

**RECOVERY AFTER PSYCHOSIS: A COMPASSION FOCUSED
RECOVERY APPROACH TO PSYCHOSIS IN A FORENSIC
MENTAL HEALTH SETTING.**

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CONTENTS PAGE

<u>Title</u>	<u>Page Number</u>
Acknowledgements	6
Abstract	8-9
Chapter One: Introduction	10-17
Chapter Two: A critical review of outcome in psychosis	
2.1 Introduction	18-23
2.2 Aim of review	23
2.3 Measurement of outcome	23-28
2.4 Methodology	28
2.5 Results	29-39
2.6 Conclusion and Discussion	39-45
Chapter Three: Recovery and Psychosis in Forensic Mental Health Settings	
3.1 Introduction	46-47
3.2 Recovery and Psychosis: Setting the scene and context to recovery	47-52
3.3 Recovery focused research and psychosis: What are the main aspects of recovery from psychosis?	52-53
3.4 What are the challenges to adopting a recovery focused approach in forensic mental health?	54-57
3.5 Fostering a recovery focused therapeutic environment	57-60
3.6 What is the evidence base for CBTp	60-66
3.7. CBTp in forensic settings	66-67
3.8 Summary and rationale of thesis	67-69
Chapter Four: A Grounded Theory study of the experiences of individuals with psychosis residing in high security.	
4.1 Introduction	70-72
4.2 Methodology	72-79
4.3 Findings	80-91
4.4 Discussion	92-96

Chapter Five: Self-esteem and psychosis: A pilot study investigating the effectiveness of a self-esteem programme on the self-esteem and positive symptomatology of mentally disordered offenders.

5.1 Introduction	97-98
5.2 Aims	98-99
5.3 Method	99-103
5.4 Results	103-104
5.5 Discussion	105-107

Chapter Six: Recovery After Psychosis (RAP): A Compassion focused programme for individuals residing in high security setting.

6.1 Introduction	108-111
6.2 Aims	111
6.3 Method	111-117
6.4 Results	118-120
6.5 Discussion	120-124

Chapter Seven: Discussion of Findings

7.1 General Discussion	125-132
7.2 Theoretical and clinical implications	132-139
7.3 Research Implications	139-140

Chapter Eight: References **141-166**

LIST OF TABLES AND FIGURES

Tables	Page
Table 2.1: First Episode Psychosis: Prospective Outcome Studies	29-33
Table 4.1: Demographic information of participants	74
Table 5.1: Self-esteem programme session content	102
Table 5.2: Change in assessment measures over course of treatment	104
Table 6.1: Recovery After Psychosis programme content	116-117
Table 6.2: Primary outcome measures: change in assessment measures Over the course of treatment	119
Table 6.3: Secondary outcome measures	120
Figures	
Figure 1.1: The Three Circles Diagram depicting the interaction Between three affect systems	16
Figure 4.1: Themes and Categories	79
Figure 6.1: “Pebble in the water”	115
Figure 7.1: Service delivery model of CFT	139

<u>APPENDICES</u>	<u>Page</u>
Appendix One: Ethical approval: Recovery After Psychosis	167
Appendix Two: Ethical approval: Qualitative study	168
Appendix Three: Ethical approval: Self-Esteem	170
Appendix Four: Clinician information leaflet: Qualitative study	171
Appendix Five: Participant consent form: Self-esteem and Psychosis	174
Appendix Six: Participant information leaflet: Self-esteem and Psychosis	176
Appendix Seven: RMO consent letter for Recovery After Psychosis	179
Appendix Eight: Participant Consent form Recovery After Psychosis	181
Appendix Nine: Recovery After Psychosis Protocol	184

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Heather Laithwaite, December 2009

The approach of a man's life out of the past is history, and the approach of time out of the future is mystery. Their meeting is the present, and it is consciousness, the only time life is alive. The endless wonder of this meeting is what causes the mind, in its inward liberty of a frozen morning, to turn back and question and remember. The world is full of places. Why is it that I am here?

Wendell Berry, The Long Legged House, 1969

*Can't see nothin' in front of me
Can't see nothin' coming up behind
I make my way through the darkness
I can't feel nothin' but this chain that binds me
Lost track of how far I've gone
How far I've gone, how high I've climbed
On my backs a sixty pound stone
On my shoulder a half mile line.*

The Rising, Bruce Springsteen, 2002

Abstract

Over the past fifty years, there has been significant improvement in the expected outcomes of individuals with psychosis, due to advances in psychotropic medication, and through the development and application of psychological approaches such as Cognitive Behavioural Therapy. Such improvements in outcome have been demonstrated through various outcome studies and meta-analyses of outcome studies. However, the recovery/consumer movement has criticised outcome studies on the basis that they focus on symptomatic outcome and do not incorporate into their studies measures of outcome as defined by individuals who experience psychosis.

The aim of this thesis was therefore to explore the experiences of individuals with psychosis in a forensic mental health setting. The objective was to develop recovery focused psychological interventions based on patients' experiences of what helped them to cope in hospital, and in essence, what they valued in their recovery.

The first study employed a social constructionist version of grounded theory methodology to explore the experiences of patients residing in a secure hospital. Thirteen individuals who had experience of psychosis were interviewed in depth about their experiences of recovery. Contrasting accounts of recovery were apparent from the way in which participants spoke about their experiences. Some participants gave rich and reflective accounts of their recovery. These participants spoke about the nature of their past experiences, the importance of those experiences in contextualising their problems and reflected on the implications of this on the tasks of recovery. In contrast, other participants' transcripts tended to be short and unelaborated. Recovery tasks seemed to be segregated from previous experiences and their reflection on their experience of psychosis seemed minimised. All participants spoke about the importance of developing their sense of self, and the importance of developing relationships with staff and with family. This study is presented in Chapter Four.

The findings of the grounded theory study led to the development of a self-esteem intervention. Research has shown that low self-esteem is common in individuals with psychosis (Bowins & Shugar, 1998; Silverstone, 1991), and that it is implicated in the development and maintenance of psychotic experiences such as delusions and auditory hallucinations (Garety et al., 2001; Smith et al., 2006). This intervention was based on a previous study carried out by Hall and Tarrier (2003), but adapted for delivery in a group setting in a secure hospital. Fifteen patients completed the self-esteem group intervention and significant improvements were found on self-esteem and depression. These improvements

were maintained over a three month-follow up period. This study is reported in detail in Chapter Five.

A recovery group was developed after this. The modules in this programme were developed from the themes of the grounded theory study and the observations made during the self-esteem programme. The recovery group was based on Compassion Focused Therapy (CFT, see below) and aimed to promote emotional recovery with the aim of improving self-soothing, coping with distress and the development of inner warmth. This programme was developed following observations that although individuals in the self-esteem group could challenge self-critical thoughts through the use of skills they had acquired in the group, they reported that they continued to feel negative and worthless about themselves. Compassion Focused Therapy (CFT) was developed by Gilbert and colleagues (Gilbert, 1992, 1997, 2000; Gilbert and Irons, 2005) for individuals with shame and self-critical and attacking thoughts. It is based on social mentality theory (Gilbert, 1989, 2001, 2005), which explains how people come to experience an internalised self-attacking narrative. This often develops as a result of trauma, abuse and loss and results in an individual experiencing shame and feeling a sense of threat. It also has implications for an individual's ability to cope with distress and to regulate affect. The purpose of CFT is therefore to help individuals move from a self-attacking style to one of self-soothing and compassion. It is anticipated that this style of self-relating will promote recovery and enable individuals to be less critical about themselves and their experiences and so, be able to seek help should they face relapse in the future. With this in mind, the Recovery After Psychosis (RAP) programme was piloted and eighteen individuals completed the group. Significant effects were found for depression, self-esteem and an improvement in sense of self compared to others. This study is discussed in Chapter Six.

The findings of the studies contained within this thesis are further discussed in Chapter seven. The findings are compared with previous studies on recovery, and also compared with other interventions employing compassion-focused approaches. The limitations of the research in this thesis are discussed. A model of compassion focused service delivery is described along with implications for future clinical practice and research.

CHAPTER ONE: INTRODUCTION

The concept of schizophrenia was originally termed “dementia praecox” by Emil Kraepelin (1919) who considered it to be a progressive and degenerative disorder. This pessimistic view of schizophrenia persisted into modern diagnostic systems. As recently as DSM-III (APA, 1980), the picture of the patient with schizophrenia was incredibly hopeless: “*A complete return to pre-morbid functioning is unusual – so rare, in fact, that some clinicians would question the diagnosis. However, there is always the possibility of full remission or recovery, although its frequency is unknown. The most common course is one of acute exacerbations with increasing residual impairment between episodes.*” (DSM-III, p.185). Similarly, the authors of DSM-IV cautioned about ‘*the unlikeness of afflicted individuals making a complete return to full functioning*’ (American Psychiatric Association, 1994, pp282). The impairments being described include flattened affect, persisting delusions and hallucinations, and increasing inability to carry out everyday functions such as work, social relationships, or basic self-care. Such notions regarding prognosis and hence potential for recovery have huge implications for concepts of aetiology and course and outcome. Furthermore, such notions might shape decisions about treatment, programme implementation, economic planning and social policy for mental health delivery systems (Harding, Brooks, Ashikaga, T, Strauss, & Brier, 1987). Liberman and Kopelowicz (2002a) and Liberman, Kopelowicz, Ventura and Gutkind (2002b) have also argued that such a pessimistic view regarding the prognosis of schizophrenia leads to stigmatisation, and consequently some patients denying the existence of their experiences and hence not accessing supports that they may require.

Over the past 50 years, there has been considerable improvement in the expected outcomes of individuals with psychosis (Ram, Bromet, Eaton, Pato & Schwartz, 1992; McGlashan, 1988; Hegarty, Ross, Baldessarini, Tohen, Waterman & Oepen, 1994; Menezes, Arenovich & Zipursky, 2006; Malla & Payne, 2005). Outcome has been influenced in the last fifty years by changes in diagnostic and therapeutic practice and improvements in research methodologies (Hegarty et al., 1994; British Psychological Society, 2000; Roth & Fonagy, 2006). Findings from retrospective and prospective studies with both chronic and first episode psychosis patients suggest that schizophrenia has a heterogeneous course, which can be favourably influenced by comprehensive and continuous treatment as well as personal factors such as family support (Liberman et al., 2002b). Therefore the original view of dementia praecox being a progressive and degenerative disorder as first outlined by Emil Kraepelin (1856-1926), has increasingly come under challenge by research that has shown that individuals with psychosis can and do recover (Harding et al., 1987; Ram et al., 1992; Menezes et al., 2006). However, despite improvements in methodologies, significant heterogeneity in

definitions and methodologies remain, resulting in limited comparison of studies (Menezes et al., 2006). This has led to an open debate over how recovery should be defined and hence operationalised (Lieberman et al., 2002). Most often, outcome is determined solely by the presence or absence of positive psychotic symptoms. As stated by Lieberman et al. (2002b), the problem of operationalising outcome as the presence or absence of positive symptoms, rather than the attainment of valued goals, or improvements in level of functioning, leads only to a partial view of the individual's recovery being considered. The outcome literature on psychosis and the debate surrounding this will be reviewed in Chapter two.

The consumer movement in the 1960s contributed to this debate. The application to the mental health setting came from the consumer/ survivor/ ex-patient movement in the United States during the 1980s and the early 1990s (Office of the Surgeon General and various United States Government agencies, 1999). From this movement, it became apparent that the concept of recovery was often defined differently between consumers/ survivors and professionals. The recovery literature emphasises that recovery is a process that the individual experiences, whereby they are an active agent in the appraisal and development of their own personal attitudes, values, goals and skills; the review of which contributes to the development of a satisfying and hopeful life with or without symptoms, and being able to live alongside psychosis (Bradstreet & Connor, 2005; Roberts & Wolfson, 2004). Central to this recovery journey is the empowerment of the individual and the sense they have of being a director over their own health and wellbeing (Davidson, 2003). Recent recovery research and systematic reviews of such research have highlighted the importance of redefining self, having a valued social role in society and feeling empowered as significant aspects of the recovery experience. Through this, hope and optimism, central aspects of recovery, are achievable (Bonney & Stickley, 2008; Pitt, Kilbride, Nothard Welford and Morrison, 2007). Prior to the generation of user-focused research, professionals generated the concept of recovery and rarely did the individual experiencing mental health problems have a role in shaping this definition. The consumer movement challenged this practice, with its core philosophy being grounded in users' experiences. It argued that recovery is not just about symptomatic reduction – that recovery is about a range of *outcomes* and *processes* that should first and foremost be determined by the individual. Essentially, recovery is a *journey* that an individual experiences, that they grow and learn from. It creates the opportunity for self-development and determination. Importantly, recovery is a process that the individual should have control over, although ideally in collaboration with those working with them (Scottish Recovery Network, 2007). It will be argued in this thesis that an individual's recovery journey is shaped by their environment and hence, recovery is a process that reflects a

dynamic interplay between the individual and their surroundings. This argument will be developed in Chapter Three.

