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REVIEW ARTICLE

Barriers and facilitators to engagement in psychological therapy in first episode psychosis: A meta-ethnography and qualitative comparative analysis

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Abstract

Objectives: Disengagement from psychological therapies in first-episode psychosis (FEP) is a common occurrence, with personal costs associated with untreated problems. This study aimed to establish the barriers and facilitators of people experiencing FEP to engagement in psychological therapies by undertaking a meta-ethnography and Qualitative Comparative Analysis (QCA) of existing qualitative literature.

Methods: A systematic search was conducted in multiple databases including Psychinfo, Ovid Medline, Web of Science, EthOs, OPENgrey and Procrest in July 2021 (updated in July 2024). The search identified 6966 titles and 71 full texts that were reviewed for eligibility. Twenty-three studies were found to meet eligibility and were critically appraised. Data was systematically extracted and synthesized in a meta-ethnography and QCA.

Results: Seven themes were identified as barriers to engagement in psychological therapy (Ambivalence to therapy, Emotional distress, Fluctuating symptoms, Negative expectations, Physical capacity, Service limitations and Therapy preference unmet) and six themes were identified as facilitators (Destigmatizing, Accessibility of digital therapy, Positive expectations of therapy are met, Service factors, Therapists interpersonal approach and skills and Therapy preferences met). The QCA identified a model with the

Therapists interpersonal approach and skills, as sufficient (i.e. whenever that condition is present, the outcome is also guaranteed to be present) for engagement in psychological therapy, while Emotional distress was a sufficient barrier to engagement.

Conclusions: Engagement is a multifaceted construct with many factors unique to an individual's experience, impacted by emotional, social, practical and service-level factors. Strengths, limitations and recommendations of the findings are discussed.

KEYWORDS

barriers, early intervention, facilitators, first-episode psychosis, qualitative, themes

BACKGROUND

Early Intervention in Psychosis services (EIS) offer comprehensive multidisciplinary care to those who are experiencing or at risk of developing their first-episode psychosis (FEP). Early intervention and engagement in treatment for FEP has been shown to be crucial for long-term outcomes, as prolonged durations of untreated psychosis (DUP) are associated with a worse prognosis, high levels of relapse, inpatient admission and comorbid physical health conditions (Albert & Weibell, 2019; Birchwood et al., 1998; Fusar-Poli et al., 2017).

The National Institute for Health and Care Excellence (NICE; (National Institute of Clinical Excellence, 2014)) guidelines for managing FEP recommend a comprehensive and holistic approach to early intervention that integrates both medical and psychosocial interventions to support recovery. Structural barriers within mental health services can delay access to early intervention teams and poor co-ordination with primary care can result in the misattribution of symptoms (Causier et al., 2024; Skrobinska et al., 2024). As such, long waiting times and complex pathways to care can deter individuals from seeking help or lead to disengagement. Once in contact with EIS, service design that does not prioritize the development of supportive relationships, shared decision-making and flexibility acts as a further barrier (Causier et al., 2024).

Cognitive Behaviour Therapy for Psychosis (CBTp) and family intervention for psychosis (FIp) are recommended first-line psychological treatments, shown to reduce symptoms, improve treatment adherence, prevent relapse and enhance outcomes (Camacho-Gomez & Castellvi, 2020; González-Ortega et al., 2021). Third-wave CBT (Ellett & Kingston, 2020; Wood et al., 2015), group therapy (Chung et al., 2013) and digital therapy interventions (Alvarez-Jimenez et al., 2021; Valentine et al., 2020) have demonstrated effectiveness but are not yet recommended for psychosis. Rates of implementation for psychological interventions for people experiencing FEP are below recommended levels, with substantial inequalities in provisions depending on location (Ince et al., 2016). People experiencing FEP have been highlighted as a group at risk of non-engagement (Dixon et al., 2016). Although there is considerable variation across studies, some research has found that 50% of young people with FEP disengaged from mental health teams at least once during their treatment (Brown et al., 2019) and across studies, on average, 15% (range: 1%–41%) dropped out of EIS within the first 1 to 2 years of treatment (Robson & Greenwood, 2022). Disengagement from treatment has been found to disrupt recovery (Kreyenbuhl et al., 2009), and early engagement is crucial for positive long-term outcomes (Birchwood et al., 1998). Implementation rates of NICE-recommended psychological interventions in EIP services ranged from 0% to 53%, showing significant gaps in timely psychological support (Bucci et al., 2016). Given the limited provisions for psychological therapy (Ince et al., 2016), and evidence that delays in accessing

treatment impact negatively on individuals (Marshall et al., 2005), it is important to understand the factors which influence engagement in therapy.

Therapeutic engagement is multifaceted, encompassing initial uptake of therapy, sustained attendance, the strength of therapeutic engagement and the working alliance (MacBeth et al., 2013; Robson & Greenwood, 2022). It has been associated to sociodemographic, clinical and service-level variables which are often poorly conceptualized in the literature (O'Brien et al., 2009; O'Driscoll et al., 2019). Disengagement has been robustly predicted by substance misuse (affecting the ability to engage), medication non-adherence (a lack of willingness to engage) and low symptom severity (no perceived need) (Robson & Greenwood, 2022) and also includes DUP, negative symptoms, insight, forensic history, family support, stigma, shame and functional impairment (Berry & Haddock, 2008; Conus et al., 2010; O'Driscoll et al., 2021; Turner et al., 2007). However, a strong therapeutic relationship and core CBTp principles like genuineness, empathy and collaboration can help overcome these barriers (Evans-Jones et al., 2009; Jung et al., 2015; Wood et al., 2015).

Qualitative methodologies provide rich, detailed, first-person accounts (Bucci et al., 2018; Fitzsimmons 2019). While these provide in-depth understanding, they limit broader conclusions and generalisability (Noble & Smith, 2015). Additionally, small-scale research projects often remain unpublished, leaving valuable service user perspectives undistributed. This necessitates the synthesis of existing literature for more robust conclusions. Previous systematic reviews on FEP service engagement have identified influential factors including help-seeking experiences, therapeutic relationships, caregiver support, substance misuse and organizational factors (Doyle et al., 2014; Ince et al., 2016; Tindall et al., 2018). Though valuable, these syntheses focus on engagement with entire health care teams rather than psychological interventions specifically.

This review explores engagement with psychological therapy as a distinct phenomenon. Using meta-ethnography, we synthesized qualitative studies to gain new insights into service users' experiences (Sattar et al., 2021). We also employed Qualitative Comparative Analysis (QCA) to identify necessary and sufficient factors for therapy engagement, examining combinations of conditions that lead to this outcome (Oana et al., 2021). The aim was to identify the barriers and facilitators that influence engagement in psychological therapies among individuals experiencing FEP and determine which factors most impact service user engagement.

MATERIALS AND METHODS

Design

A systematic review and meta-ethnography were undertaken to synthesize qualitative research on the barriers and facilitators of engagement in psychological therapy in FEP. Meta-ethnography was selected as the synthesis method as it is particularly suited to developing new interpretations and conceptual understandings from qualitative studies while preserving the context and meaning of the primary studies' findings. This approach allows us to systematically compare and contrast themes across studies to develop a deeper understanding of barriers and facilitators to engagement in psychological therapy. The meta-ethnography was pre-registered on Prospero (ID: CRD42021228573) following PRIMSA (Moher et al., 2009) and eMERGe guidance (France et al., 2019). Data collected from this meta-ethnography was used for the QCA and analysed using QCApro (Thiem, 2017) in R (R Core Team, 2021).

