract screening then resulted in 59 papers, which were then included in a methods screening. Following methods screening, 18 papers were included in full text screening. Thirteen papers progressed to final inclusion in the study, and their reference lists were screened for any additional relevant papers. One additional paper met the inclusion criteria. Fourteen papers met the full eligibility criteria and were included in the analysis.

Study characteristics

Ten (71%) of the 14 studies took a purely qualitative approach, while four (29%) used mixed methods. Only qualitative components were included in analysis. Ten (71%) studies focused solely on depression, three (21%) studies focused on both anxiety and depression, and one study (7%) on anxiety. Six studies (43%) were completed in the UK, three (21%) in Belgium, whereas Sweden, Switzerland, Norway, Denmark, and Canada contributed one study (7%) each. Publication dates of studies ranged from 2004 to 2021. Detailed characteristics of the studies are included in the supplementary appendix.

Figure 1

Prisma diagram showing screening process



Main meta-syntheses

Four main themes emerged from participants' experiences across the studies. These themes included: 1) the therapeutic alliance, 2) gaining insight 3) barriers to recovery, and 4) life after CBT. Three of the four main themes contain multiple sub-themes which are discussed alongside illustrative quotes.

<u>Therapeutic alliance</u>

The importance of the therapeutic relationship between clients and clinician was mentioned in all but one of the included studies and was discussed as the key ingredient for a positive and effective therapeutic experience. The sub-themes that emerged were associated with rapport-related factors which facilitated therapy and better

enabled participants to engage with the intervention. These factors were: 1) not being judged, 2) having trust, and 3) being understood.

Not being judged

Studies highlighted the perception from participants that a non-judgemental and accepting therapist was beneficial to the therapeutic process. In fact, an 'unbiased, non-judgemental' therapist was noted as being the most important part of both therapy in Finning et al. (2017) qualitative exploration of participant experience of CBT and behavioural activation (BA). As well as 'open, non-judgemental discussions' being considered the most helpful aspects of therapist-client interaction (Haller et al., 2019). Participants' experiences relating to 'not being judged' were presented as a facilitative factor towards a successful participant/therapist interaction and intervention, and 'being judged' was a barrier towards successful engagement.

"I simply felt comfortable and felt like I was being in safe hands in terms of having the feeling that I can open up, without it getting to anyone or that someone would make fun of it or … No, not at all, I felt comfortable and was able to open up. I always had the feeling that I could tell whatever I want and that she [the therapist] absorbs it, embraces it and reacts to it." (Haller et al, 2019).

Participants feeling able to share and 'let it all hang (out)' (Pert et al, 2013) with non-judgemental therapist allowed them to 'speak openly and show their true self' (De Smet et al, 2020b) without fear of being made fun of or perceived as 'stupid' (Westra, Aviram, Barnes, & Angus; 2011).

Having trust

Many participants reflected upon their time in therapy and noted that they trusted their therapist. Trust was an "an essential catalyst" (Malkomsen et al, 2021) for the therapeutic process, providing participants with the safety to open up, as well as drawing on the memory of a trusted therapist to guide self-maintenance after therapy (Glasman, Finlay, & Brock, 2004).

"I do think, 'If I was sitting with Clifford [therapist], what would he say to me?' and I try to think of it that way because I ended up having a great deal of trust in this guy () and I thought, 'What would he say, if he was in this situation', and I would try to put myself into his situation. This may sound strange, I talk to myself as if I am him and thinking, 'how would he do this" (Glasman et al., 2004).

Trust was developed in several ways for participants. For example, Socratic questioning allowed a participant the safety to open up when the therapist asked questions which showed they were 'genuinely interested' in them (Malkomsen et al., 2021). The option of privacy and confidentiality was valued, as well as mentions of body language, tone of voice, and 'chemistry' being factors which facilitated the development of a trusting therapeutic environment.

''It was rewarding just being in there and speaking to someone who I barely know but I trust his recommendations, just by being comfortable.'' (Westra et al., 2011).

Being understood

The concept of feeling seen and understood by another person was valued highly by participants. This seemingly reduced both feelings of isolation and the perception of oneself as abnormal. Having a therapist that accepted participants allowed them to view themselves in a "less pathologizing way" (Redhead et al., 2015).