As mentioned above, outcomes for individuals with psychosis have improved over the past fifty years. This has been partly due to advances in pharmacological treatments. However, not all individuals respond to anti-psychotic medication (Wykes, Steel, Everitt & Tarrier, 2008), leading to the development of psychological interventions to help ameliorate the distress associated with psychosis and restore functioning. Therefore, considerable research has been carried out which has led to a greater understanding of the psychological processes underpinning psychosis, leading to advances in psychological interventions- most notably cognitive behavioural therapy. Cognitive models of psychosis (Morrison, Haddock & Tarrier, 1995; Morrison, 2001; Garety, Kuipers, Fowler, Freeman & Bebbington, 2001) have highlighted the role of thinking styles and thought content in the development and maintenance of psychotic experiences and that the underpinning cognitive processes are similar to those underpinning anxiety, depression, obsessive compulsive disorder. Essentially, these models have highlighted how hallucinations and delusions can occur when anomalous experiences that are common to the majority of the population are misattributed in a way that has extreme and threatening personal meaning (Tai & Turkington, 2009). The aim of Cognitive Behavioural Therapy for psychosis (CBTp) is to work collaboratively with the individual to help them identify their thinking styles, their safety behaviours and to develop appropriate strategies to either develop alternative thinking styles, reduce safety behaviours or develop coping strategies (Garety et al., 2001; Tai & Turkington, 2009). Recent reviews on outcome for CBTp (Tarrier & Wykes, 2004; Wykes et al., 2008; Zimmerman, Farrod, Trieu, & Pomini, 2005) have pointed to its beneficial effects with both acute and chronic cohorts. However, the literature is limited by different approaches to CBT being utilised, different comparison groups being used and different “doses” of CBT being provided (Roth & Fonagy, 2006; Wykes et al., 2008). A more detailed review of the evidence for CBTp will be presented in the thesis (Chapter Three).

Approaches to CBT for psychosis have developed over the last decade (Tai & Turkington, 2009). For example, Birchwood and Trower (2006) argued that CBTp is not a “quasi-neuroleptic” and that treatment should not necessarily be focused on the reduction of symptoms but on the alleviation of distress. Evidence from research into command hallucinations has added to this, with the finding that distress in individuals receiving CBTp was reduced despite the ongoing presence of auditory hallucinations (Trower et al, 2004). Furthermore, research into the cognitive model of psychosis has shown that there are other psychological processes involved in the development and maintenance of psychosis than

thinking styles. For example, research has shown that early developmental experiences, such as attachment, loss, abuse and trauma (Boswell, 1996; Drayton, Birchwood & Trower, 1998; van Os, Jones, Sham, Bebbington & Murray, 1998; Read and Gumley, 2008; MacBeth, Schwannauer and Gumley, 2008) have implications not only for development of psychosis but maintenance through for example sealing over recovery styles (McGlashan, 1987; Tait, Birchwood & Trower, 2004). Furthermore, self-esteem, and interpersonal factors such as expressed emotion all have a bearing on the development and maintenance of psychosis (Bentall, Kinderman and Kaney, 1994; Garety et al., 2001; Smith, Fowler, Freeman, Bebbington, Bashforth, Garety, Dunn & Kuipers, 2006; Barrowclough, Tarrier, Humphreys, Ward, Gregg & Andrews, 2003). Complimentary to this are the findings of user-focused research into psychosis which have highlighted the importance that individuals place on self-determination, self identity and self-esteem and the development of valued roles and relationships in their recovery (Anthony, 1993; Andresen, Oades & Caputi, 2003; Scottish Recovery Network, 2007). Therefore, traditional approaches to CBTp have shifted over recent years to consider those other factors involved in an individual's recovery. These new approaches to CBT are considered the "third wave" and will be discussed further in this thesis.

The programme of research contained in this thesis was carried out at The State Hospital, Scotland. Until recently, The State Hospital was the National medium/ high secure hospital for Scotland and Northern Ireland. It has recently, with the expansion of the Managed Forensic Care Network in Scotland, become the only High Secure Hospital for Scotland and Northern Ireland. It is supported in the forensic network by two medium secure units in Scotland; the Orchard Clinic in Edinburgh, which serves patients along the East Coast of Scotland, and Rowanbank Clinic, the medium secure unit for the West of Scotland.

The State Hospital provides care and treatment for patients, who due to the nature of their mental disorder (as defined by the Mental Health (Care and Treatment) Scotland Act [2003]) have to be detained in conditions of high security because of the risk of serious harm they pose to themselves and to others. This risk may or may not be associated with their mental health. This means that patients are most often detained on a Compulsion Order with Restriction Order (CORO) and any change to their treatment plan, or plans to move them forward in their rehabilitation or out of the hospital has to meet approval from the Scottish Government. Approximately seventy percent of patients in the State Hospital have a primary diagnosis of schizophrenia. This is usually co-morbid with personality disorder, most commonly anti-social and borderline personality disorder, a history of substance misuse, trauma and offending behaviours (The State Hospital Annual Review, 2005).

In 1999, what has now become known as the “Ruddle Act” (The Public Safety and Appeals Scotland Act, 1999) was passed through the Scottish Government. This was a result of a “high profile” patient being discharged from the Hospital, through a legal loophole in the old pre-existing mental health act, which argued that a patient could not be detained in hospital if they were not receiving treatment. That is, he did not meet the “treatability test” which is that patients can only be detained if treatment is available that will alleviate or prevent a deterioration in their mental state. Scottish Ministers acted to close the gap and the Mental Health Public Safety and Appeals Scotland Act (1999) became law on the 8th September 1999. This therefore meant that a restricted patient could remain in hospital, without receiving treatment if they pose a risk of serious harm to others. The Scottish Health Minister, Susan Deacon, ordered a review of this case. Various recommendations were made, but of significance, it was recommended that the State Hospital should make changes into the organisation of specialist psychological therapies. This new legislation therefore led to the development of the Psychological Therapies Service (PTS) at the State Hospital in 2000. The emphasis from the Scottish government on a recovery-focused approach has also shaped the development of psychological therapies at the State Hospital (Delivering for Mental Health Scotland, 2006). The Scottish government funded the Scottish Recovery Network (SRN) to carry out this task, which led to user-focused research on recovery and severe and enduring mental (SRN, 2007).

The Psychosocial Interventions Service for Psychosis was developed in 2002. Following best practice guidelines (National Institute for Clinical Excellence, NICE 2002; Clinical Standards Board Scotland, CSBS, 2002) the first intervention to be developed was CBT for Psychosis. The model followed was that of Garety et al. (2001), but was also informed by Davidson’s cognitive model of personality disorder (2000; 2007), and Meuser and colleagues’ work on Trauma (2000). The objective of the PSI service was to expand its range of interventions for patients and as part of this, to develop group interventions.

This thesis therefore aimed to develop a recovery focused intervention for patients with psychosis residing in a forensic mental health setting. At the commencement of this PhD, only one published study (Haddock, Lowens, Brosnan, Barrowclough & Novaco, 2004) of CBT with this population was found, highlighting the limited literature that exists in this area. It was therefore anticipated that these interventions would be unique, due to the limited research in this area, but also because their development would be grounded in the patient’s experiences of recovery. This, it was hoped, would lead to greater engagement in those interventions, and hence promote patients staying well in the future. The first study in this

thesis therefore involved a grounded theory study of patients with psychosis in forensic mental health. The primary goal of this study was to develop recovery narratives, and then to explore themes that could be used to develop psychological interventions. Thirteen individuals were recruited for this grounded theory study. Transcripts were analysed and coded. The main themes arising from this study were that patients had early adverse experiences that were characterised by loss, trauma and interpersonal breakdown. Many perceived the hospital as a secure base, where they managed to develop strong relationships with staff, which provided the opportunity for them to re-define their sense of self – a process and a goal of recovery discussed in all the narratives.

Sense of self was considered an important aspect of recovery for all patients involved in the study. Research has shown that low self-esteem is common in individuals with psychosis (Bowins & Shugar, 1998; Silverstone, 1991), and that it is implicated in the development and maintenance of psychotic experiences such as delusions and auditory hallucinations (Garety et al., 2001; Smith et al., 2006). A recent study by Hall and Tarrier (2003) had shown promising outcomes with an individually delivered CBT intervention for self-esteem and psychosis, which also had led to a decrease in symptomatology. As a result, a self-esteem group intervention was developed and piloted. Fifteen patients completed the self-esteem intervention and significant improvements were found on self-esteem and depression. These improvements were maintained over a three-month follow-up period. Although patients reported having skills to challenge negative thoughts about themselves, they further stated that they continued to feel negative about themselves (Chapter five).

Subsequently, a recovery group intervention was developed. This was based on both the themes developed from the grounded theory study and the experience of running the self-esteem group intervention. The recovery group aimed to empower patients in their recovery, by focusing on emotional recovery with the aim of improving self-soothing, coping with distress and the development inner warmth. This was grounded in literature that has shown that individuals with psychosis often have developmental histories characterised by disrupted attachment histories, loss, and trauma (Read & Gumley, 2008; Bebbington, Bhugra, Brugha, Singleton, Farrell, Jenkins et al., 2004; Romme and Escher, 1989). Such experiences may compromise the ability to cope and manage distress in later life (Liotti & Gumley, 2008; Read & Gumley, 2008). Compassionate Mind Training (CMT; Gilbert, 1992, 1997, 2000; Gilbert and Irons, 2005) is considered one of the “third wave” approaches to CBT. It is based on Social Mentality Theory (Gilbert, 1989, 2001, 2005) and helps people to develop compassion and the ability to self-soothe, and regulate affect. Social Mentality Theory refers to the interplay that exists in interpersonal situations, between emotional, motivational, cognitive

and behavioural processes. This interplay is conceptualised as reflecting underlying systems, that are evolutionary in nature, and that shape relationships between self and others. Gilbert, 2005, refers to three types of affect systems that drive our behavioural, motivational, emotional and cognitive processes (see Figure 1 below).

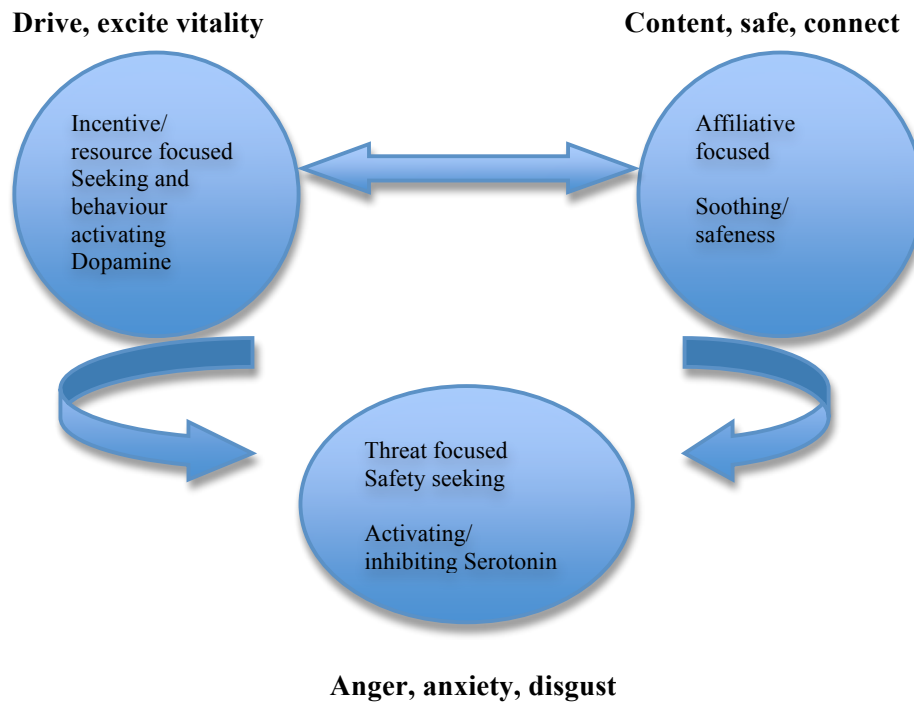


FIGURE 1:1 The Three Circles Diagram Depicting the Interaction Between the Three Affect Systems (taken from Gilbert, Lee and Welford, 2006).