Eligibility criteria

Studies met inclusion criteria if they were qualitative empirical studies (interviews, focus groups or surveys with qualitative components) examining engagement in psychological therapies during FEP. Engagement encompassed treatment acceptance, therapeutic rapport and collaborative goal-setting during early therapy stages (MacBeth et al., 2013). Eligible psychological therapies included individual,

digital and group formats involving the formulation, psychoeducation and distress-reduction strategies (Morrison & Barratt, 2010), delivered by accredited practitioners. FEP was defined as the first psychotic episode within 3 years.

Exclusion criteria: Studies of participants with chronic serious mental illness or those exclusively involving mental health professionals/family members.

Information sources and search strategies

Initial searches were conducted across 13 databases in July 2021: PsychINFO, OvidMEDLINE, OvidEMCARE, OvidEMBASE, Web of Science, Procrest, EThOS, OATD, OpenDOAR OPENGrey, BASE, Library Hub Discover and WorldCat. Follow-up searches in July 2024 excluded EThOS (cyber-attack outage), OPENGrey (closed 2021), OpenDOAR (under construction) and BASE (redundant with OATD for theses). Full search strategy details are available in Tables S1–S6 and Data S1.

Selection process

In July 2021 one reviewer (L.F.) conducted an initial screening of the study titles and abstracts to identify studies for a full-text review. C.O. reviewed 30% of the full-text studies against the inclusion criteria ($k = .92$), and any discrepancies were resolved through discussion. In the July 2024 updated search, two reviewers (L.L. and L.N.) independently screened 50% of the titles, abstracts and full texts retrieved, with 20% being cross-checked for inter-rater reliability ($k = 0.98$). Discrepancies were resolved via discussion with LW. Citation searching of included studies was conducted to try and identify any additional publications for inclusion.

Synthesis methods and data analysis

Study characteristics were extracted, based on the JBI Qualitative Data Extraction Tool (Aromataris & Munn, 2024). This included information on study aims, engagement in psychological therapy aims, intervention modality, setting, geographical location, participant recruitment information (number of, gender, age and where available ethnicity), data collection and data analysis methods.

Meta-ethnography data

Data synthesis followed meta-ethnography phases (Noble & Smith, 2015). We extracted FEP service users' descriptions of psychological therapy engagement, including service user quotes (first-order data) and authors' concepts (second-order data) (see Tables S1–S6 and Data S1). L.F. coded data into concepts using NVivo (Ltd QSRIP, n.d.), sharing theme structures and coded examples with L.W. and C.O. Data translation involved grouping codes by engagement type (barrier/facilitator) and intervention format (individual/group/digital). Third-order themes were generated to interpret code units. Due to commonalities, intervention types were combined to enable a comprehensive comparison. Researchers refined themes through reciprocal analysis. LN and LL applied the same analytical process to papers from the updated search.

Qualitative comparative analysis (QCA) data

Themes from the meta-ethnography review were entered into the QCA following established guidance (Oana et al., 2021; Rihoux & Ragin, 2009). QCA is a systematic method that bridges qualitative and

quantitative approaches, identifying combinations of conditions that lead to a specific outcome, in this case, engagement in psychological therapy. QCA identifies conditions impacting the investigated phenomenon, seeking the shortest expression of condition combinations sufficient and necessary for engagement. Meta-ethnography data was translated from qualitative to quantitative by counting theme references in each study and calibrating scores. Two types of calibration were used: crisp sets, which treat conditions as either fully present or absent and fuzzy sets, which allow for partial membership showing degrees of membership (four data points: 0, 0.33, 0.67, 1.0) (Oana et al., 2021). See Data S1 for a detailed QCA process.

Set theory analysis modelled 'if… then' hypotheses to identify 'necessary' (a condition that must be present for an event to occur, but it does not guarantee the occurrence of the event), and 'sufficient' (a condition which guarantees the occurrence of the event) conditions (Bjornestad et al., 2018; Lucksted et al., 2015) for FEP therapy engagement. The QCA followed six stages (Programme cas, 2023): data table completion, truth table construction (all possible combinations), resolving any contradictory findings, simplifying the combinations through boolean algebra, considering cases with missing data and interpretation. The minimum threshold for condition consideration was two studies. Both fuzzy and crisp analyses were conducted, prioritizing fuzzy sets for their ability to capture nuanced concepts.

Reporting bias assessment

The CASP Qualitative Research Checklist (Programme cas, 2023) was used to assess study quality. LF completed assessments using CASP guidance prompts, consulting CO and LW to resolve dilemmas. LN and LL assessed additional studies from the updated search.

Reflexivity

Reflexivity requires researchers to examine how their own role and the research process considering their assumptions, experiences and personal characteristics throughout the review. The team comprised four females (one Asian, one Asian-White British, two White-British) and one White-Irish male, all with clinical or research experience in FEP (ranging from 1 to 15 years). Regular team meetings involved explicit discussions of how our varied clinical backgrounds shaped our interpretation of engagement barriers and facilitators. We particularly noted how our professional roles as therapists might lead us to emphasize therapeutic relationship factors, and actively worked to remain open to alternative interpretations.

RESULTS

Search results

A total of $n = 6966$ results were identified (inclusive of the updated search) via the predefined databases and additional searching (published papers from identified eligible protocols/ thesis'). $N = 71$ full-text records were assessed for eligibility, with $n = 48$ being screened as ineligible, leaving $n = 23$ studies included. See Figure 1 for more details.

Ineligible studies

Of the $n = 48$ ineligible studies, there were $n = 53$ instances of ineligibility recorded, as some studies were ineligible due to multiple reasons. With most instances being due to studies not meeting the criteria of FEP ($n = 18$ instances; 34%) or not meeting the criteria of psychological therapy ($n = 17$ instances; 32%).

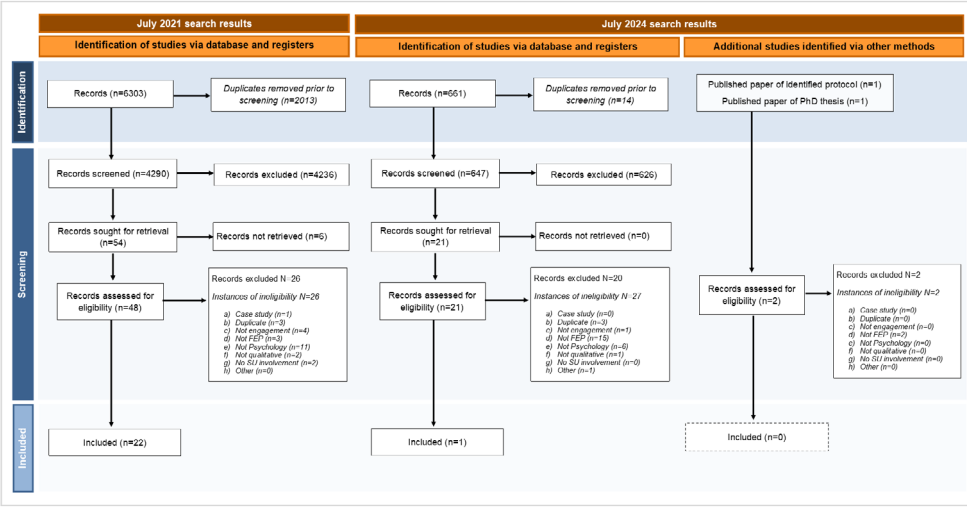

FIGURE 1 PRISMA flow chart. Key: FEP, first-episode psychosis; SU, service user.