"I love it. I love talking to another adult. It's somebody that understands how you feel. Because for all my family talk to me, but they don't talk to me in the way I want them to talk to me." (Pert et al., 2013).

Feeling understood in a therapeutic context was reported in several ways, indicating that there are many ways that the fostering of an understanding and accepting environment can be cultivated. For example, a participant in Straarup & Poulsen (2015) described being understood from the simple act of the therapist listening actively. An accurate formulation helped participants in Redhead et al. (2015) to feel understood, while in depth questioning led to a perceived understanding in Malkomsen et al. (2021).

Gaining insight

Many participants reported that CBT was a process of self-discovery that helped them to better understand themselves and their difficulties. This was reported in 12 of the 14 studies. Insight appeared to not only improve facets of participants' lives following the intervention but contributed to recovery during treatment. With an improved understanding of their mental health difficulties, and often factors which contributed to its development and maintenance, participants were better equipped to manage these difficulties. This was described by one participant (Straarup & Poulsen, 2015) as 'essential.'

"I wasn't really aware I had these thoughts, until in therapy I started to be able to identify all this stuff...I was surprised by how many thoughts I had." (Gega et al., 2013).

Cognitive restructuring, in the form of challenging negative thoughts and self-beliefs, was evident as an effective and employed CBT skill in participants. Often this work involved the therapist directly challenging preconceptions and thoughts, which was helpful to 'realise certain aspects of themselves they had been unaware of' (De Smet et al., 2020b). For example, when sharing beliefs of being a bad mother due to struggling to get her children to brush their teeth:

"They just didn't listen. Then she (the therapist) asked "Do you read for them at night? Do you feed them? Do you help them with their homework? Do you tell them you love them?" And I answered yes to all those questions. (. . .) Then I started thinking about all the things I actually managed." (Malkomsen et al., 2021).

Two studies (Kahlon et al., 2014, and Redhead et al., 2015) focused on experiences of a CBT formulation. This was generally considered by participants as a powerful and positive process towards the development of insight and was described Kahlon et al. (2014) as 'a journey of making a new sense of themselves.' All participants in both studies expressed a changed perception or greater understanding of their difficulties due to formulation. The quality of formulation also appeared to be connected to the collaborative nature of the process. When formulation was perceived to be less collaborative, this was seen as less accurate, which resulted in a poorer understanding of participants' own difficulties. This again highlights the importance of a good therapeutic alliance, particularly being heard and understood.

"To eventually feel 'Oh my goodness I'm ok, I'm normal', it's hard to describe the feeling. I suppose it's like running a marathon...you eventually get to the finishing line, and all that pain can stop." (Redhead et al.2015).

Barriers to recovery

There were several identified barriers that prevented participants from either engaging fully with therapy or things that limited their progress in therapy. Participants' barriers to accessing and engaging with CBT were experienced and discussed by participants across seven of the included papers. This theme included two sub-themes; 1) a lack of depth and time; and 2) the demands and difficulties of CBT.

Lack of depth and time

Seven studies highlighted perceptions from participants that the CBT intervention they received was beneficial in their personal development and recovery, but often lacked sufficient focus or intensity to get to the root of certain issues. In two studies, DeSmet et al., (2019) and DeSmet et al., (2020b) therapy was perceived as 'superficial,' only focussing on the present and not considering the whole person.

"The first three to four sessions, you tell your whole life story and all that is said about it is just okay, 'you suffer most from the discussions [at home/with your partner] so let's see how we can handle them.' While I thought okay, I just told you my entire life story, about who I am and how I became who I am, that could have been included in therapy, but I actually felt that it wasn't at all, we just looked at one segment." (De Smet et al., 2019).

Overall, participants who voiced such perceptions deemed CBT as 'not going deep enough to enable the adequate handling of feelings' (Gottberg et al., 2016) and often failing to 'get to the root' of their issues (Redhead et al., 2015).

Duration-related concerns were also a common barrier experienced by participants across the studies. Some participants simply felt the length of the intervention did not suffice to 'solidify the therapeutic effect' (Haller et al., 2019) and was too short to reach treatment goals. For example, one participant stated:

''It's 43 years of here I am and it's hard to undo it all in eight weeks" (Westra et al., 2010).