Social mentalities are implicated in care-giving, care-eliciting, forming relationships, sexual behaviour and social rank (that is position within society or a group). Furthermore, this theory argues that human beings are driven to pursue and acquire certain goals in life, whether this be sexual behaviour, status in society, acquiring food etc. However, environments can be threatening and as such, human beings have to acquire and develop strategies in order to acquire those goals and to survive in often threatening and hostile environments. Therefore, social mentality theory helps us to understand what drives individuals and how certain behavioural, emotional, motivational and cognitive responses emerge as a way of us adapting to our environment.

An example of this is the development of the “human warmth syndrome”, whereby human beings develop the capacity to have compassion towards themselves and towards others as a result of their own experiences of being cared for. The experience of having had a secure

attachment with a primary care-giver, facilitates the development of this compassion and enables an individual to function within the social mentalities that create positive affect (whether that be drive or self-soothing). However, individuals who have had early developmental experiences of abuse, neglect and trauma may have had limited experiences of compassion and therefore the development of their own social mentality that enable self-soothing is compromised. It is likely that they function more within a threat-focused mentality, possibly experiencing shame and self-critical thinking. Therefore, what can initially start out as an external threat to self (such as neglectful or harsh parenting, trauma etc) can become an internally focused threat through the development of self-critical thinking and shame. Often, individuals can acquire safety strategies to try and minimise this experience of threat, through for example avoidance, lack of trust of others etc, but this can lead to unintended consequences. For example, when one takes on a submissive response to reduce a sense of threat, it can result in further self-critical behaviour and hence internally generated threat due to inability to stand up for oneself. Such early experiences of threat and the ongoing repetition of internally generated threat have implications for regulation of affect as the ability to self-soothe enables individuals to cope with distress. It also has implications for behavioural responses too, such as individuals taking on submissive responses to interpersonal threat, which is explained through our understanding of social rank theory.

CMT aims to change internalised dominating-attacking style that elicits a submissive response to one that elicits a caring and compassionate response. The Recovery After Psychosis (RAP) group intervention was based on CMT. Eighteen patients completed this group intervention and significant effects were found for depression, self-esteem, and an improvement in sense of self, compared to others. The findings and implications of this research will be discussed in depth in this thesis (Chapter six).

This thesis now commences with a review of the outcome literature into psychosis. As stated in the opening paragraph, the outcome literature raises questions regarding the concept of outcome and how it is operationalised. The leads onto a discussion of the recovery movement and how this has shaped current practice in mental health. It is argued therefore that the environment, in which an individual resides, shapes an individual's experience of recovery. It will be further argued that this is particularly the case in forensic mental health settings whereby the restricted nature of the environment presents a challenge to implementing a recovery-focused approach as espoused by the Scottish Recovery Network (SRN, 2007). Following this, the three research studies will be presented, followed by a discussion and critical review of the findings, with recommendations for future clinical practice and research.

CHAPTER TWO: A CRITICAL REVIEW OF OUTCOME IN PSYCHOSIS

2.1 Introduction

Schizophrenia: Epidemiology

Schizophrenia typically begins in early adulthood and can have catastrophic effects on an individual's capacity to lead a rich and meaningful life, with it compromising efforts to develop relationships, engage in society (such as having employment, social life) and achieve age appropriate developmental milestones. The onset of psychosis is usually preceded by a period of non-psychotic symptoms, known as prodromal symptoms. Schizophrenia affects approximately one percent of the population and tends to be more severe in young males. Age of onset is on average before aged 25 years for males, with females being approximately five years older at onset (Torney, 1987; Cooper, 1978). There is evidence that the prevalence of schizophrenia varies across the world (Jablensky, Sartorius, Ernberg, & Anker, 1992) and within countries (Kirkbride et al., 2006). Furthermore, research has shown the association between living in an urban environment and being diagnosed with schizophrenia (i.e. it is more prevalent), even after factors such as drug use, ethnic group and size of social group are controlled for (van Os, 2004)

History

The original concept of schizophrenia was formulated by Kraepelin (1856-1926) as “dementia praecox”. He identified two major groups of endogenous, or internally caused psychoses – manic-depressive illness and dementia praecox. Dementia praecox included several diagnostic concepts – dementia paranoid, catatonia, and hebephrenia – already singled out and regarded as distinct entities by clinicians in the previous few decades. Kraepelin believed that these disorders shared a common core – *an early onset* (praecox) and a *progressive intellectual deterioration* (dementia). These features contrasted with the relatively intact, late onset and episodic nature of illness in patients with manic-depressive psychosis, whereby episodes of psychopathology alternated with periods of normal functioning.

Bleuler (1857-1939) proposed the term “Schizophrenia” from the Greek words *schizien* meaning “to split” and *phren* meaning “mind”, to capture what he viewed as the essential nature of the condition. In essence, he was referring to a separation between the different psychic functions of personality, thinking, memory and perception (Bentall, 2004). Bleuler described the main symptoms characterising Schizophrenia as the four As; flattened *affect*, *autism*, impaired *association* of ideas and *ambivalence*. In describing schizophrenia, Bleuler broke with Kraepelin on two major points: he proposed that the disorder in question did not

necessarily have an early onset and that it did not inevitably progress toward dementia. Bleuler's criticism of Kraepelin's dementia praecox centred around his observations of many catatonics and other types who symptomatologically should be included in Kraepelin's dementia praecox, who did not go on to complete deterioration. It has been argued that Bleuler's approach was notable for three reasons (Tsuang, Stone, & Faraone, 2000). First, his reformulation of dementia praecox as the 'group of schizophrenias' foreshadowed the contemporary view that schizophrenia is a heterogeneous group of disorders with similar clinical presentations. Second, Bleuler included defects in affect as a core feature of the disorder and third, his view of schizophrenia allowed for the possibility of recovery. This is perhaps evidenced by the following quote: "*To begin with, practical and theoretical cures should not be equated. An individual who can support himself outside an institution can be cured in a certain sense. However, such individuals may retain a number of peculiarities and sensitivities resulting from the disease.*" (p.g 255, 1911, 1950). This view is similar to contemporary proponents of the recovery movement who argue that functional outcome should be considered as important, when considering outcome, as symptomatic outcome (Lieberman et al., 2002b)

Positive and Negative symptoms

Schizophrenia is often referred to in terms of 'positive and negative' symptoms (Sims, 2002). Positive symptoms refer to symptoms such as delusions, auditory hallucinations and thought disorder. They are generally considered to be symptoms that individuals do not typically normally experience.

Negative symptoms are so named because they are considered to be the *loss or absence* of normal traits or abilities. They include the following features:

- Alogia – flat or blunted affect and emotion or poverty of speech
- Anhedonia – inability to experience pleasure
- Asociality – lack of desire to form relationships
- Avolition – lack of motivation.

Diagnostic criteria

The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, DSM-IV and the World Health Organisation's International Statistical Classification of Diseases and Related Health Problems, ICD-10 are the two most widely recognised classification systems for diagnosing mental health conditions. ICD-10 is more commonly used in European countries, whilst DSM-IV is used in the United States.

Diagnostic criteria have changed significantly over the last fifty years. For example, the criteria of DSM-I and DSM-II provided brief and vague descriptions of the schizophrenic disorders, lacking specific operational criteria. The development of DSM-III saw a significant change in diagnostic classification, the development of which was shaped by the importance of empirical, psychometric validation of psychiatric syndromes (Blashfield, 1984; Klerman, 1988; Robins & Guze, 1970). With DSM-III came clearly defined criteria, which limited clinician's discretion and narrowed the construct of schizophrenia. This improved the clinical homogeneity of the disorder and raised diagnostic reliability (Tsuang et al., 2000).

DSM-IV criteria for schizophrenia defines it as a discrete category, the implication being that it differs qualitatively from other states of health. The DSM-IV criteria for a diagnosis of schizophrenia is as follows:

- A. Characteristic symptoms. Two (or more) of the following, each present for a significant portion of time during a one month period (or less if successfully treated);
 - 1.) delusions
 - 2.) hallucinations
 - 3.) disorganised speech (e.g. frequent derailment or incoherence)
 - 4.) grossly disorganised or catatonic behaviour
 - 5.) negative symptoms i.e. affective flattening, alogia or avolition

Only one Criterion A symptom is required if delusions are bizarre or hallucinations consist of a voice keeping up a running commentary on the person's behaviour or thoughts, or two or more voices conversing with each other.

- B. Social/ occupational dysfunction: For a significant portion of the time, since the onset of the disturbance, one or more major areas of functioning such as work, interpersonal relations or self-care, are markedly below the level achieved prior to the onset.
- C. Duration: Continuous signs of the disturbance persist for at least 6 months. This 6 month period must include at least one month of symptoms (or less if symptoms remitted with treatment).
- D. Exclusion of mood disorders
- E. Exclusion of known organic causes.

The diagnostic concept of schizophrenia has been criticised for being scientifically meaningless on the grounds that it groups together a whole range of different problems under one label, with the assumption that all people in this group have the same disorder. Bentall,

Read, Moshier and Loren (2004) have argued that patients should be treated on the basis of individual symptoms as opposed to an overarching category. From an epidemiological perspective, Rose and Barker (1978) have argued that, contrary to the situation in clinical practice, 'disease' at the level of the general population generally exists as a continuum of severity rather than as an all or nothing phenomenon. Johns and van Os (2001) argue that if psychosis was the result of a single, unfounded gene, then the distribution would be truly dichotomous. However, they argue that it is very unlikely that it is caused by a single factor and a multi-factorial aetiology similar to that seen in chronic disorders such as diabetes or cardiovascular disease is more likely (Jones & Cannon, 1998). Johns and van Os (2001) have further stated that if we view psychotic symptoms as varying along quantitative dimensions, then this facilitates psychological research into the factors that drive such variation. In support of a continuum model of psychosis is evidence that psychological mechanisms associated with psychotic symptoms also operate in non-patient samples (Jackson, 1997; Verdoux, Maurice-Tison, Gay, van Os, Salamon & Bourgeois, 1998; Peters, Day, McKenna & Orbach, 1999; Peters, Joseph, & Garety, 1999)

Outcome: Previous Reviews and Meta-analyses

Outcome studies are important clinically because knowledge of which risk factors predict chronicity is valuable in everyday clinical practice and may open the way forward for targeted introduction of measures aimed at preventing poor outcome and hence promoting recovery. Outcome, course and prognosis in Schizophrenia has been the focus of extensive investigation, largely due to the pessimistic view regarding outcome in psychosis generated by Kraepelin's original view of dementia praecox. It has been argued (Ram et al., 1992) that the longitudinal outcome literature suffers from serious methodological limitations in terms of sampling, diagnosis and data collection procedures. Furthermore, Ram et al. (1992) have stated that the most "striking deficiency" has been the difficulty in identifying a homogenous patient cohort, making the argument that for prognostic purposes, cohort patients should be seen at the onset of their psychosis in order to test hypotheses about predictors and course of outcome.

In perhaps the biggest review carried out to date entitled "One Hundred Years of Schizophrenia: A Meta-Analysis of the Outcome Literature" (Hegarty, Ross, Baldessarini, Tohen, Wateraux & Oepen; 1994), the literature, from the twentieth century on outcome in schizophrenia, was explored for historical trends that might be associated with changes in diagnostic and therapeutic practice. Furthermore, this review aimed to test the hypothesis that both improved biological treatment and changes in diagnostic criteria have influenced outcome. This study reviewed the international literature on outcome in schizophrenia or

dementia praecox from 1895-1992, and identified 821 studies; 320 of these, with 51,800 subjects in 368 cohorts, met inclusion criteria for the study. This review demonstrated the impact of diagnostic criteria on the reported rates of individuals recovering from psychosis. For example, outcome was considered better in patients when broader diagnostic criteria were used. Furthermore, between the 1920s and the 1970s, favourable outcome from an average of 24.3% to 50.5% was shown. This was attributed to new treatments, particularly neuroleptic medication (introduced from the 1950s) and an increased emphasis on family and community interventions from the 1960s. Overall, 40.2% of patients were considered improved after follow-ups averaging 5.6 years (the range of follow-up was 1-40 years). Therefore, this review concluded that less than half of patients diagnosed with schizophrenia showed substantial improvements after follow-up averaging nearly six years.