Critical appraisal of studies

Using the CASP tool (Programme cas, 2023) to assess study quality, all studies demonstrated clear aims and research value, with eight scoring appropriately across all domains. The remaining 15 had unclear elements in methodology, design, recruitment, data collection, user-researcher relationships, ethics, analysis or findings. The user-researcher relationship domain showed the most uncertainty ($n = 9$). Studies scored 56%–100% appropriately across domains, averaging 80%. No studies were excluded based on quality. Full CASP findings are in Table 1.

Description of included studies

Study characteristics are outlined in Table 2. The included studies were published between 2007 and 2022 with 95% ($n = 22$) being published in 2012 or later, and 52% ($n = 12$) being published in 2018 or later. The majority ($N = 6$; 26%) of included studies were published in 2020.

Participant demographics

The sample ($n = 330$) included 140 males (42.4%), 186 females (56.4%) and 4 transgender individuals (1.2%), aged 14–65 years. Only 10 studies reported employment, housing and education data, while 13 studies provided ethnicity data for 209 participants. Inconsistent reporting and conflation of ethnicity with nationality prevented comprehensive demographic analysis. Complete ethnicity data is available in Tables S1–S6.

Intervention modality

Of the included studies, interventions were delivered via group settings ($n = 3$, including peer and family interventions), digital means ($n = 4$) and individual therapy ($n = 16$). Some interventions combined individual therapy with other approaches like family intervention, common in UK EIP services. Table 2

TABLE 1 Critical appraisal of included studies (Key: ●Yes? Can't tell/unclear).

Study	Clear research aims?	Qualitative methodology appropriate?	Research design appropriate?	Recruitment strategy appropriate?	Data collection appropriate?	Service user-researcher relationship?	Ethical issues considered?	Data analysis sufficient?	Clear statement of findings?	How valuable is the research?
Arnold et al. (2020)	●	●	●	●	●	●	?	●	●	Very
Artaud et al. (2020)	●	●	●	●	●	?	●	●	●	Very
Bjornestad et al. (2018)	●	●	●	●	●	?	●	●	●	Very
Fitzsimmons, (2019)	●	●	●	●	●	●	●	●	●	Very
Bucci et al. (2018)	●	●	●	●	●	●	●	●	●	Very
Byrne and Morrison (2014)	●	●	●	●	●	?	●	●	●	Very
Cardario et al. (2012)	●	●	?	?	●	●	●	●	●	Very
Cowan et al. (2020)	●	●	●	●	●	●	●	●	●	Very
Cowdrey et al. (2018)	●	●	?	?	●	?	●	●	?	Very
Harris et al. (2012)	●	●	●	●	●	●	●	●	●	Very
Islam et al. (2015)	●	●	●	●	●	?	●	●	●	Very
Jansen et al. (2015)	●	●	●	?	●	?	●	●	●	Very
Kilbride et al. (2013)	●	●	●	●	?	●	?	●	●	Very
Lucksted et al. (2015)	●	●	●	●	●	●	●	●	●	Very
Mankiewicz et al. (2018)	●	●	●	?	●	●	●	●	●	Very
Newton et al. (2007)	●	●	●	●	●	●	●	●	●	Very
Nilsen et al. (2014)	●	●	?	●	●	●	●	●	●	Very
Sidis et al. (2020)	●	●	●	●	●	?	●	●	●	Very
Stewart (2013)	●	●	●	●	●	●	●	●	●	Very
Tindall et al. (2020)	●	●	●	●	●	●	●	●	●	Very
Valentine et al. (2020)	●	●	?	●	●	●	●	●	●	Very
Valentine et al. (2020)	●	?	●	●	●	?	?	?	●	Very
Schalkwyk et al. (2015)	●	●	●	●	●	?	●	●	●	Very

TABLE 2 Summary of Included Studies.

Author (year)	Aims	EIT aim	Intervention modality (type)	Setting	Location (city/locality)	SU number and (F/M/T)	Age (mean)	Ethnicity	Data collection method	Data analysis method
Arnold et al. (2020)	To explore what influenced SUs engagement with a web-based intervention for psychosis.	Yes	Digital (self-help)	SMART	Australia	17 (F = 11, M = 6)	18–65	Not reported	Semi-structured interviews	Thematic analysis
Artaud et al. (2020)	To explore why individuals with early psychosis accept or refuse treatment.	No	Individual/Individual + group (unclear: 'psychotherapy')	Specialized clinic	Canada (Montreal)	18 (F = 5, M = 13)	21–37 (26.8)	Not reported	Semi-structured interviews	Grounded theory
Bjornestad et al. (2018)	To explore SUs perceptions of the working ingredients of psychotherapy after psychosis.	No	Individual (CBT or modern relational psychodynamic frameworks)	FEP program	Norway (Rogaland)	20 (F = 10, M = 10)	17–58 (25.8)	Norwegian ($n = 20$)	Semi-structured interviews	IPA with thematic analysis
Fitzsimmons (2019)	To investigate disengagement within an EIP service from the perspective of SUs and staff.	Yes	Individual/Individual + group (CBTp/FIp)	EIP	UK (north-west)	12 (F = 3, M = 9)	19–38	White British ($n = 7$), British Asian ($n = 1$), Black African ($n = 1$)	Semi-structured interviews	Framework analysis approach
Bucci et al. (2018)	To explore early psychosis service users' subjective views on DHI.	No	Digital (self-help)	EIP	UK (north-west)	21 (F = 11, M = 10)	16–34 (26)	Not reported	Semi-structured interviews	Framework analysis approach
Byrne and Morrison (2014)	To explore service users' experiences of 'enhanced monitoring' and CBT.	No	Individual (CBTp)	EDIE	UK (Manchester)	10 (F = 4, M = 6)	14–35 (27.5)	White British ($n = 9$), Black British ($n = 1$)	Semi-structured interviews	Thematic analysis
Cadario et al. (2012)	To examine the experience of adolescences and their caregivers in FEP and accessing effective treatment.	No	Individual/Individual + group (unclear: 'therapy')	CAMHS	New Zealand (Auckland)	12 (F = 5, M = 7)	15–18 (24.9)	NZ European ($n = 7$), NZ Maori ($n = 4$), NZ Maori/Cook Island Maori ($n = 1$)	Semi-structured interviews	General inductive approach
Cowan et al. (2020)	To explore how SUs define their engagement with a specialized early intervention program.	No	Individual/Individual + group (unclear: 'therapy')	EIP	Montreal, Canada	24 (F = 6, M = 16, T = 2)	17–34 (22.67)	Person of colour ($n = 13$), White ($n = 9$), unknown ($n = 2$)	Semi-structured interviews	Thematic analysis
Cowdrey et al. (2018)	To investigate health care professionals' and SUs attitudes towards treatment options.	No	Individual/Individual + group (CBT)	EIP	UK (inner city)	7 (F = 2, M = 5)	22–39 (26.1)	Not reported	Survey	Thematic analysis
Harris et al. (2012)	To explore SUs experiences of EIP, its impact of their psychosis and current life situation.	No	Individual/Individual + group (peer group, unclear)	EIP	UK	8 (F = 3, M = 5)	21–37	White British ($n = 5$), White and Asian ($n = 2$), White and Caribbean ($n = 1$)	Semi-structured interviews	IPA