Haller et al. (2019) highlighted how some service users believed the therapeutic process ended too abruptly. These participants had more favourable views of a tapered end to therapy or even additional sessions. Similar sentiments were noted in other studies, with participants feeling a need to continue the intervention, and expressing that they wanted to continue treatment (DeSmet, 2020a) and didn't want to stop seeing the therapist (Pert et al., 2013).

CBT is demanding and difficult

"It was too much pressure coming here because I always had to bring something to talk about. It almost felt like a job I had to prepare for" (Malkomsen et al., 2021).

For many participants, partaking in CBT was described as hard work and this theme was identified in seven studies to varying degrees. Participants felt that CBT was a process which 'demanded constant effort' (Gottberg et al., 2016) and was both mentally challenging and time-consuming. For many recipients of therapy, fully engaging with CBT was not feasible to fit into their lives. A lack of time to engage with tasks, and managing concentrating in and attending sessions due to life circumstances such as raising small children and work was

difficult for participants. Even depression itself was identified as a motivational barrier to engage with the significant workload of the therapy.

''I understand that the CBT need lots of homework and maybe because of my health situation I was not able to always do the homework as it should have been done'' (Westra et al., 2011)

The high demands and 'difficult process' of CBT may also impact participants of therapy negatively. For example, one participant (Malkomsen et al., 2021) found that upon struggling to complete homework, they became distressed, which led to feelings of insecurity. Gottberg et al. (2016) also reported participants speaking of 'frustration, discomfort, and anger' at the beginning of therapy. While a positive and collaborative environment may negate some of these feelings, CBT is seemingly a therapy which many participants find challenging and draining.

Life after CBT

Longer term positive results were mentioned in all but one paper. While CBT was not always seen positively by participants, direct quotes and text showed that it had contributed significantly to mental health recovery, the gaining of skills, and positive improvements in many other areas of life. Two sub-themes of positive long-term impacts of CBT were identified, 1) improved mood, and 2) gaining confidence.

Improved mood

Many participants noted that their emotions were manageable, and their positive mood had increased following CBT. Most studies aimed to support participants with low mood, and there were several mentions of participants feeling calmer, less despondent, and enjoying life more, in addition to negative emotions being felt less intensely. One study (Gottberg et al, 2016) reported improvement in anxiety symptoms.

"Now I don't feel so full of despair as I used to be. Sort of, oh it's like taming the beast, really… it's given me the tools to get through day-to-day life and be more aware of moods and what effect they have on me and how to change that mood." (Finning et al, 2017)

CBT helped participants recognise triggers. In Finning et al. (2017), this led to a better understanding of the 'consequences of their response to triggers,' including more control over feelings and being able to choose different behavioural responses. Participants in Glasman et al. (2004) and Gottberg et al. (2016) noted similar

changes, in which low mood was still present, but acceptance of the depression and the development of coping skills reduced its intensity.

Gaining confidence

The concept of gaining confidence and the development of self-belief was a positive secondary outcome of participation in CBT. Participants were less self-critical, and less afraid to try new things, both physical and social. A newfound confidence had resulted in improvements in other areas of life such as assertiveness and learning to 'stand up for themselves rather than adapting to other people' (Straarup & Poulsen, 2015). This was noted in areas such as success at work. For example:

"I really claimed my spot, I'm now a worthy member of the team. If something needs to be done, I now dare to ask someone else to do it" (De Smet et al., 2020a).

In the qualitative exploration of the continued use of CBT skills following cessation of treatment for depression by Glasman et al. (2004), no participants claimed to be 'cured' by CBT. However, it was acknowledged that there were observable changes in self-confidence attributed to the therapy. This increased self-confidence was also reported and expanded upon in Finning et al. (2017) in which participants could blame themselves less when things went wrong, had more self-belief, and reduced feelings of worthlessness. CBT can seemingly support the development of self-belief, confidence, and assertiveness, even when that is not the focus of the intervention.

"It's given me a different way of looking at things and I suppose that's the way of believing in things, I have more belief in myself, that has helped a lot." (Finning et al, 2017).