Ram et al. (1992) reviewed the natural course of schizophrenia in first admission studies by looking at data from three types of longitudinal investigations; 1) statistical reports of discharge patterns conducted before the neuroleptic era; 2) long-term follow-back studies of patients with schizophrenia that used direct diagnostic assessments and systematic follow-up interviews and; 3) prospective studies (a prospective study follows over time a group of similar individuals). Three main conclusions were drawn from this review. The first, that the pattern of illness course is variable, and that this variability is associated with length of follow-up reported in the studies. Furthermore, differences in the samples and clinical heterogeneity impacted on course and outcome. Secondly, this review found that a large proportion of first admission patients had reasonably good outcome compared with follow up studies of consecutive admissions. The third point was that the evidence available suggests that certain variables predict outcome in newly diagnosed individuals such as early neuroleptic treatment and shorter duration of illness before hospitalisation. Ram et al. (1992) noted in this review several limitations with the data available. First of all, individuals with significant drug and alcohol histories would more than likely have been excluded from the prospective studies for both practical and diagnostic purposes, limiting the generalisability of the findings. Furthermore, operational definitions of remission and relapse varied across the studies. In addition, many of the follow-up studies did not separate clinical from functional outcome.

Malla and Payne (2005) conducted a narrative review of the psychopathology, quality of life and functional outcome in individuals with a first episode psychosis. This review focused on functional outcome due to the recognition, through the recovery movement, that occupational and social functioning may be more important as a measure of outcome than psychopathology. The study concluded that there is continuity of some psychopathological

dimensions from pre-morbid through prodromal to post-onset psychosis. Short-term functional outcome improves after treatment of the first episode, but longer terms outcomes remain relatively poor for a substantial proportion of patients.

In 2006, Menezes, Arenovich and Zipursky carried out a systematic review of longitudinal outcome studies of first-episode psychosis. Although reporting that outcomes may be more favourable than previously reported, similar concerns were raised in this study as those by Ram et al. (1992). Namely, that significant heterogeneity in definitions and methodologies render it difficult to draw comparisons across studies. The authors recommended that a multi-dimensional, globally used definition of outcome be developed for research purposes.

2.2 Aim of Review

The purpose of this review was to critically appraise the literature on outcome in first episode psychosis (first episode refer to the first time someone experiences psychotic symptoms). This was addressed by exploring various aspects of outcome considered relevant to recovery in psychosis. Outcome in first episode psychosis was reviewed by looking at prospective studies over a minimum five-year outcome period. The majority of published reviews on outcome and first episode psychosis do not delineate time scales, this is despite the fact that five year outcome is generally referred to as the “critical period hypothesis” (Birchwood, Todd & Jackson, 1998) which proposes that the early phase of psychosis, including any period of initially untreated psychosis, is a “critical period” during which symptomatic and psychosocial deterioration progresses rapidly. Afterwards, progression of morbidity slows or stops, and the level of disability sustained, or recovery attained, by the end of the critical period endures in the long term (Birchwood, et al., 1998). Although two-three years after onset was the duration suggested in the original paper (Birchwood et al., 1998) other authors extended it to five years (Garety & Jolley, 2000; McGorry, 2002). Furthermore, Manfred Bleuler (1972) posited five years as the point beyond which outcomes stabilise in schizophrenia. The most methodologically sound studies are prospective and recruit from a first episode cohort. First we must consider the key outcomes considered important in psychosis. These outcomes have been established from reviewing the literature.

2.3 Measurement of outcome in psychosis

The rationale for the range of outcomes being reviewed is based on the outcomes that we know from previous reviews, as being relevant to psychosis, but also the outcomes considered by the Remission in Schizophrenia Working Group (symptomatic, functional and cognitive outcomes, cited in Andreasen, Carpenter, Kane, Lasser, Marder & Weinberger, 2005). Furthermore, schizophrenia is a multi-faceted disorder and therefore emotional distress is

common (Tarrier, 2005) Therefore, affective outcome (in relation to depression and anxiety, suicide), violence, aggression and substance misuse will all be considered. The rationale for each of these outcomes will be given in more depth below.

Course, remission and relapse

Outcome is a variable factor in studies of outcome and psychosis, contributing to the heterogeneity of findings (Ram et al., 1992). In 2003, the Remission in Schizophrenia Working Group was established to provide remission criteria for schizophrenia. The working group concluded that any remission criteria should include a significant time component and be applicable to patients across the stages of psychosis. Furthermore, it was recommended that the assessment instruments should be objective and consistent with regards to test-re-test reliability. The group considered incorporating symptomatic, functional (activities of daily living, social relationships, employment and quality of life) and cognitive outcomes in to the definition of outcome. However, it was noted that symptomatic resolution is not a pre-requisite for functional improvement therefore it was recommended that a two-phase model for patient outcomes be developed (remission followed by recovery). The development of functional remission criteria would be developed following the broader dissemination of the symptomatic remission criteria.

The recommendations of the working group led to the development of a consensus based operational criteria for symptomatic remission in schizophrenia, which is based on distinct thresholds for reaching and maintaining improvement as opposed to change criteria (Andreasen, Carpenter, Kane, Lasser, Marder & Weinberger, 2005). On the basis of the three identified dimensions of schizophrenia (negative symptom dimension, disorganisation dimension and psychoticism dimension) they suggested the Scale for the Assessment of Positive Symptoms (SAPS, Andreasen, 1984); Scale for the Assessment of Negative Symptoms (SANS; Andreasen, 1983); the Positive and Negative Syndrome Scale (PANSS, Kay, Fiszbein & Opler, 1987) and the Brief Psychiatric Rating Scale (BPRS, Overall & Gorham, 1962). Symptomatic remission is considered to have occurred if there is maintenance over a six-month period of simultaneous ratings of mild or less on all items. In addition, use of BPRS criteria may be complemented by using the SANS criteria for measuring overall remission.

Falloon (1983) emphasised the importance of duration criteria in terms of recovery and relapse, remission and relapse. Recovery is conceived as a more complete and prolonged phenomenon than remission, which can be seen as a necessary but not sufficient step towards it.

Symptomatic severity

Related to remission, the reduction in symptomatology is the most common outcome in outcome studies. Most studies review changes in positive and negative symptoms. Positive symptoms refer to auditory hallucinations and delusions and tend to be the most overt sign of psychosis.

Negative symptoms are acknowledged to represent a core aspect of the disease process that significantly interferes with successful rehabilitation and re-insertion into active community life. Negative symptoms in FEP are associated with poor functional outcome (Galletly, Clark, MacFarlane & Weber, 1997; Browne, Roe and Lane 1996) and a strong relationship with cognitive functioning (Ho, Nopoulos, Flaum, Arndt & Andreasen, 1998; Liddle & Morris 1997) compared with positive symptoms, and a relatively poor response to antipsychotic medication (Tollefson & Sanger 1997).

A variety of psychometric assessments have been utilised to measure change in symptom severity such as the positive and negative syndrome scale (PANSS), the Scale for the Assessment of Positive Symptoms (SAPS) and the Scale for the Assessment of Negative Symptoms (SANS) and the Brief Psychiatric Rating Scale (BPRS). Measures looking at reduction in distress associated with symptomatology have also been employed, such as the PSYRATS (Haddock, McCarron, Tarner & Faragher, 1999).

Functional outcome

Functional outcome considers activities of daily living, social relationships, employment and quality of life (Andreasen et al., 2005). As stated previously, many of the first generation outcome studies into first episode psychosis did not separate functional and symptomatic outcomes (Ram et al., 1992; Malla & Payne, 2005) Liberman et al. (2002a, 2000b) have proposed that certain domains are central to defining recovery, including symptoms and functional status (vocation, independent living and social relationships). Often the clinical and social functioning paths do not recover in parallel fashion and should be evaluated separately when reporting on outcome (Andreasen et al., 2005).

Functional outcome is often measured by scales such as the Social Adjustment Scale (SAS; Paykel et al., 1978) and the Global Assessment Scale (GAS; Endicott, Spitzer, Fleiss & Cohen 1976). The SAS assessments include five different areas; parental, work, family, marital, and leisure, each rated from one to five, with five being the worst. The GAS was

designed to evaluate global functioning specifically associated with psychiatric symptoms and the scores range from 1-100, with higher scores indicating better functioning.

Cognitive functioning

Cognitive functioning is generally considered to be associated with poor social and functional outcome in psychosis (Green, Neucherterlein & Mintz, 1994; Green, Kern & Heaton, 2004) although. However, as reported by Addington and Addington (2008), there is notable variance in the results, whereby cognitive functioning can explain as little as 10% or as much as 50% of the variance in social functioning. In a three-year follow-up study of individuals with a first episode psychosis, Addington and Addington concluded that although related, poor social functioning may be independent of cognitive functioning. Recently, Addington and Addington (2008) stated that there is a clear link between cognitive and social functioning but the nature of the association is not clear. The association may be an indication of how social functioning is conceptualised and assessed.

Affective recovery

Symptoms of emotional distress are common in psychosis and have a bearing on recovery. Affect and the role in outcome and psychosis have been long considered. In his description of schizophrenia, Bleuler (1911, 1950) drew attention to “*emotional deterioration*” – the role of affect in the course and prognosis of the psychoses; “*in the outspoken forms of schizophrenia, the “emotional deterioration” stands in the forefront of the clinical picture. It has been known since the early years of modern psychiatry that an “acute curable” psychosis became “chronic” when the affects began to disappear*”(pg 40).

Depression and Anxiety

Anxiety and depression are both common feature of psychosis. In a cross-sectional study, Mulholland and Cooper (2000) reported rates of depression ranging from 13%-80%. The lifetime prevalence for depression in schizophrenia is higher than the general population with figures ranging from 60%-80% compared with 8%-26% for the general population (Tarrier, 2005). Depression often goes unrecognised due to it being confused with negative symptoms, and side effects of medication (Mulholland & Cooper, 2000).

In a recent review of co-morbidity and schizophrenia, Buckley, Peter, Miller, Lehrer and Castle (2009) reported an estimated prevalence rate of 15% for panic disorder, 29% for post-traumatic disorder and 23% for obsessive-compulsive disorder.

It has been argued that a key aspect in relapse in psychosis is high levels of emotional distress and affective dys-regulation in the period before, during and following the acute phase of psychosis (Birchwood, Smith, Macmillan, Hogg, Prasad, Harvey et al., 1989; Birchwood, Mason, MacMillan & Healy, 1993). For example, findings from retrospective and prospective studies have shown that the most commonly reported early signs of relapse are fearfulness, anxiety, poor sleep, irritability, tension, depression and social withdrawal (Herz & Melville, 1980; McCandless-Glimcher et al., 1986; Birchwood et al., 1989). Birchwood and Iqbal (1998) found that residual symptoms of both hallucinations and delusions are more common in depressed people with psychosis, and they propose that feelings of hopelessness and uncontrollability contribute to symptom maintenance.

Suicide and Hopelessness

The lifetime risk of suicide in schizophrenia is between 4% and 6% (Palmer, Pankratz & Bostwick, 2005). Individuals in the early phase of psychosis are more likely to develop depression and suicidal thinking (Birchwood, Iqbal, Chadwick & Trower, 2000; Iqbal, Birchwood, Chadwick & Trower, 2000; Palmer et al., 2005). The presence of depression and psychotic symptoms, especially hallucinations, appear to be identified as the two most significant factors (Heila, Isometsa, Neriksson, Heikkinen, Marttunen & Lonnqvist, 1997, Bertelsen, Jeppesen, Peteresen, Thorup, Ohlenschlaeger et al., 2008). The OPUS trial found that in first episode psychosis cohort, risk of suicide is associated with depressive and psychotic symptoms, especially hallucinations, predicted suicidal plans and attempts, and persistent suicidal behaviour and ideation (Bertelsen et al., 2007). Tarrier, Barrowclough, Andrews and Gregg (2004) investigated the psychology of suicide behaviour in people with schizophrenia. Longer duration of illness, up to three years since onset, increased the probability of medium risk by 8% and high risk by 13%. Greater hopelessness increased medium risk by 19% and high risk by 22%. Hopelessness was associated with low self-esteem and higher social isolation.

Violence/ aggression

Reports have typically reported that schizophrenia is related to a 4-6 fold increase in violent behaviour (Joyal, Dubreucq, Grendon & Millaud, 2007). However there is a huge variation in the reported rates of violence, with studies reporting a 7 fold increase compared with the general population (Tiihonen, Isohanni, Rasaneri, Kouranen, Moring, 1997; Mulen, Burgess, Wallace, Palmer & Ruschena, 2000) to no association in one prospective investigation (Steadman, Mulvey, Monahan et al., 1998). In a recent review of schizophrenia, violence and substance misuse (Fazel, Langstrom, Hjern, Grann & Lichtenstein, 2009) they concluded that schizophrenia and other psychoses are associated with violence and violent offending

(particularly homicide). Most of the excess risk appears to be mediated by substance use co-morbidity. The risk in these patients with co-morbidity is similar to that for substance abuse without psychosis.