(Continues)

TABLE 2 (Continued)

Author (year)	Aims	EIT aim	Intervention modality (type)	Setting	Location (city/ locality)	SU number and (F/M/T)	Age (mean)	Ethnicity	Data collection method	Data analysis method
Islam et al. (2015)	To examines the cultural appropriateness, accessibility, and acceptability of the EIP.	No	Individual/Individual + group (counselling/ psychotherapy)	EIP	UK (Birmingham)	21 (F = 11, M = 11)	18–35 (22)	Asian/Asian British Pakistan (n = 9), Asian/ Asian British Bengal (n = 1), Black/Black British African (n = 3), Black/ Black British Caribbean (n = 8), other (n = 1)	Focus groups	Thematic approach and framework analysis
Jansen et al. (2015)	To describe SUs perspectives on helpful aspects in their pathway to care.	No	Individual/Individual + group (unclear)	Specialized clinic	Denmark (Zealand)	11 (F = 5, M = 6)	15–24 (20)	Danish (n = 11)	Semi-structured interviews	Thematic analysis
Kilbride et al. (2013)	To explore SUs experiences of Cognitive Behavioural Therapy for psychosis.	No	Individual (CBTp)	EIP / CMHT	UK (Greater Manchester)	9 (F = 5, M = 4)	21–65 (26)	White British (n = 8) Black British (n = 1)	Semi-structured interview.	IPA
Lucksted et al. (2015)	To assess factors that facilitated or impeded clients' engagement in RAISE services.	No	Individual/Individual + group (counselling)	RAISE	USA (Baltimore, New York)	32 (F = 11, M = 21)	15–35	African American (n = 16) Asian/Pacific Islander (n = 1) White, Caucasian (n = 10), Other (n = 5)	Semi-structured interviews	Thematic analysis
Mankiewicz et al. (2018)	To explore expectations and experiences of receiving CBTp among EIP clients with FEP.	Yes	Individual (CBTp)	EIP	UK (London)	9 (F = 4, M = 5)	17–33 (24.9)	Not reported	Semi-structured interviews	Thematic analysis
Newton et al. (2007)	To explore the experience of group-CBT for young people experiencing distressing auditory hallucinations.	No	Group (CBT group)	Voice hearing group	UK (London)	8 (F = 5, M = 3)	17–18	Not reported	Semi-structured interviews	IPA
Nilsen et al. (2014)	SUs and family members' experiences of psychoeducational family intervention.	No	Group (psychoeducational family intervention)	3x Hospitals	Norway (South-East)	12 (F = 7, M = 5)	19–38 (26.8)	White/Caucasian (n = 9), Asian (n = 3)	Semi-structured interviews	Systematic text condensation
Sidis et al. (2020)	The experiences and perspectives of clinicians, SUs and families, following training in Open Dialogue.	No	Group (open dialogue–network-based therapy)	CAMHS, inpatient	Australia (New South Wales)	2 (F = 1, M = 1)	19–21 (20)	Not reported	Semi-structured interviews	IPA

TABLE 2 (Continued)

Author (year)	Aims	EIT aim	Intervention modality (type)	Setting	Location (city/locality)	SU number and (F/M/T)	Age (mean)	Ethnicity	Data collection method	Data analysis method
Stewart (2013)	To describe SUs experience of successful engagement in the initial stages of treatment.	No	Individual/Individual + group (peer group, unclear)	EPP	Australia (Eastern City)	30 (F = 15, M = 15)	18–20	Born in Hong Kong, Greece, Spain, Fij (n = 4). First-born Australians from Italy, Turkey, Scotland, Philippines, Serbia, Germany, Malta, India (n = 21), English (n = 5)	Semi-structured interviews	Grounded theory
Tindall et al. (2020)	To understand what causes and maintains periods of disengagement from EIP.	No	Individual/Individual + group (unclear 'therapy' and 'group')	EIP	Australia (Melbourne)	9 (F = 3, M = 6)	15–24 (18.4)	Australian (n = 4), Australian/British (n = 3), Asian (n = 1), North American (n = 1)	Semi-structured interviews	Trajectory analysis
Valentine et al. (2020)	To explore how young people experience, a social media–based mental health intervention for social functioning.	Yes	Digital (social media-based intervention)	Early Psychosis Centre	Australia (Melbourne)	12 (F = 7, M = 4, T = 1)	19–28 (23)	Not reported	Semi-structured interviews	IPA
Valentine et al. (2020)	To understand young people's experience of a long-term online digital social intervention for FEP.	Yes	Digital (social media-based intervention/moderated online therapy)	Early Psychosis Centre	Australia (Melbourne)	12 (F = 7, M = 4, T = 1)	19–28 (23)	Not reported	Semi-structured interviews	IPA
Schalkwyk et al. (2015)	To collect service users' narratives of their early treatment experience.	No	Individual/Individual + group (unclear 'talking therapy' and peer group)	STEP	USA, Connecticut	11 (F = 1, M = 10)	20–35	Not reported	Semi-structured interviews	Thematic analysis

Abbreviations: CAMHS, Children and adolescent mental health service; CBTp, Cognitive behavioural therapy for psychosis; CMHT, Community mental health team; DHI, digital health intervention; EDIE, early detection and intervention evaluation; EIT, Engagement in psychological therapy; EPP, Early psychosis program; F, female; FIp, family intervention for psychosis; IPA, Interpretive Phenomenological Analysis; M, male; N, Number; NZ, New Zealand; RAISE, Recovery After an Initial Schizophrenia Episode; SMART, Self-Management and Recovery Technology; STEP, Specialized Treatment Early in Psychosis; SU, Service users; T, transgender.

categorizes these as 'individual' or 'individual + group.' Studies primarily focused on individual therapy are labelled as 'individual therapy' in subsequent analysis.

Setting/service

The studies were conducted in specialist adult/children's FEP services, primarily in the UK ($n = 9$) and Australia ($n = 6$), with additional sites in Canada ($n = 2$), Norway ($n = 2$), USA ($n = 2$), New Zealand ($n = 1$) and Denmark ($n = 1$).

Data collection and analysis

Most studies used semi-structured interviews, except (Cowdrey et al., 2018) (surveys) and (Islam et al., 2015) (focus groups). Thematic analysis ($n = 8$) and Interpretive Phenomenological Analyses (IPA) ($n = 6$) were predominant, followed by grounded theory ($n = 2$), IPA with thematic analysis ($n = 2$), framework analysis ($n = 2$) and single instances of general inductive, systematic text condensation and trajectory analysis.

META-ETHNOGRAPHY: THEME SUMMARY

Overall, 13 themes were identified as part of the meta-ethnography (see Figure 2). The synthesis involved concurrent analysis of both first-order constructs (participant quotes) and second-order constructs (author interpretations) to develop comprehensive themes that captured both participant experiences and researcher interpretations of engagement barriers and facilitators. These themes and the subsequent 48 subthemes are explored further in the following sections of the paper. Example quotes for each subtheme are provided in tables in the Tables S1–S6.