Discussion

Summary of main findings

This systematic review and meta-synthesis explored the available qualitative literature in relation to perceptions and lived experiences of adults who had participated in CBT for anxiety and depression. Recipients reported a wide range of perceptions and experiences of their time in therapy, with four overarching themes amongst the included studies. There were noted barriers towards engagement and recovery in CBT. The first being the

demands and level of difficulty. Another noted barrier was the fact that the interventions were not long enough and the sessions did not explore symptoms of depression/anxiety in enough depth which could prevent long-term change as the root causes of these symptoms were not addressed. However, CBT was well-received and helped participants tackle mood related difficulties and develop confidence and insight. A good therapist seemed to play a significant part in its effectiveness and acceptability.

It is apparent from exploring participant perceptions and experiences that CBT is a therapeutic medium which asks a lot of its participants. The therapy requires participants not only to attend sessions, but to complete between-session tasks in addition to engaging in ongoing self-maintenance which continues past the end of therapy. Despite its apparent difficulty and demands, recipients of therapy are often described as 'not engaging,' but less often is therapy considered as "not working" for the service user. There are many factors which can impact on how much energy, time, and resources a service user can dedicate to completing CBT. Participants struggled to complete the work of CBT due to health and socioeconomic factors. These included issues such as ill-health, living conditions, having small children, working, and the presence of depression itself, which was a motivational barrier to engagement (DeSmet et al., 2020b; Finning et al., 2017; Glasman et al., 2004; Gottberg et al., 2016; Westra et al., 2010). CBT could potentially be more effective if such factors were taken into consideration resulting in a therapy that is tailored to the individual instead of 'one size fits all' – an established criticism of the therapy (Gaudiano, 2008). Allowing participants to engage fully at a pace that is challenging enough to drive progress toward recovery, but without being so demanding that participants disengage or develop feelings of guilt that they are 'underperforming' could potentially improve the experience and outcome of CBT. This could be addressed by increasing treatment length to allow for more sessions. CBT is typically conceptualised as a short-term intervention (Kaczkurkin & Foa, 2015). However, this status-quo is something that was noted by participants as a perceived barrier towards recovery in CBT. In the sub-theme 'lack of time and depth', participants felt like they would benefit from further therapy to better address their difficulties. Participants felt limited by the pre-determined intervention length which was often perceived as too short and the treatment was judged to be superficial (DeSmet et al., 2019; DeSmet et al., 2020a; DeSmet et al., 2020b; Gottberg et al., 2016; Haller et al., 2019; Westra et al., 2010). Findings of the synthesis support the individualisation of therapy length based on recipient needs to include longer-term interventions for those who would benefit therapeutically from longer-term psychological input. This indicates the need to review current practice of CBT in which it is typically only offered as a brief intervention and often with outcomes assessed

through measures of symptom reduction rather than user defined preferred outcomes across the UK, Europe, and the US (McPherson et al., 2020).

The therapist service user alliance was perceived as highly important, if not the most important factor in therapy by participants. This indicates an ongoing need to provide clinician led therapy despite the growing trend towards lower-intensity interventions such as guided self-help and CBT apps which have little or no therapist involvement. However, the mere presence of a clinician is not the most important factor. Having a non-judgemental therapist (DeSmet et al., 2020b; Finning et al., 2017; Gega et al., 2013; Haller et al., 2019; Pert et al., 2013; Westra et al., 2010), being able to trust the therapist (Glasman et al., 2004; Gottberg et al., 2016; Malkomsen et al., 2021; Pert et al., 2013; Westra et al., 2010) and being understood by the therapist (DeSmet et al., 2019; Malkomsen et al., 2021; Pert et al., 2013; Redhead et al., 2015; Straarup & Poulsen, 2015) were all mentioned frequently by participants when recollecting what was important to them in a clinician and helped to facilitate recovery. These findings support previous research in the area, such as the study of Littauer et al. (2005) where 'being accepting' and 'understanding' were vital therapist qualities. Currently, there is a gap in the literature on service users' beliefs and preferences on beneficial therapist traits and approaches. This is an area which needs further and more up-to-date research. Positive therapeutic alliances, and potentially better therapeutic outcomes, can be developed through a better understanding of what qualities are valued by therapy recipients. This knowledge can allow for opportunities for clinicians to reflect upon how these qualities are demonstrated in their practice. Finally, the importance to service users of a positive therapeutic alliance reinforces the potential importance of longer interventions. Strengthening of the therapeutic alliance can develop over time (Stiles & Goldsmith, 2010), and shorter, time-constrained interventions may inhibit this opportunity for development.