Drugs and alcohol

The rate of substance misuse in patients with severe mental illness is high. Estimates of recent or current abuse from community samples range from 20%-40% (Mueser, Yarnold, Levinson, Singh, Bellack, Kee, Mornson, & Yadam, 1992), with rates being higher than that seen in the general population (Regier, Farmer, Rae, Locke, Keith, Judd & Goodwin (1990). Substance misuse in schizophrenia causes significant concern because it is associated with suicide, poor compliance with treatment, more inpatient stays, violence and poor overall progress (Smith & Hucker, 1994; Lehman & Dixon, 1995).

In summary, Schizophrenia is a multi-faceted disorder, resulting in an individual experiencing an array of symptoms. Most commonly associated with schizophrenia is the experience of positive and negative symptoms. However, Schizophrenia also leads to distress and depression, both pre-morbidly, during an acute episode but also following a psychotic relapse. The experience of depression and hopelessness is associated with a higher risk of suicide. Furthermore, substance misuse is a common problem in individuals with psychosis, leading to poor recovery, suicide, and also increasing the risk of violent and aggressive behaviour. This review will now explore the outcomes of individuals in relation to the key outcomes described above.

2.4 METHODOLOGY

Relevant studies were initially identified by searching the following databases: PsychINFO (January-1987-April 2009); MEDLINE (January 1980-April 2009). The sensitivity of the search was analysed by scrutiny of the reference lists of relevant studies identified by the search strategy. Only studies that involved prospective outcome in first episode psychosis patients over a 5-year period were reviewed. Studies with the purpose of testing out treatment interventions were excluded from the review.

The keywords used, in various combinations were; early, first, incident, episode, admission, contact, psychosis, schizophrenia, psychotic disorders, course, outcome, follow-up, longitudinal, prospective, cohort, qualitative and recovery. Eighteen studies have been identified for review. Some studies have been grouped together in recognition that one than one studied was published from the same cohort of patients.

2.5 RESULTS:

Table 2.1: First Episode Psychosis: Prospective Outcome Studies

Study	Study aims	Participants	F.U	Outcome measures	Outcome
Scottish Schizophrenia Research Group (1987, 1988, 1992); McCreadie et al. (1989)	Prospective study First Hospital Admission	44 FEP	12,24,60 months	Outcome good = no relapses/ symptoms Poor – relapse and or symptoms at follow-up; unemployment, remission, readmission.	44 patients were followed up over 5 year period. 30% had no relapse and of those who did, this was within first 42 months. At 5 years, 19% were in employment. Unemployment was strongly associated with outcome. Poor outcome was associated with greater psychological distress among relatives at 1 st admission.
Shepherd et al (1989)	Prospective outcome study of first episode psychosis	49	5 years	Employment, symptoms, course, readmission, social functioning, mortality. Remission = one episode and no impairment; improved = several episodes and no/ minimum impairment, poor = no return to normality.	Duration of admission at entry, younger age of onset, predicted poorer outcome in terms of duration of readmissions.
Ganev, 2000; Ganev, Onchev, & Ivanov, 1998 (Part of WHO studies)	A first episode psychosis follow-up study. Part of WHO RAPyD	60 patients with functional non-affective psychosis. ICD-9 clinical diagnosis	16 years	PSE-9; Psychological Impairments rating scale; Schedule for the Assessment of Negative Symptoms; Disability Assessment Schedule; Life Chart Schedule; the Broad Rating Schedule and the Family Interview Schedule. Global Assessment of Functioning	55% on disability; 24% lived alone; 46% continually experiencing psychotic symptoms; 13% episodic symptoms; 53% had GAF in severe range; 65% continued treatment 5.9% had assaulted others and 7.7% had made suicide attempts.
Heglason (1990)	First Episode prospective outcome.	107	20 years	Range of functional and symptomatic outcomes	84 patients were f.u over the 20 years. Over half were never married and 32% had divorced. Those who underwent treatment improved but only 295 achieved an acceptable level of health. There was significant non-compliance, with only 54% of those requiring treatment accepting it.

Study	Study aims	Participants	F.U	Outcome measures	Outcome
Carpenter and Strauss (1991)	Eleven year follow-up of patients with schizophrenia participating in the WHO ISoS programme.	40 ICD-9 Schizophrenia	11 years	Explored social, occupation, hospital utilisation and symptom severity.	More social contact, more stable relationships and greater distress at entry predicted better outcome. Illness tends to reach a plateau of psychopathology early in the course, with as many patients tending to improve in the long-term as those who tend to show further deterioration.
Thara et al (1994);	FEP sample f.u for 10 years	76 Schizophrenia ICD-9	10 years	Present State Examination and Personal History Schedule	Pattern of illness "good" in 67% of the cases. Being male, having negative symptoms and religious/grandiose delusions predicted poorer outcome. Five committed suicide (3.8%). 60% in employment over course of review period.
Mason et al (1996)	To describe 13 year course of illness in FEP	67 patients with ICD-9 schizophrenia	13 years	Assessments at 1,2 and 13 years. Present State Examination; Psychological Impairments Rating Scale; Psychiatric and Personal History Schedule; Disability Assessment Schedule. At 13 years: Life Chart Schedule; Substance Abuse Schedule; Disability Assessment Schedule.	First relapses and re-admissions occur over first five years. Amount of time in psychotic episodes and in hospital is greatest in first year of follow-up. Small deterioration in social adjustment between 2 and 13 years. Number with good social adjustment increased from 13.6% to 31.8%. Poor social adjustment decreased from 52.3% to 43.2%
Wieselgren and Lindstrom (1996)	Prospective outcome study	FEP 120 DSM-III-R patients with schizophrenia. 117 diagnosed with schizophrenia and 3 schizophreniform disorder	1-5 year follow-up	Outcome measured by Strauss and Carpenter outcome scale Poor outcome: has spent 6-9 months in hospital during last year, has a sheltered occupation, does not see close friends at all and displays moderate or severe psychotic symptoms. Good outcome: less than 3 months in hospital, working half-time, meets friends 2-3 times a months and has had mild or transient symptoms in the last month.	7% of patients committed suicide over the 5 year period. At 5 years 14% of sample were considered to have "poor outcome" and 30% of the sample were considered to have "good outcome". 41% had no or only mild psychotic symptoms at 5 years and 6% had severe symptoms. At 5 years, 27% had worked half time, 8% worked sporadically, 18% in sheltered work and 47% had never worked at all.

Study	Study Aims	Participants	F.U	Outcome measures	Outcome
Takei et al. (1998)	FEP in Afro-Caribbean and White people.	34 Afro-Caribbean and 54 White people. Present State Examination diagnosis	18 year	PSE; The Social Adjustment Scale and the Global Assessment Scale. Negative symptoms measured on PSE "blunted affect" and "poverty of speech" scales.	A slightly increased (though non-significant) proportion of Afro-Caribbean were diagnosed with schizophrenia at admission and at follow-up. Significant difference found between the length of hospital admissions, involuntary admissions and number of admissions. Afro-Caribbeans had fewer negative symptoms at f.u than white counterparts.
Wiersma et al (1998)	Data from a 15 year natural course of schizophrenia and other non-affective functional psychoses	82 First episode patients ICD-9	15 years	Present State Examination The Disability Assessment Schedule The Life Chart Schedule	Two thirds of participants had at least one relapse. After each relapse 1 of 6 participants did not remit from the episode; 1 of 10 committed suicide.
Herberner and Harrow (2001); Racenstein et al (2002); Harrow et al (2005) All above part of the Chicago follow-up study.	Longitudinal assessment of negative symptoms in schizophrenia/schizo-affective disorder compared with other psychosis and depression	150 patients studied prospectively Index hospitalisation (75% had one or fewer hospitalisations) RDC: 52 schizophrenia, 20 schizo-affective, 36 presenting with other psychosis, 42 diagnosed with depression	4.5, 7.5 and 10 yr follow-up	Schedule for affective disorders and schizophrenia (SADS) Schizophrenia State Inventory Negative symptoms: 12 behavioural items from the Psychiatric Assessment Interview. Ratings of depression based on RDC.	Herberner et al. (2001) Negative symptoms typically most severe and most common in the schizophrenia/schizo-affective group compared with the other psychosis and depression group. Racenstein et al. (2002) a significant relationship between psychosis and increased impairment in work functioning. The most severely psychotic patients, regardless of diagnosis, are least likely to be working effectively. Harrow et al (2005) found that cumulatively over the 15 year period, slightly over 40% of patients with schizophrenia showed one or more periods of recovery. Over 50% of the schizophrenia patients did not have a disorder that was chronic and continuous.

Study	Study aims	Participants	F.U	Outcome measures	Outcome
Linszen et al (2001)	To see whether early differential treatment after acute psychotic break improved outcome as compared with other studies.	76	15,60 months	At intake: relatives assessed using the psychiatric and social history schedule (PSHS); BPRS-E. At f.u EE measured using five minute speech sample; Life History Chart (LCS) Social functioning also measured through employment, activities etc.	At 5 years, low relapse rate could not be maintained. 52% had one or more psychotic relapses, 25% developed chronic positive symptoms and 23% did not have another psychotic episode. Social functioning was also low.
Bottlender et al (2003); Bottlender et al 2004; Jager et al, 2004; Moller et al 2000; Moller et al 2002.	ICD-10; 105 SZ ; 41 SA.	241 inpatients at baseline, 222 at 15 years	15 years	Global Assessment of functioning; AMDP system.	33 died; negative symptoms and longer DUP were associated with poorer outcome.
Kua et al (2003)	To assess outcome and predictors of outcome in patients with schizophrenia over a 20 year period in Asia	ICD-9 diagnosis of schizophrenia 420 cohort Inpatient index hospitalisation cohort	5,10, 15 and 20 year follow-up	Global functioning measured with the Global Assessment Scale. Outcome determined by treatment and work status: Good – patient not receiving treatment, well and working; Fair – patient not receiving treatment and not working, or receiving out-patient treatment and working; Poor – patient receiving treatment and not working or receiving in-patient treatment.	Approximately two thirds of patients had a good/ fair outcome. A shorter duration of illness before admission was significantly associated with good outcome. Suicide was highest in the first 10 years.
Stirling et al (2003)	To characterise neurocognitive impairments and how this relates to long-term outcome.	62 FEP; Research Diagnostic Criteria diagnosis	10 years	Clinical: SANS; SADS-L, SAPS, case notes and GPQ Neurocognitive: WAIS sub-scales; WRMT W and F, MFD, WCST and VFT; NART Other: WHO life charts, time trends and GAFS, Birchwood insight scale.	Poor outcome associated with decline in performance on visuo-spatial tasks and a failure to improve on frontal-temporal tasks during f.u. Executive deficits may be apparent in F.E but do not progress over 10-12 years Visuo-spatial function is spared in FE but may deteriorate over time.

Study	Study aims	Participants	F.U	Outcome measures	Outcome
Robinson et al (2004)	Symptomatic and functional outcome in FEP	118 FEP diagnosed with SAD	5 years	Schedule for Affective Disorders and Schizophrenia and the SADS-C./ SANS Premorbid functioning – Premorbid Adjustment Scale Neuro-psychological tests – cognitive battery of 41 tests covering 6 domains. Social Adjustment – the Social Adjustment Scale II Magnetic Resonance Imaging	At 5 years 47.2% achieved full symptom remission and 25.5% had adequate social functioning for 2 years or more. Only 13.7% met full recovery criteria for 2 years or longer. Better cognitive functioning at stabilisation was associated with full recovery, adequate social and vocational functioning and symptom remission. Shorter DUP at study entry predicted full recovery and symptom remission.
Harris et al (2005)	The relationship between duration of untreated psychosis and outcome in an 8 year prospective study	318 First Episode Cohorts. DSM-III-R diagnosis	8 years	BPRS-Expanded Version Schedule for the Assessment of Negative Symptoms Quality of Life Scale Social and Occupational Functioning Scale Positive Symptoms sub-scale derived from the BPRS-E	Shorter duration of untreated psychosis correlated moderately with decreased severity of positive symptoms and enhanced social and occupational functioning and quality of life. No association was found between DUP and negative symptoms.
Crumlish et al (2009)	Does outcome in non-affective psychosis stabilise beyond the critical period; is DUP correlated with 8 year outcome; does DUI have any independent effect on outcome?	118 people with FEP; DSM-IV diagnosis of non-affective psychosis.	8 year follow-up	PANSS;SCID (DSM-IV); GAF and QLS; Pre-morbid adjustment scale; Beiser scale to measure DUP. Follow-up assessments: all above repeated except the Premorbid adjustment scale and the Beiser scale. The Strauss-Carpenter Level of Functioning Scale was added.	Symptomatic outcome: At 8 year f.u 49.3% were in remission. Psychosocial outcome: 32.8% serious functional impairment; 28.3% moderate impairment, 13.4% mild impairment and 25.4% no impairment.