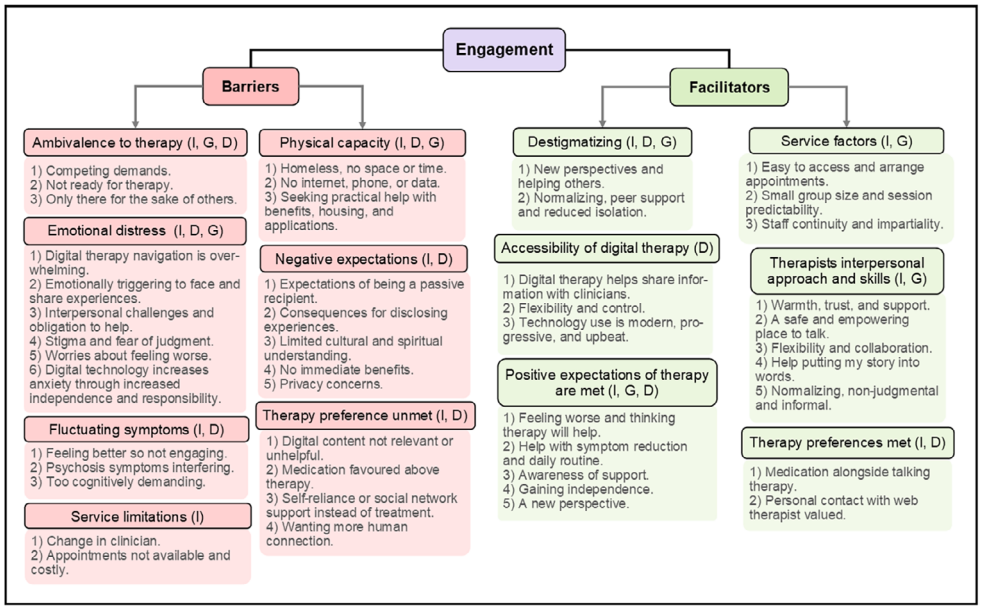

FIGURE 2 Summary of themes and subthemes. Key: D, digital therapy; G, group therapy; I, individual therapy.

BARRIERS

Seven themes were identified as barriers to engagement in psychological therapy: (1) Ambivalence to therapy, (2) Emotional distress, (3) Fluctuating symptoms, (4) Negative expectations, (5) Physical capacity, (6) Service limitations and (7) Therapy preference unmet. These themes encompassed 26 subthemes, each supported by multiple studies (see Table 3). Complete first- and second-order data and illustrative quotes are available in Tables S1–S6.

Ambivalence to therapy

Six studies found that service users showed ambivalence towards engagement due to multiple factors including unfamiliar concepts, stigma and uncertainty of therapy. The findings were categorized into three subthemes. The first theme (1) *Competing demands* outlined how therapy involved giving up personal time that would otherwise be spent undertaking personal activities, which was sometimes reluctantly given. The second theme (2) *Not being ready for therapy* reflected how participants were not ready to talk about their personal experiences and therefore therapy was not a beneficial space at that point in time. Some service users also described alternative explanations for their experiences and reported being 'in denial' of their difficulties. The third theme (3) *Only there for the sake of others* highlighted how service users only attended therapy for their family's/other people's reassurance rather than for their own benefit. There was a sense that individuals will only fully experience the benefits of engaging in the therapeutic process when doing so for themselves, rather than out of obligation to others.

Emotional distress

Twelve studies highlighted service users' descriptions of emotional distress. The results were further contextualized into six subthemes. The first theme (1) *Digital therapy navigation* is overwhelming and reflects how service users felt emotionally overwhelmed using the digital therapy platform and found it effortful to navigate. Theme two (2) *Emotionally triggering to face and share experiences* outlines how the experience of starting therapy was reported to be one of anxiety and hesitation, finding therapy initially challenging as it forced them to confront their difficulties. The third theme (3) *Interpersonal challenges and obligation to help* highlights how anxiety was experienced due to conflict within the family or peer group during therapy. Service users highlighted how listening to the experience of others was described as emotionally difficult. The fourth theme (4) *Stigma and fear of judgement* focused on shame being triggered by others' judgements about service users' diagnosis, impacting their willingness to open up in individual sessions. Service users were also found to hold stigmatized views about therapy, that is, therapy as a weakness. For digital therapy, the use of forums and messaging created pressure to respond, with embarrassment at the thought of no one replying. The fifth theme (5) *Worries about feeling worse* identified how service users feared that therapy could worsen their symptoms or that discussing their psychosis might trigger a recurrence. The final sixth theme looked at (6) *Digital technology increases anxiety through increased independence and responsibility* and related to the perceived need for independence in digital therapy, compared to face-to-face sessions, leading to rumination and anxiety, which hindered engagement.

Fluctuating symptoms

Nine studies described how fluctuating symptoms and the changeable nature of symptoms of psychosis. Findings were divided into three subthemes. The first theme (1) *Feeling better so not engaging* found that improvements in well-being and feelings of self-sufficiency were factors in disengagement from individual

TABLE 3 Summary of the studies that barrier and facilitator themes were derived from.

	Arnold et al. (2020)	Artaud et al. (2020)	Bjornestad et al. (2018)	Fitzsimmons, (2019)	Bucci et al. (2018)	Byrne & Morrison, 2014	Cadario et al. (2012)	Cowan et al., 2020	Cowdrey et al. (2018)	Harris et al. (2012)	Islam et al. (2015)	Jansen et al. (2015)
Barrier												
Ambivalence to therapy	·	✓	·	·	·	·	·	✓	·	·	·	·
Emotional Distress	✓	·	·	✓	✓	✓	·	✓	·	✓	·	·
Fluctuating symptoms	✓	·	·	·	·	·	·	✓	·	·	✓	·
Negative expectations	·	·	·	·	✓	·	·	✓	·	·	✓	·
Physical capacity	✓	·	·	✓	✓	·	·	·	·	·	·	·
Service Limitations	·	·	·	·	·	·	·	·	·	·	·	✓
Therapy preference unmet	✓	·	·	·	✓	·	·	·	✓	✓	·	·
Facilitators												
Destigmatizing	✓	·	·	·	✓	✓	·	·	·	·	·	·
Accessibility of digital therapy	✓	·	·	·	✓	·	·	·	·	·	·	·
Positive expectations of therapy are met	·	·	✓	·	·	·	·	✓	·	✓	✓	·
Service factors	·	·	·	·	·	✓	·	·	·	·	·	·
Therapists interpersonal approach and skills	·	·	✓	·	·	✓	·	·	·	·	·	·
Therapy preferences met	✓	·	·	·	·	✓	✓	✓	✓	·	·	·

therapy, with some service users feeling they had gained what they needed, such as socialization from group therapy. The second theme (2) *Psychosis symptoms interfering* focused on how negative symptoms and paranoid thoughts impacted engaging with digital therapy. Hearing voices also posed an additional challenge in individual therapy, both during and after sessions, with some finding it worsened by discussing their voices. The third theme (3) *Too cognitively demanding* highlighted how therapy was often seen as cognitively demanding, with noted participant concentration difficulties and self-guided online therapy being considered burdensome due to the decision-making required and the overwhelming number of choices.