Participants reported a reduction in feelings of low mood (DeSmet et al., 2019; DeSmet et al., 2020a; Finning et al., 2017; Gega et al., 2013; Glasman et al., 2004; Gottberg et al., 2016), increased stability of mood (DeSmet et al., 2020a, Finning et al., 2017; Gottberg et al., 2016), and reduced anxiety (Gottberg et al., 2016). However, secondary positive outcomes were identified in two additional areas: the development of insight into oneself, and increased confidence. Insight was considered a crucial part of recovery from mental health conditions (Buchman-Wildbaum et al., 2020) and the development of insight was a powerful mechanism of change as part of the therapeutic process. An increase of confidence was a strong theme throughout the review (DeSmet et al, 2020a; Finning et al, 2017; Glasman et al., 2004; Gottberg et al, 2016; Kahlon et al., 2014; Straarup & Poulsen, 2015), not just in terms of mental health, but across multiple areas of participants' lives such as being open to

trying new things, and a newfound assertiveness in their careers. CBT is seemingly not just beneficial in terms of reducing symptoms of worry and low mood but can be an important part of self-discovery and improvement in different areas which in turn seemed to improve mood.

Strengths and weaknesses

To the best of our knowledge, this is the first systematic meta-synthesis of adults' experiences of CBT for anxiety and depression and fills an important research gap. Transparent and reproducible methods were used for the review; all screening stages were documented in detail. Two researchers independently screened papers for inclusion in the review to avoid systematic errors and mistakes, which is an international standard (Waffenschmidt et al., 2019). Furthermore, the authors excluded papers in which interventions were delivered by non-qualified persons. This controlled for the quality of CBT intervention experienced by recipients across studies.

There are, however, several limitations. There was a lack of appropriate papers exploring service user experiences particularly when compared with quantitative papers. Additionally, a high majority of the papers included were related to depression. Ten had a sole focus on depression, three had a focus on both anxiety and depression, and one focused only on anxiety. There was significantly less available research relating to anxiety as represented by the number of relevant papers included in this review. To enhance the quality of future analysis, further qualitative research in the area would be beneficial. Particularly in the area of recipient experiences of CBT for anxiety, as this was underrepresented in the data obtained for the synthesis.

When reading the studies, there was a notable lack of information in most papers relating to the specifics of participants and interventions. These included vague descriptions of therapist qualifications, a lack of demographic information for participants, and limited description of the intervention content and length. These are things which are frequently reported in quantitative research but are perhaps overlooked in this context. Reporting of information relating to the interventions would strengthen the synthesis and should be considered for more consistent inclusion in qualitative studies.

Literature searches were completed in English, and any studies retrieved which were written in another language were excluded due to the lack of language capabilities of the authors. Additionally, while there were several countries represented in the study, the papers included were conducted in high-income countries, and

predominantly European perspective of CBT experiences, with the exception of one study which was conducted in Canada. There is an absence of data in the review from other parts of the world. Interestingly, no research included in the systematic review originated from the USA. While reviewing literature in the area, there is a significant presence of American quantitative research relating to CBT, but a considerable lack of qualitative research. A lack of data from other countries may also have further limited the scope of the review in terms of number of appropriate studies included. The quality of future analysis would be enhanced by further qualitative exploration of CBT experiences in non-Western countries.

Conclusion

This review supports the delivery of in-depth clinician-led CBT for anxiety and depression. A non-judgemental, trustworthy, and understanding clinician appears to be highly significant to the recovery process. CBT being not in-depth or long enough and being too demanding were considerable barriers to engagement with therapy. This supports the provision of therapy which is not limited to a pre-determined number of sessions, but rather a natural stopping point of therapy upon reaching recovery goals. This may allow service users to reach goals without the pressure of the need to make progress in a time limited setting. Overall, despite its perceived flaws, CBT was mostly well-received and facilitated positive changes relating to mood, confidence, and self-discovery, with a proficient therapist playing a significant part in the recovery process. Future research should focus on greater exploration of participant experiences of CBT, and more consideration should be given to the inclusion of qualitative evaluations of therapy.

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