Sample selection

The majority of first episode psychosis studies used formal diagnostic criteria such as ICD-9, ICD-10 (World Health Organisation) or DSM-III, DSM-IV (American Psychiatric Association, 1994). All patients experienced psychosis and were considered to be first episode cases. However, the definition of “first episode psychosis” varied between studies. For example, some studies referred to first episode as index hospitalisation or first admission (Helgason 1990; McCreddie, Wiles, Grant, Crockett, Mahmood, Livingston et al 1989; Thara, Henrietta, Josephy, Rajkumar & Eaton, 1994; Wieselgren and Lindstrom, 1996; Mason,

Harrison, Glazerbrook, Medley & Croudace, 1996; Takei, Persaud, Woodruff, Brockington & Murray, 1998; Herberner and Harrow, 2001; Racenstein et al., 2002; Harrow et al., 2005) whereas other studies defined first episode as “first ever psychosis” (Wiersma et al., 1998) or first presentation to any psychiatric service with a psychotic episode (Mason et al., 1996; Crumlish et al., 2009). In the remaining studies it was not clear how first episode was defined. In addition, there was variation in the length of follow-up with some studies reporting outcomes after five years whilst others reported after 20 years (see Table 2.1 above for details).

Symptomatic outcome

Course, remission and relapse - definitions

Most of the studies (Moller et al., 2002; Takei et al., 1998, Shepherd et al., 1989, Wieselgren & Lindstrom, 1996, Heglason, 1990; Kua et al., 2003; Stirling et al., 2002) referred to outcome in terms of total number of re-hospitalisations after first admission, duration of hospitalisation, the severity of illness, and global functioning at follow-up (such as independent living, employment). Some studies divided the illness course into psychotic episodes. For example, Wiersma et al. (1998) divided the illness course into psychotic episode which was defined as a discrete period of symptomatology characterised by overt psychotic signs and symptoms of hallucinations, delusions, cognitive distortions, marked psycho-motor disturbance or grossly inappropriate behaviour. It must be preceded by or followed by at least 30 days of no psychotic symptoms. A non-psychotic episode was defined as a neurotic (anxiety or depression) or a residual state with negative symptoms such as loss of interest and social withdrawal. Complete remission was defined as symptom free with pre-morbid personality evident, lasting more than 30 days. Kua et al. (2003) defined outcome on the basis of treatment and work status. Therefore, good outcome was when the patient was not receiving treatment, is well and was working; fair outcome was when the patient was not receiving treatment and not working, or receiving out-patient treatment and working and poor outcome was when the patient was receiving treatment and not working or receiving in-patient treatment. By contrast, Wieselgren and Lindstrom (1996) defined outcome as measured by the Strauss and Carpenter outcome scale (1977). This scale considers four aspects of outcome, hospitalisation, social contacts, employment and symptoms, providing a rating of 1-5 (1 being poor and 5 being good) on each. A total score is calculated, whereby good outcome is a total score greater than 15 and poor is a score less than 8. Thara et al. (1994) defined an individual as suffering from psychosis when there was the presence of delusions, hallucinations, or thought disorder. Relapse was the reappearance of one or more psychotic symptoms after one month of total remission. Remission was the total absence of positive symptoms. Thara et al. (1994) also defined five patterns of course; 1) complete

recovery without relapse; 2) no relapses but with residual symptoms; 3) one or more relapses, complete remissions; 4) one or more relapse, incomplete remissions; 5) continuously psychotic.

Other studies did not refer to hospital admissions to define remission or relapse. For example, Linszen et al. (2001) rated relapse on the basis of the BPRS-E scores and used two different criteria of relapse, one based on a) monthly assessed BPRS ratings, done blindly by the research psychologist and the second based on b) the clinical psychiatric notes (Linszen et al., 1994). Criteria for outcome was as follows, Good= no relapse, intermediate = more than one relapse, poor = chronic positive symptoms.

Course, remission and relapse

All eighteen studies reported an episodic pattern. Mason et al. (1996) reported that the amount of time in psychotic episodes was greatest in the first year of follow-up and that first relapse and re-admissions occur over the first five years. In this 13-year follow-up, 60.9% of their participants had an episodic course (no episode being longer than 2 years) and 32% had a continuous course (no remission longer than 6 months) and 6.3% could be classified as neither episodic nor continuous. Furthermore, 18% of the sample did not relapse. Thara et al. (1994) reported that the pattern of course was largely favourable, the commonest one being repeated episodes (observed in 76% of the sample).

Wieselgren and Lindstrom (1996) explored outcome over a 5-year period. One year after index hospitalisation, 20% of the participants were scored as having a good overall function. This improved to 30% at the five-year period. 58% had been in hospital during the last year prior to review, and 15% had spent no time at all in hospital after the first year. 8% had been in hospital during the entire course of the 5- year follow-up. Harrow et al. (2005) found that cumulatively over a 15- year period, slightly over 40% of patients with schizophrenia showed one or more periods of recovery. Over 50% of the patients with schizophrenia did not have a disorder that was chronic and continuous. Robinson et al. (2004) reported that at five years, 47.2 % achieved full symptom remission. Similarly, Kua et al. (2003) who explored outcome and predictors of psychosis over a twenty-year period in Asia reported that approximately two thirds of patients had a good/ fair outcome. This finding was consistent with Wiersma et al. (1998) who similarly reported that two thirds of participants over a 15-year period had at least one relapse, but 26.7% of the cohort remitted completely. Furthermore, each individual had on average 2.7 psychotic episodes over the 15-year period. Crumlish et al. (2009) who reported that 49.3% of participants were in symptomatic remission at eight year follow up.

Linszen et al. (2001) reported that the initial low relapse rates could not be maintained at 5 years. Fifty two percent had one or more psychotic relapses, 25% developed chronic positive symptoms and 23% did not have another psychotic episode.

Symptom severity

Positive symptoms

Not all the studies reported on symptomatic outcome. Nine studies out of the eighteen reported on symptomatic outcome in relation to positive and negative symptoms. In the MADRAS study (Thara et al., 1994), most positive symptoms (as measured by the Present State Examination) were absent at the 10-year follow-up. The syndromes that remained present were the residual syndrome (in 14%), affective flattening (10%), delusions of persecution (13%) self-neglect (10%) and social unease (11%). There was a general decline in both positive and negative symptoms during the 10 year period. Wieselgren and Lindstrom (1996) reported that at five year, 41% of their cohort had no or only mild positive symptoms and 6% had severe psychotic symptoms. Robinson et al. (2004) reported that approximately 50% of their cohort experienced symptom remission for two years or more by the end of the five years.

Ganev et al. (1998) reported that 46% of individuals had experienced continuous positive symptoms in the two years prior to assessment. However, 38% had not experienced any psychotic symptoms during the last two years. A relatively small percentage – 12.7% experienced episodic symptoms. Mason et al. (1996) reported that 32.8% of their cohort experienced continuous psychotic symptoms over the review period.

Negative symptoms

Most of the studies included in this review measured negative symptoms as part of outcome in psychosis. Some of the studies reported that negative symptoms predicted poorer outcome (Thara et al., 1994; Ganev et al., 1998; Bottlender et al., 2003; Bottlender et al., 2004; Jager et al., 2004; Moller et al., 2000; Moller et al., 2002). Furthermore, Moller et al. (2002) concluded that negative symptoms occur in all functional psychoses, but presented more frequently and prominently in the group with schizophrenia than it did in the other two diagnostic groups. In the group with schizophrenia, negative symptoms at admission and duration of rehospitalisation were correlated. Negative syndromes at discharge were highly and significantly correlated with all outcome parameters in the patients with schizophrenia.

Herbener and Harrow (2001) conducted a longitudinal assessment of negative symptoms in schizophrenia/ schizo-affective disorder compared with other psychosis and depressed

patients. They found that negative symptoms were more serious in the group with schizophrenia and schizo-affective disorder although negative symptoms are not particular to this group. Some cultural variations were noted. Takei et al. (1998) compared outcome in FEP between Afro-Caribbean and White people. They reported that Afro-Caribbeans had fewer negative symptoms than white counterparts.

Ganev et al. (1998) reported that the presence and severity of negative symptoms was associated with the prominence of psychotic symptoms. Over 25% of subjects without psychotic symptoms had experienced negative symptoms. 63.6% had experienced negative symptoms over the two-year review period.

Functional outcomes

Eight of the eighteen studies reported directly on functional outcome. Mason et al (1996) found that functioning improved in their first episode cohort over the 13-year period. At entry to the study, 13.6% of the cohort was considered to have good social adjustment. This improved to 31.8% at the 13-year period. Poor social adjustment decreased over the review period from 52.3% at entry to 43.2% at the 13-year period.

Wieselgren and Lindstrom (1996) reported on social functioning and after a 5-year period, 27% of their cohort worked half time or more, 8% sporadically and 18% in sheltered work. Forty seven percent had not worked at all in the year prior to interview. They compared a first episode cohort (considered index hospitalisation) with a chronic group and found that employment was highest in the First Episode cohort. Robinson et al. (2004) reported that 25.5% of the cohort had adequate social functioning for two years or more (during a 5-year period).

Racenstein et al. (2002) looked specifically at the relationship between positive symptomatology and work functioning. They measured work functioning with the Strauss-Carpenter Outcome Scale. The data from this study demonstrates a significant relationship between psychosis and increased impairment in work functioning. The most severely psychotic patient, regardless of diagnosis, are the least likely to be working effectively. Similarly, Helgason (1990) found that unemployment predicted poor outcome in first episode patients over a twenty year period.

Kua et al. (2003) considered treatment and work status as measures of outcome in their 20 year follow-up of patients with first episode psychosis in Asia. They found that approximately two-thirds of their cohort had good/fair outcome which is a comparable result

with other studies. In contrast, Crumlish et al. (2009) commented on psychosocial outcome. At 8 year follow-up, 32.8% had serious functional impairment, 28.3% moderate impairment, 13.4% mild impairment and 25.4% no impairment. Sixty percent of the sample in the Thara et al. (1994) study had continuous employment over the past ten years.

Cognitive functioning

Only one of the papers reviewed focused exclusively on neuro-cognitive function and outcome in first episode psychosis (Stirling et al., 2003) although Robinson et al. (2004) reported on cognitive functioning as part of a study looking at symptomatic and functional outcome. Stirling et al., (2003) focused on ten-year outcome data using neuro-cognitive and multi-dimensional outcome assessments on a cohort of 70 participants with non-affective psychosis. Forty-nine participants were followed up at the 10 years. They concluded that although many were living relatively independently in the community, most maintained regular contact with psychiatric services and continued to receive treatment. The authors concluded that poor outcome was associated with a decline in performance on visuo-spatial tasks and a failure to improve on frontal-temporal tasks during the follow-up period. They found that executive deficits may be present in the First Episode, but do not progress over 10-12 years. However, visuo-spatial function is spared in the FE but may deteriorate over time. Robinson et al. (2004) found that better cognitive functioning was associated with full recovery, adequate social and vocational functioning and symptom remission.

Substance misuse

One study reported on substance and alcohol misuse. Mason et al. (1996) reported that 2.4% of cohort reported cases of alcohol dependence at some stage over the 13 years.

Violence/ aggressive behaviour

Two studies reported on violence. Thara et al. (1994) reported that 6.8% of their cohort had displayed dangerous behaviour involving harm to others over a 10-year period. It is not clear from the study over what period the dangerous behaviour occurred, such as at index hospitalisation or later on in the course of the illness. Ganey et al. (1998) reported that in their 16 year follow-up 5.9% of patients had assaulted others. Those who had been violent had experienced continuous psychotic symptoms.

Affective recovery

Depression/ anxiety

Three studies reported on depression and anxiety. Mason et al. (1996) reported that 32.8% of their cohort experienced episodes of depression over a 13-year period and 1.83% experienced

anxiety. Thara et al. (1994) reported that over 50% of individuals had entered the study with depressive symptoms but this had reduced to less than 10% (as measured by the Present State Examination). General anxiety had also reduced from approximately 15% to under 5%. Wiersma et al. (1998) reported that 14% experienced at least one episode with affective symptoms, which started on average 6 years after the onset of psychosis.