Negative expectations

Eight studies highlighted service users' negative expectations of therapy. Results were divided into five subthemes. The first theme (1) *Expectations of being a passive recipient* looked at how service users assumed therapy would be more passive or less work for them as a patient, that is, finding CBT more demanding than expected. The second theme (2) *Consequences for disclosing experiences* related to service users believing that they would be detained or sectioned for disclosing their experiences. Family tension could also deter engagement, whereby families were not supportive of their relatives accessing mental health support, and in one instance resulted in family members arguing with staff, embarrassing the service user and making them question their ongoing engagement. The third theme (3) *Limited cultural and spiritual understanding* outlined service users describing that their beliefs would not be understood, that is, professionals would not understand their perspective on health, illness or traditional remedies. The fourth theme (4) *No immediate benefits* indicated that some service users expressed hopelessness about longer term improvement when no immediate benefits or only small benefits of therapy were found. The fifth and final theme (5) *Privacy concerns* found that some service users were uncomfortable with their digital entries being shared with their team, leading them to filter the information they provided. This hesitation stemmed from being unready to share personal details and not wanting to worry the therapist that the treatment was not working.

Kilbride et al. (2013)	Lucksted et al. (2015)	Mankiewicz et al. (2018)	Newton et al. (2007)	Nilsen et al. (2014)	Sidis et al. (2020)	Stewart (2013)	Tindall et al. (2020)	Valentine et al. (2020)	Valentine et al. (2020)	Schalkwyk et al. (2015)	Total (*N* =)
✓	✓	·	·	✓	·	·	·	·	✓	·	6
✓	·	✓	·	✓	✓	·	·	✓	✓	·	12
✓	✓	✓	·	✓	·	·	·	✓	✓	·	9
✓	✓	✓	·	✓	·	·	✓	·	·	·	8
·	·	·	·	✓	·	·	✓	·	·	·	5
·	·	·	·	·	·	·	✓	·	·	·	2
·	✓	✓	·	·	·	·	·	✓	✓	·	8
·	✓	✓	✓	✓	✓	✓	·	✓	✓	·	11
·	·	·	·	·	·	·	·	✓	✓	·	4
·	✓	✓	·	·	✓	·	·	·	✓	·	8
·	✓	✓	·	✓	·	·	✓	·	·	✓	6
✓	✓	✓	✓	✓	✓	✓	·	·	·	✓	10
·	·	·	·	·	·	·	·	·	·	·	5

Physical capacity

Five studies highlighted physical capacity as a challenge for service users. This was divided into three subthemes. The first theme (1) *Homeless, no space or time* was identified as some service users found it challenging to spend time on the digital therapy website, due to an absence of time, physical space or capacity. Similarly, group therapy was noted to be time demanding. The second theme (2) *No internet, phone or data* was derived from practical issues such as having limited phone data, an uncharged phone battery, lost or broken phones and not having access to the internet. The third theme (3) *Seeking practical help with benefits, housing and applications* highlighted how service users prioritized needs like housing, finances and employment over psychological therapy, and the unmet expectation of receiving practical support in sessions led to a breakdown in the therapeutic relationship and disengagement.

Service limitations

Two studies described service limitations. This theme comprises two subthemes. The first theme (1) *Change in clinician* was described as having a marked negative impact on engagement and was associated with a sense of loss of trust. The second theme (2) *Appointments not available and costly* identified that when service users returned to work or school, engagement in therapy became a secondary priority for some, which due to the service opening hour constraints, resulted in disengagement. Other service users did not have the financial availability for therapy and their parents declined to pay for this.

Therapy preference unmet

Eight studies described service as users having an unmet preference for the way in which they receive therapy. This theme consisted of four subthemes. The first theme (1) *Digital content not relevant or unhelpful* set out that, when it came to digital platforms/therapy, service users found the content repetitive, generic,

overly positive or aimed at a younger audience. The second theme (2) *Medication favoured above therapy* indicated that some service users favoured medication over other treatments, describing themselves as 'biased in favour of medication' (Cowdrey et al., 2018). The third theme (3) *Self-reliance or social network support instead of treatment* reflected how some service users emphasized agency and self-reliance over therapy, believing only they could resolve their issues. With others preferring to discuss their experiences with trusted family or friends, reducing their motivation to engage in online therapy, as this need was met elsewhere. Additionally, the fourth theme (4) *Wanting more human connection* proposed that some service users felt technology should be an aid, rather than a replacement, for individual therapy, as a result, digital therapy was felt to provide limited opportunities to connect and interact at an emotional and interpersonal level.

Facilitators

Six main themes were identified as facilitators of engagement, and they were: (1) Destigmatizing and connecting with peers, (2) Accessibility of digital therapy, (3) Positive expectations of therapy are met, (4) Service factors, (5) Therapists' interpersonal approach and skills and (6) Therapy preferences met. Each of which contains between two to five subthemes, with 22 subthemes overall. Each of the facilitator themes was derived from the syntheses of multiple studies, please see supplemental materials for the complete first- and second-order data sets.

Destigmatizing

Eleven studies were found to describe a connection with peers and a destigmatizing and normalizing element which emerged from interacting with other people who understand psychosis, or who have had similar difficulties. This theme was separated into 2 subthemes. The first subtheme (1) *New perspectives and helping others* explained that the sense of helping each other through learning and sharing of coping strategies was found by service users to be positive and beneficial. The second subtheme (2) *Normalizing, peer support and reduced isolation* indicated that psychological therapy was reported to be normalizing and facilitated the connection between service users and their peers through shared experiences.

Accessibility of digital therapy

This theme describes the benefits that service users reported from digital therapy, including aiding information sharing with their team, memory prompts and enhancing feelings of control. It consists of three subthemes. The first subtheme (1) *Digital therapy helps share information with clinicians* highlighted how service users described feeling more comfortable using digital therapy as opposed to attending face-to-face therapy, as it allowed them to be more honest and truthful. The second subtheme (2) *Flexibility and control* explained how the accessibility and flexibility of digital therapy helped overcome challenges to engagement in conventional therapy, such as social anxiety and sleep disturbance. It also empowered service users by allowing them to have control in tracking their own progress. The third subtheme (3) *Technology use is modern, progressive and upbeat* identified that digital therapy not only aligned with how the service users communicate, but also fostered a positive environment that aided their engagement.

Positive expectations of therapy are met

Eight studies were found to describe service users' expectations that therapy would be helpful for them. For some, their symptom severity motivated them to seek help, whereas others had previous positive experiences of therapy. Alongside this, experiencing early gains in therapy was found to facilitate

engagement. It was divided into four subthemes. The first subtheme (1) *Feeling worse and thinking therapy will help* was derived from service users' explanation that their concerns about symptoms worsening encouraged them to engage with therapy. They hoped to gain coping strategies from therapy that would improve their functioning. The second subtheme (2) *Help with symptom reduction and daily routine* highlighted that suggestions on how to manage daily structures, sleep habits and managing experiences such as voice hearing at night were often seen as useful and encouraged service users to engage in therapy. In the third subtheme (3) *Awareness of support* service users described becoming more aware of their social network and realizing that people close to them were trying to understand and help them. These experiences of emotional support could unburden service users from their thoughts and motivate them to engage in therapy. The fourth subtheme (4) *Gaining independence* explained how therapy was viewed as a meaningful component in the process of regaining independence and a place in society following an episode of psychosis. The fifth subtheme (5) *A new perspective* suggested that the expectation that therapy could allow service users to obtain an alternative perspective on their experiences aided engagement.

Service factors

Six studies were found to describe service factors including ease of access to appointments and staff consistency as facilitators of engagement. This was divided into three subthemes. The first subtheme (1) *Easy to access and arrange appointments* highlighted practical factors, including how easy it was to get to the appointments via public transport and how safe and pleasant the location was, which positively affected service users' engagement. For the second subtheme (2) *Small group size and session predictability*, service users reported that having a smaller group was noted as less anxiety provoking and having pre-agreed session length was highly valued. The third subtheme (3) *Staff continuity and impartiality* identified that service users found the impartiality of a professional allowed them to share experiences they had not shared with others. Staff continuity also deepened the therapeutic relationship over time.

Therapists' interpersonal approach and skills

Ten studies describe how the approach of the therapist and skills they had facilitated engagement, including their warmth, ability to listen, work collaboratively and foster positive relationships. This theme was comprised of five subthemes. The first subtheme (1) *Warmth, trust and support* identified that service users found therapists who had a warm, friendly and respectful style, alongside an unconditional acceptance and genuine desire to help allowed for a trusting relationship, which facilitated open and honest in-depth conversations. The second subtheme (2) *A safe and empowering place to talk* suggested how service users could speak about their experiences without fear of stigma when they were positioned as experts in their experiences. This humanistic, client-centred approach fostered a safe environment where they felt empowered, listened to and that their 'opinions were taken seriously. The third subtheme (3) *Flexibility and collaboration* described a collaborative partnership between the service user and therapist, where they have shared control was described as integral, especially in areas such as agenda setting. In the fourth subtheme (4) *Help putting my story into words* psychological therapy was described as a language-creating process to help putting difficult to express thoughts and emotions into words. The fifth subtheme (5) *Normalizing, non-judgmental and informal* explained that clinicians taking a non-judgmental stance and having an informal, normalizing approach enabled service users to feel that their clinician understood them, hence fostering a strong alliance.

Therapy preferences met

Several studies described participates expressing a preference for the way in which they received therapy. When this was facilitated, it was described as aiding engagement. This theme was comprised of two

subthemes. The first subtheme (1) *Medication alongside talking therapy* indicated that for some service users, medication was only viewed as beneficial alongside other psychological support. The second subtheme (2) *Personal contact with web therapist valued* suggested that having a connection with a web-based therapist facilitated engagement. For several service users, personal contact enabled fears surrounding information safety to be allayed through reassurance.

Qualitative comparative analysis (QCA) results

The complete data set showing the 23 papers set membership to each condition for barriers can be found in Tables S1–S6 and Data S1, where both crisp and fuzzy scores are included to indicate whether a particular paper had met the inclusion to that set (crisp) and to the extent to which it had met that inclusion (fuzzy). The current QCA had a consistency threshold of 0.75 (75% of studies with a given combination of conditions must display the outcome for that combination to be considered sufficient for the outcome to occur).

Barriers to engagement QCA results

The fuzzy set and crisp-set analyses identified 'emotional distress' as a sufficient condition for barriers to engagement, indicating that when emotional distress is present, disengagement is likely to occur. This was derived from five papers for fuzzy solution (Doyle et al., 2014; Evans-Jones et al., 2009; France et al., 2019; Moher et al., 2009; Turner et al., 2007) with a consistency value of 1 and coverage of 0.35, and four papers for the crisp (Evans-Jones et al., 2009; France et al., 2019; Islam et al., 2015; O'Driscoll et al., 2021) with a consistency value of 1 and coverage of 0.52.

Facilitators to engagement QCA results

The fuzzy set analysis identified 'Therapists' interpersonal approach and skills' as sufficient for the outcome, while the crisp-set analysis indicated that the combination of, 'Positive expectations of therapy are met', 'Therapy preferences met' and 'Therapists' interpersonal approach', together were sufficient for engagement in therapy.

The crisp minimization of barriers to engagement provided two models as solutions to facilitators to engagement. Model 1 included the conditions of 'Positive expectations of therapy are met' * 'Therapy preferences met' * 'Therapists' interpersonal approach and skills' with a consistency value of 0.94 and coverage of 0.77. Model 2 included the conditions of 'Positive expectations of therapy are met' * 'Therapy preferences met' * 'Destigmatizing' with a consistency value of 0.94 and coverage of 0.73. In this QCA there is model ambiguity, where there is more than one solution to a formula to succinctly summarize the information in the truth table (Oana et al., 2021). 'Therapists' interpersonal approach' had higher raw coverage (0.46) and unique coverage (9% of the outcome is explained uniquely by this path) than destigmatising (0.14 and 5%) and the fuzzy minimalization indicated 'Therapists' interpersonal approach', as such model 1 was preferred, however, both models are potential explanations.

DISCUSSION

The meta-ethnography confirms engagement as a complex phenomenon influenced by sociodemographic, clinical and service-level factors (MacBeth et al., 2013; O'Brien et al., 2009). Data from 23 studies were distilled into key themes. The findings suggest that emotional distress alone was enough to prevent people from engaging in therapy, while a therapist's interpersonal skills and approach were

crucial for facilitating engagement. The therapist's interpersonal skills and approach worked both as a standalone factor and in combination with other elements to promote engagement in psychological therapy for people with FEP.

The most relevant theme facilitating therapy engagement was Therapist interpersonal skills and approach, particularly warmth, genuineness, active listening and collaboration (Bjornestad et al., 2018; Lucksted et al., 2015). This aligns with existing findings on therapeutic relationships and CBTp principles (Evans-Jones et al., 2009; Jung et al., 2015; Wood et al., 2015). Evidence also supported an interaction between Positive expectations of therapy being met and Therapy preferences met with either Therapists' interpersonal approach and skills or Destigmatizing. Positive expectations of therapy being met form the foundation; when early sessions fulfil initial hopes, this fosters trust and motivation (Bjornestad et al., 2018; Cowan et al., 2020). Therapy preferences met may then reinforce engagement by enhancing client agency (Cowdrey et al., 2018; Stewart, 2013). The configuration is then solidified either through the therapists' interpersonal approach or through destigmatising experiences, where validation and normalization reduce shame and empower clients (Byrne & Morrison, 2014; Newton et al., 2007).

Emotional distress commonly occurs during psychological therapy in FEP, affecting service users' engagement and continuation (Kilbride et al., 2013). This distress arises from confronting and sharing experiences (Cowan et al., 2020). managing digital platforms (Arnold et al., 2020; Valentine et al., 2020), fear of judgement and stigma (Harris et al., 2012) and concerns about symptom worsening (Mankiewicz et al., 2018). Addressing these concerns and helping users manage distress is crucial. Low symptomatology has also been shown to be a predictor of disengagement, and for those who do engage, those with low symptomatology are less likely to engage well with services (Robson & Greenwood, 2022). The perceived need for psychological therapy needs to be carefully assessed and discussed with service users, with clinicians taking time to explore and validate emotional concerns while providing clear psychoeducation about the therapeutic process and its potential benefits. It may be beneficial to adapt the pace of engagement to suit individual needs (Tiller et al., 2023). Early positive changes in symptoms or functioning may help maintain engagement by offsetting negative feelings and demonstrating therapy's value (Bjornestad et al., 2018; Harris et al., 2012). Stigma has previously been identified in reviews as a barrier to engagement with EIS more broadly suggesting a need for more community-based mental health literacy adapted to address culturally shaped stigma (Skrobinska et al., 2024; Tiller et al., 2023). Utilization of peer support workers and befriending schemes in teams can improve engagement, and can positively affect stigma, knowledge and relationships (Proctor et al., 2019).