Suicide

Six studies (Ganev et al., 1998; Thara et al., 1994; Mason et al., 1996; Wiersma et al. 1998; Wieselgren and Lindstrom, 1996; and Kua et al., 2003) reported on suicide. Ganev et al. (1998) reported that 7.7% of the cohort had made suicide attempts. Thara et al. (1994) reported that 3.8% of their cohort had committed suicide. Wiersma et al. (1998) found that 10% of their cohort had committed suicide over the 15-year period. Wieselgren and Lindstrom (1996) reported that 8.4% patients in their cohort of 120 committed suicide over a 5-year period and Mason et al. (1996) reported 2.68% suicides over a 13-year period in a cohort of 67 patients. Kua et al. (2003) considered suicide outcome in their study of 402 patients over a 20- year period. By the first five year follow up the suicide rate was 8.5 per 1000 patients per year. This rate was maintained at 10 years. By 15- years, this had dropped to a rate of 6.5 per 1000 patients per year and to 4.9 per 1000 patients per year by the 20-year follow-up. The authors concluded that that suicide risk was greatest in the first 10 years.

2.6 CONCLUSION AND DISCUSSION

The process of conducting this review highlighted several limitations with the literature on outcome in first episode psychosis, which resulted in difficulties drawing conclusions about the course and outcome of psychosis. The studies employed different diagnostic criteria (such as ICD-10; DSM-III-R; DSM-IV), selected patient cohorts on the basis of different definitions of first episode psychosis (such as first presentation at services; index hospitalisation; presentation at community services). The studies also ranged in the length of follow up and the outcome measures used. Furthermore, schizophrenia is clinically heterogeneous, even in first episode cohorts, as history prior to psychosis differs. This is particularly the case in studies that look at first admission to hospital as definition of first episode psychosis, as cohorts will vary on symptom severity, tolerance of others in their environment and duration of untreated psychosis (Ram et al., 1992). This will contribute to clinical heterogeneity and therefore will influence outcome.

Eighteen prospective first episode psychosis outcome studies were reviewed. All studies reported on symptomatic and functional outcome. Only six of the eighteen reported on suicide outcome, three studies reported on affective outcome and two on violence and aggression. It

may be concluded from this review that the course of first episode psychosis is one characterised by an episodic pattern – that is, all of the studies reviewed reported that approximately half of the individuals relapsed over the review period. However, findings also demonstrated that in some studies, up to 50% of individuals are in remission at the time of review. A similar statistic is found with regards to functional outcome, that approximately 50% of patients are considered to have good functional outcome at a 5-year period. These findings are consistent with the results over other reviews in this area (Ram et al., 1992; Hegarty et al., 1994, Menezes et al., 2006). Only six studies commented on suicide. Between 2.6% and 10% of individuals committed suicide over the review periods. It is not clear what factors would have influenced this, although it is possible that cohort sample, such as an inpatient sample versus community sample, may have led to a higher incidence of suicides in the community sample. Also, cultural and religious factors may also have influenced suicide rates. Few studies reported on the other outcomes of affective, violence and aggression, making it difficult to draw any conclusions. From the findings that exist, it would appear that violence was more associated with persistent psychotic experiences.

Most of the studies reported only on symptomatic and functional outcome, and within those domains, considerable variation in measures used was found. Few of the studies reported on the use of illicit substances and alcohol, with many excluding patients at the start of the study with such co-morbid presentations. Substance misuse is common in individuals with psychosis (Mueser et al., 1992) and has a detrimental effect on prognosis and recovery (Smith & Hucker, 1994; Lehman & Dixon, 1995). Future studies could inform clinical practice by including such patients into their design. Similarly only three studies reported on depression. This is disappointing given that research has shown that prior to relapse, the first signs that individuals experience is often emotional distress (Birchwood et al., 1989). Furthermore, post-psychotic depression is a risk factor for suicide and for poor recovery (Birchwood & Iqbal, 1998). Likewise, only two studies reported on violence and aggression in this group of patients. Knowing what predicts such behaviour is important for overall risk management. Patients who present with aggressive and challenging behaviour often end up in secure facilities for significant periods of time. Prospective studies that look at violence and aggression as one of the outcome measures may help determine the predictors of this behaviour in this relatively small cohort of patients.

First episode cohorts are used in prospective outcomes of psychosis to help us understand the course and pattern of recovery in psychosis, as clinical heterogeneity is reduced (although not completely reduced due to factors outlined above) with this population. However, whilst methodologies are improved, our understanding of course and prognosis in chronic cohorts in

more limited. Two seminal studies examining outcome in patients experiencing chronic psychosis will now be discussed. The Vermont Longitudinal Research Project (Harding et al., 1987) involved a 32-year prospective follow-up study, combined with a systematic retrospective follow-back study to document the lives of 262 individuals with chronic psychosis. The individuals in the cohort had been provided with a comprehensive rehabilitation package prior to being released into the community (20-25 years prior to the reporting of these results). The follow-up study was carried out over 5-10 years. At the start of the study, the authors had hypothesised that individuals in the research cohort with a DSM-III diagnosis of schizophrenia would still have signs and symptoms of schizophrenia at follow-up and that they would uniformly have poor outcomes in areas such as work, social relations and self-care. This study used similar measures to assess outcome as those used in the first episode outcome studies. For example, the Brief Psychiatric Rating Scale (Overall & Gorham, 1962); the Mini-Mental State Examination (Folstein, Folstein & McHugh, 1975), The Global Assessment Scale (Spitzer et al., 1975) and the Strauss-Carpenter Levels of Function Scale (Strauss & Carpenter, 1977) were used. With regards to symptomatology, at follow-up, 1% of the cohort had definite positive symptoms and 9% probable positive symptoms. 9% had definite negative symptoms and 9% had probable negative symptoms. 10% had probably affective disorders and 1% had probable alcoholism. The findings showed heterogeneity of functioning at outcome, although it was concluded that over two thirds of the sample did not experience psychotic symptoms at follow-up. In this study, Harding and colleagues used a *multi-dimensional* (including symptomatic and social/ vocational) definition of recovery from schizophrenia and found that using this, more than half the individuals were able to live satisfying and productive lives unencumbered by continuous and disabling psychotic symptoms. This research group documented that recovery among carefully and conservatively diagnosed persons with schizophrenia could be characterised by measures of work, community functioning, subjective quality of life, hospitalisations and symptoms. Of the 262 individuals in their study, 48-68 per cent met criteria for the various dimensions of recovery. The findings of the study were significant as they demonstrated that recovery (if a multi-dimensional perspective of recovery be given) from schizophrenia is possible, even in a cohort characterised by chronic schizophrenia and lengthy periods of institutionalisation. Several factors may have influenced the outcome of this study. The sample was biased towards a chronic long-term institutionalised group and that DSM III diagnosis had to be made retrospectively, with the potential for some patients to be wrongly diagnosed with schizophrenia, hence affecting the outcome. However, neuroleptic medication was introduced to Vermont State Hospital for the first time in 1954. Some of the patients responded very quickly to this but were unable to leave the institution due to lack of family etc. It was for this group of patients that the rehabilitation/ community programmes were devised. Such patients

were drug responsive but deskilled secondary to institutionalisation, not deterioration (Brooks, 1960). This study demonstrates the potential for recovery in people with chronic psychosis, and highlights the importance of taking a multi-dimensional approach to recovery – that is, more than symptomatic alleviation/ remission. Furthermore, this study highlights the importance of rehabilitation in the recovery of individuals with psychosis.

The Chestnut Lodge study (McGlashan, 1984) involved a retrospective study on patients discharged over a 25-year period from Chestnut Lodge. Patients were largely young, and considered to be treatment resistant. Outcome was assessed on average 15 years post-discharge. At this stage, the cohort distributed as follows on a 5 point global outcome scale (this scale consisted of a global view of outcome based on functional and symptomatic recovery): recovered – 6 percent; good – 8 percent; moderate – 23 percent; marginal, 23 percent continuously incapacitated – 41 percent. Long-term course proved to be a stable plateau with no evidence of trends toward improvement or deterioration. Suicidality was also explored in the follow-up study populations. Forty percent of patients reported suicidal ideation, 23% reported suicide attempts and 6.4% died from suicide. Individuals who completed suicide had less severe negative symptoms, but were higher on paranoid ideation.

These studies demonstrate similar findings to the first-episode outcome studies, that course is variable in psychosis. Studies looking at first episode and chronic cohorts show that approximately 50% go on to experience recovery, although the definition of this is influenced by the outcome measures used.

Both the first episode and the chronic group studies largely reported on functional and symptomatic outcomes. In recent years, there has been a growth in the use of qualitative methodologies that have been used to explore user's experiences of recovery. The emphasis in this research has not been on outcome as such, but the processes involved in achieving recovery or outcome. Due to concerns about methodological rigour and inherent problems of small and non-representative samples, qualitative research has previously lacked status in the larger scientific field. In recognition of this, standards for regulating methodological quality, whilst respecting core values and diversity, have been developed (e.g. Elliot, Fischer & Rennie, 1999, Critical Appraisal Skills Programme, 2002). There has also been an increase in the application of more systematic approaches as Grounded Theory (Glaser & Strauss, 1967) and Interpretative Phenomenological Analysis (Smith, 2003) in psychosis research (e.g. Boyd & Gumley, 2007). As a result, there has been a significant growth in the volume of recovery-focused research into psychosis. This research focuses on understanding the processes involved in achieving recovery, but also questions the concept of recovery and what it means

to the individual, rather than the group (which is the focus of outcome research described above).

There is a general consensus in the recovery literature that recovery involves *an individual process* of changing personal attitudes, values, goals and skills in order to live a satisfying and hopeful life. It involves moving on from a mental illness and living well, even in the continuing presence of symptoms (Anthony, 1993, Noorsdy, Torrey, Meuser et al., 2002). As stated by Stewart and Wheeler (2005) the recovery journey is undertaken through empowerment, with a gradual transfer of responsibility from external care to the individual taking on board more ownership of this.

To help define recovery from schizophrenia from the consumer perspective, Andresen, Oades & Caputi (2003) conducted a comprehensive review of published experiential accounts, consumer articles, qualitative studies and theoretical literature. In a review of the literature, Andresen, Oades and Caputi (2003) focused on two psychological dimensions of recovery in schizophrenia. These two dimensions were, *component processes* and *stages of recovery*. Four component processes of recovery were salient: *finding hope; redefining identity; finding meaning in life* and *taking responsibility for recovery*. The authors presented a five-stage model of recovery, based on qualitative studies they had reviewed. The first stage was referred to as *moratorium* and was characterised by denial, confusion, hopelessness, identity confusion and self-protective withdrawal. The second stage was *awareness*, where the person has a first glimmer of hope of a better life, and that recovery is possible. It involves an awareness of a possible self other than that of 'sick person' – a self that is capable of recovery. The third stage was referred to as *preparation*, which involves awareness of core values, strengths and weaknesses, and further involves learning about mental illness, services available, recovery skills etc. The fourth stage was *rebuilding*. This stage involves taking responsibility for managing the illness¹ and taking control of ones life. The final stage of recovery is referred to as *growth*, where the individual may not be free of symptoms, but knows how to manage the illness and to stay well. Andresen et al (2003) state the individual in this stage, has a positive sense of self, feeling that the experience has made them a better person than they might otherwise have been.

Lysaker (2005) amongst others (Davidson & Strauss, 1992; Young & Ensign, 1999) has suggested that the reconstruction of a coherent personal narrative is an essential aspect of recovery. As Corrigan (2003) notes, this includes accepting strengths and weaknesses, or

“the boundaries that mental illness has placed upon life and...that most of the experiences that define essential humankind are still attainable.” (p 349). A central recovery theme in the research literature described above is developing an *integrated sense of self*. Helping the individual to construct a more coherent story about who they are, articulating and integrating dreams, desires, losses and triumphs into a richer narrative can help to develop this integrated sense of self (Holma & Aaltonen, 1997; Lysaker & France, 1999). Specifically, with a more coherent narrative of self and illness, it has been widely argued that a person should be better able to critically examine and articulate beliefs and emotions, maintain connections with others and embrace a realistic sense of agency (Davidson, 1999; Lysaker, Lysaker, & Lysaker, 2001; Williams & Collins, 1999).

The recovery literature has therefore identified *narrative transformation* as a meaningful dimension of outcome in its own right, emphasising how developments in an individual's self- understanding play a pivotal role in movements towards health and wellness. It has been suggested, for instance, that recovery may necessitate the development of a coherent, future-oriented identity (Davidson & Strauss, 1992; Polkinghorne, 1995; Roe & Ben-Yaskai, 1999). Similarly it has be argued that the ability to actively plan for one's own future requires that over-riding themes of passivity within personal narrative be replaced with themes of agency and that personal strengths and weaknesses be integrated into a larger story.

What are the implications for future research into outcome and psychosis?