Service users varied in their therapy preferences. While some found clinician contact alongside digital therapy facilitated engagement, others felt this support was insufficient (Arnold et al., 2020). Service factors also had varying impacts: staff consistency and accessible locations enhanced engagement for some while staff changes and inconvenient appointment times hindered others (Tindall et al., 2020). Some users prioritized practical support with housing, benefits and paperwork over psychological interventions (Fitzsimmons, 2019). This suggests therapists should discuss potential barriers and support needs individually. Supported decision-making approaches, which empower individuals to seek help with the assistance of an associate may facilitate this (Causier et al., 2024).

Unmet therapeutic expectations created engagement challenges. Expectations of practical support, when unfulfilled, led to therapeutic rupture (Kilbride et al., 2013; Tindall et al., 2020). While fluctuating psychotic symptoms like low mood, paranoia and voice hearing affected engagement (Arnold et al., 2020; Kilbride et al., 2013; Turkington et al., 2006), the key barrier was not the symptoms themselves but rather the disconnect between service users' and professionals' understanding of these experiences (Cowan et al., 2020). These interventions often lack cultural adaptation (Islam et al., 2015), with minority service users frequently consulting faith/spiritual healers before seeking medical help, reflecting diverse explanatory models. While clinicians should incorporate religious and spiritual perspectives in therapy, many lack adequate cultural awareness training. Despite recent improvements in cross-cultural adaptation of psychological interventions

(Arundell et al., 2021), this remains an area needing development. Therapists must remain open to multiple frameworks for understanding psychosis throughout treatment.

The theme 'Ambivalence to therapy' reflected motivational challenges, with some rejecting their psychosis diagnosis despite others' views (Artaud et al., 2020; Cowan et al., 2020). Service users found their experiences too shameful to share with loved ones (Schalkwyk et al., 2015), aligning with literature on stigma and disempowerment as engagement barriers (Berry & Haddock, 2008). However, speaking with impartial professionals who have heard similar experiences may facilitate therapeutic engagement (Mankiewicz et al., 2018). Where parental relationships are both facilitators and barriers to accessing services (Tiller et al., 2023), involving families where possible early can improve outcomes and reduce disengagement (Skrobinska et al., 2024; Tiller et al., 2023).

Engagement has been found to be a dynamic construct that changes over time (MacBeth et al., 2013). Service users reported difficulty socializing after psychotic episodes, making group therapy initially helpful, but disengaging once their social confidence returned (Cowan et al., 2020). This demonstrates how engagement fluctuates based on changing needs, suggesting that the benefits of specific therapeutic approaches may vary over time. While this review examines barriers and facilitators to engagement broadly, engagement encompasses distinct but related concepts (Robson & Greenwood, 2022). These components, while related, may be influenced by different factors at different stages of therapy. Addressing the complex interplay of systemic, service-related and individual factors is crucial to improving engagement with early intervention services.

These findings underscore the individualized nature of experience, where personal circumstances affect therapy engagement depending on service accessibility, available resources, therapy modality and current experiences of emotional distress or psychotic symptoms. For some, psychological therapy was just one of multiple support needs and not always prioritized. When service accessibility aligned with users' needs, the therapeutic relationship was valued, with trust, warmth and normalization proving particularly engaging.

Strengths and limitations

To maximize data capture, a broad search was conducted, including unpublished worldwide studies without language restrictions. While most papers contributed to multiple themes, there was variation, from one (Jansen et al., 2015) to six (Bucci et al., 2018) themes, an inevitable consequence of broad inclusion criteria. The final sample was limited to English-language published research from high-income countries, despite efforts to achieve greater diversity.

A notable limitation is the paradox of studying therapy engagement in FEP: those who never engage with mental health services remain unrepresented. This particularly affects minoritized ethnic groups, especially black service users, who experience different EIS trajectories (O'Driscoll et al., 2021). Ethnicity documentation was inconsistent, appearing in only 14 studies with varying descriptive approaches.

During analysis, researchers' coding of first-hand data sometimes differed from the original authors' interpretations. For example, in (Schalkwyk et al., 2015), content categorized under 'an important relationship with a professional' was recorded as 'feeling listened to' under 'therapist interpersonal skills'. This approach enabled new theory generation but relied on available quotes selected by original researchers, highlighting the subjective nature of the analysis. As noted, meta-ethnographic synthesis reflects both the content and synthesizer perspective (Noblit & Hare, 1988).

The QCA complemented the meta-ethnography by identifying minimal combinations of conditions sufficient for therapy engagement. No necessary conditions were identified, suggesting multiple pathways to engagement exist (Jeffreys et al., 1999). While QCA has limitations, including arbitrary set inclusion criteria in crisp-set analysis (Vink & Vliet, 2009) and assumptions of error-free measurement (Hug, 2013), it moves beyond theme identification to examine how different factor combinations influence therapy engagement.

Recommendations and future research

Although this meta-ethnography uniquely focused on psychological therapy engagement, other FEP service engagement reviews found similar themes, particularly regarding therapeutic relationships (Tindall et al., 2018). This suggests some engagement factors may be common across mental health services, while others are specific to psychological therapy. Further longitudinal research is needed to explore how these factors influence engagement over time, as engagement may be dynamic for some service users. While this research did not examine interactions between barriers and facilitators, the literature suggests these factors are interconnected (Wood et al., 2015). For instance, a destigmatizing environment and strong therapist interpersonal skills may offset engagement barriers like emotional distress. Research should investigate whether such facilitators effectively counteract therapy-related distress. Future research could develop and validate screening tools for both service users and therapists based on the sufficient conditions identified in the QCA. Such tools could enable early identification of engagement risks and guide targeted interventions to enhance engagement.

Conclusion

The meta-ethnography revealed emotional distress as a key barrier to engagement while destigmatizing therapy and therapist interpersonal skills emerged as crucial facilitators. QCA proved valuable in complementing traditional methodologies to understand these complex interactions. Further research should explore both factor interactions in FEP therapy engagement, and the impact of digital modalities, given the increased reliance on digital modalities since the COVID-19 pandemic.

AUTHOR CONTRIBUTIONS

Leanne Fahy: Conceptualization; methodology; data curation; formal analysis; writing – original draft. **Linda Lee:** Writing – review and editing; formal analysis; data curation. **Liberty Newlove:** Data curation; formal analysis; writing – review and editing. **Lisa Wood:** Conceptualization; writing – review and editing; supervision. **Ciarán O'Driscoll:** Conceptualization; methodology; formal analysis; supervision; writing – review and editing.

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CONFLICT OF INTEREST STATEMENT

None declared.

DATA AVAILABILITY STATEMENT

Data openly available in a public repository: https://osf.io/e5p2a/.

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

Tables S1–S6.

Data S1.

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