The findings of this review point to various potential developments in both the research and clinical arenas. From this review it may be concluded that outcome in schizophrenia is heterogeneous. Contributing to this heterogeneity are methodological weaknesses in outcome studies in which different outcome measures are used, different lengths of follow-up and even different definitions of first episode. Furthermore, this review has shown that the majority of outcome studies emphasise symptomatic (in terms of course, remissions, relapse and symptom severity) along with functional outcome, above affective outcome and other aspects of the multi-faceted picture of schizophrenia, such as substance misuse, violence and aggression. Despite these limitations in the literature, it may be concluded that up to half of patients with first episode psychosis experience recovery and experience a good outcome (bearing in mind the differences in how this is defined) beyond 5 years. These findings are broadly consistent with other reviews of outcome in first episode psychosis (Ram et al., 1992; Menezes et al., 2006).

The recovery movement and the emphasis on user-focused research may enhance our understanding of outcome in psychosis. By integrating the findings from user-focused

recovery research into outcome based research it may be possible to develop a user focused outcome measure – one that is grounded in the experiences of the individual and what they consider important in their recovery. Adopting such measures into this research field may lead to different ratings of recovery and hence different outcomes.

All eighteen first episode studies that were reviewed and the studies that reviewed outcome in chronic groups portrayed a picture of psychosis characterised by relapse and periods of remission. Furthermore, up to 20% of individuals in some of the studies did not experience any periods of remission during the review periods. This would imply that despite advances in psychopharmacology, a significant group of individuals do not respond. This would suggest the importance of looking to other forms of care and treatment to promote recovery. The development of CBTp over the past 10-20 years has demonstrated that this can improve outcome in individuals with acute and chronic presentations (see chapter three for review), and through research into cognitive models in psychosis, can also challenge notions that reduction in symptoms is the only outcome that defines recovery. The following chapter will now discuss the recovery movement and how this has influenced how we think about severe and enduring mental health problems. This will then proceed to a discussion of CBTp and how this can aid a recovery-focused approach to care and treatment.

CHAPTER THREE: RECOVERY AND PSYCHOSIS IN FORENSIC MENTAL HEALTH SETTINGS

3.1 Introduction

“It should be pointed out that a key element in these favourable long-term outcomes was access to continuous and reasonably comprehensive mental health services. That the social and symptomatic recovery of patients is not a consequence of some aging or ‘burning out’ process has been shown by studies of older persons with schizophrenia (Palmer et al., 1999) as well as by controlled studies that have shown the necessity of well-co-ordinated treatment to achieve salutary outcomes (Paul & Lentz, 1977; DeSisto et al., 1995a; 1995b).” (Lieberman 2002).

As noted in the previous chapter on outcome in psychosis, there has been considerable effort over the past five decades into evaluating the longer-term outcomes in psychosis. Studies have in the past been hampered by methodological limitations as a result of heterogeneous samples, retrospective designs and poorly defined outcome measures (Ram et al., 1992). Subsequently, outcome literature has, in the past, suggested a progressive course and poor outcome for schizophrenia (Menezes, Arenovich & Zipursky, 2006). More recently, outcome studies have employed prospective longitudinal designs with first episode psychosis (FEP) clients in order to reduce this heterogeneity. These studies have shown that between half to two thirds of individuals with a first episode psychosis will show periods of recovery over a five-year period (Robinson et al., 2004). Beyond the five-year period, some studies have demonstrated that up to 50 % of individuals are in remission (Robinson et al., 2004; Crumlish et al., 2009; Harrow et al., 2005; Kua et al., 2003). Therefore, outcome from FEP appears to be more favourable now than in the past, with treatment and methodological factors being an important contributor to outcome (Menezes et al., 2006). However, studies are still limited by poorly defined outcome measures, with the recommendation that there be a globally defined and agreed outcome measure (Menezes et al., 2006; Lieberman & Kopelowicz., 2002).

The majority of prospective outcome studies focus on functional and symptomatic outcome measures (see Menezes et al., 2006; Malla and Payne., 2005; Ram et al., 1992 for reviews). It has been argued in the previous chapter that other relevant outcomes are often not considered, such as substance and alcohol misuse, depression, and challenging and aggressive behaviours. Individuals with psychosis often present with the above, which has implications for outcome and care and treatment (Barowclough, Haddock, Beardmore et al., in press; Dean et al., 2007; Graham et al., 2001; Birchwood et al., 2000). The literature has also shown that access to

treatment and rehabilitation has a significant bearing on outcome (Harding et al., 1984; Menezes et al., 2006).

Therefore, it may be argued that the outcome literature in psychosis has to date, focused primarily on symptomatic and functional outcomes. Although this research gives us an indication of the likelihood that an individual will go on to experience symptomatic remission over a five year period (Crumlish et al., 2009; Robinson et al., 2004) or periods of recovery over a 15-year period (Harrow et al., 2005), it does not state *how* the individual achieves this, the *processes* involved in this and what might be the obstacles in achieving this. Furthermore, there is an inherent assumption in this literature that the outcomes being measured are the outcomes that matter. Therefore the outcome literature generates further points for consideration. The first point is whether the outcomes that are measured are those that matter to the individual with psychosis. The second point considers the processes involved for the individual in achieving those outcomes. The recovery movement and the research emanating from this with respect to recovery and psychosis (Davidson & Strauss, 1992 Andresen, Oades & Caputi, 2003; Morrison et al., 2007), provides greater insight into these processes. By having an understanding of the processes involved in recovery, it allows for the development of interventions aimed at facilitating those processes. Therefore, if the development of self-esteem, for example, is a key process in recovery, then developing psychological interventions of self-esteem may be important. This will be discussed further in this chapter.

This chapter therefore argues that recovery and psychosis is about a process; a journey that an individual experiences in order to achieve certain valued outcomes. These outcomes will vary according to the individual, what they consider meaningful to their existence and what the environment in which this individual resides values. Therefore, this chapter will argue that recovery is more than just outcome, but a process experienced by the individual and shaped by their environment. This chapter will also consider the implications of this view on recovery and outcome in psychosis with respect to recent developments in cognitive behavioural therapy. Having conducted the research for this thesis in a forensic mental health setting, the challenges to adopting a recovery focused approach in this setting will be reviewed along with the existing literature on CBT for psychosis in this setting. This will be followed by recommendations for further research.

3.2 Recovery and Psychosis: Setting the scene and context to recovery

The broader concept of recovery as a general philosophy and model came from the substance abuse/ drug addiction movement. The application to the mental health setting came from the consumer/ survivor/ ex-patient movement in the United States during the 1980s and the early

1990s (Office of the Surgeon General and various United States Government agencies, 1999). From this movement, it became apparent that the concept of recovery was often defined differently between consumers/ survivors and professionals.

The recovery literature emphasises that recovery is a process that the individual experiences, whereby they are an active agent in the appraisal and development of their own personal attitudes, values, goals and skills; the review of which contributes to the development of a satisfying and hopeful life with or without symptoms, and being able to live alongside psychosis (Bradstreet & Connor, 2005; Martyn, 2002; Roberts & Wolfson, 2004). Central to this recovery journey is the empowerment of the individual and the sense they have of being a director over their own health and wellbeing (Noorsdy et al., 2002; Stewart and Wheeler, 2005). Anthony (1993) suggests that recovery from serious mental health problems is a multi-dimensional concept whereby social and psychological recovery processes are seen as being as important as clinical recovery. Anthony (1993) draws the distinction between clinical recovery, social recovery and psychological recovery. Clinical recovery is defined by reduction in “symptoms” (e.g. voices and unusual beliefs). Social recovery describes the development of meaningful social relationships and roles, vocational activities and access to decent housing. Psychological recovery describes the process of developing ways to understand and manage psychotic experiences and regain some sense of structure in one’s life. Anthony, (1993) described the following eight principles as important in understanding recovery:

- Each person’s recovery is different;
- Recovery requires other people to believe in and stand by the person. Other people/ opportunities play an important part in enabling the person to make this recovery journey;
- Recovery does not mean cure. It does not mean the complete disappearance of difficulties;
- Recovery can occur without professional help. Service users hold the key to recovery;
- Recovery is an ongoing process. During the recovery journey there will be growth and setbacks, times of change and time where little changes;
- Recovery from the consequences of mental distress (stigma, unemployment, poor housing, loss of rights etc) can sometimes be more difficult than recovery from the distress and confusion itself;
- People who have or are recovering from confusion and distress have valuable knowledge about recovery and can help others who are recovering;
- A recovery vision does not require a particular view of mental health problems.

When considering recovery it is necessary to take into account that the definition, in real terms, is influenced by the various stakeholders involved – for example, the service provision agenda; the International context; government targets, the individual, their family and their carers. Consistent with this, May (2001) has argued that recovery is both an *internal* and *external* process – the internal is what happens within oneself, while the external includes interactions with others. “Others” include the policies, procedures, and actions of the mental health system and the people who fund and provide mental health systems; social supports such as financial support, housing assistance and employment support, natural supports such as family, friends, community, religious organisations; and peer supports, both organised and informal. Therefore, recovery involves the dynamic interplay between what the individual values and finds meaningful (for example, developing friendships might be more important than reducing symptoms) and what service providers, carers and family consider central to recovery. In light of this dynamic, May, Risman, Kidder et al. (1999) has stated that current statutory emphasis upon maintenance and relapse prevention maybe contrary to recovery as this appears to be an agenda driven more by the “external” rather than the needs of the individual. Furthermore, Padilla (2001) has stated that the symptoms practitioners often wish to reduce, such as positive symptoms of schizophrenia (hearing voices, paranoid delusions) may not be important and meaningful to the person experiencing them. Therefore, services should not make the assumption that recovery is about symptom reduction. Indeed, research has shown that many individuals may lead meaningful lives and continue to have ongoing symptoms. Padilla further argues that people need to recover from the effects (whether this be social, interpersonal etc) of mental illness, its diagnosis and treatment. Harding et al. (1987a; 1987b) demonstrated the partial independence of symptomatology, social functioning, and occupational or educational functioning. They reported that any participants were able to function adequately in society despite the presence of persisting symptoms, and that many had developed coping strategies to manage with these symptoms. May (2000) states that recovery from social expectations can be more challenging than recovery from psychosis: “*recovery lies in the social contexts within which this process occurs*” (pg 10). Furthermore, the recovery literature has emphasised that recovery is perhaps not about reduction in symptomatology but about recovery from social exclusion, stigma, labelling, restrictions, civil rights, discrimination, guilt and shame.

The recovery agenda has an International, National and Local perspective. On an International level, the concept of recovery is high on the agenda. In the United States and Canada, the New Freedom Commission on Mental Health has proposed to transfer care from one that has been traditionally a psychiatric paradigm to a recovery-focused model. In New

Zealand (since 1998) and the Australian National Mental Health Plan (2003-2008) suggests that all services adopt a recovery-focused approach (Rickwood, 2004).

At a National Level, the National Institute for Mental Health in England (NIMHE, 2005) has promoted a recovery-focused approach. More locally, a recovery approach to mental health is currently supported by the Mental Health (Care and Treatment) (Scotland) Act 2003. The primary objective of the Act is to protect the rights of people with mental health problems. A fundamental difference between the new Act and previous ones is the introduction of “guiding principles” (Scottish Executive, 2003). Although the Act makes no explicit reference to the promotion of recovery, both the principles and repeated emphasis on safeguarding the rights and benefits of service users endorse values of the recovery movement. It outlines ten principles as the basis for any action taken under the act. Of these, the principles of ‘non-discrimination’, ‘equality’, ‘respect for diversity’, ‘reciprocity’, ‘participation’, and ‘respect for carers’ in particular have direct relevance for a recovery-oriented mental health system.

In Scotland, the Scottish Executive’s National Programme presently drives a recovery approach to mental health for Improving Mental Health and Well-Being. One of its key aims is to ‘support and promote recovery’. The development of the Scottish Recovery Network (SRN) is central in achieving this aim. In its brochure “Raising Expectations and Sharing Ideas for Mental Health Recovery” (2009), the SRN defines itself as a ‘vehicle for learning and sharing ideas’ (pg 5) and brings together organisations and individuals in a debate on how to build the capacity for recovery in Scotland as well as carrying out primary research on the experience of recovery.

“Recovering Mental Health in Scotland” (2007) was carried out by the Scottish Recovery Network. This research drew upon the experiences of 64 people in Scotland to highlight the factors that helped and hindered their recovery from long-term mental health problems. Six internal (individual and self-controlled) and six external (social and environmental) factors were found to promote recovery: -

Internal

- ❖ Belief in self and developing a positive identity
- ❖ Knowing that recovery is possible
- ❖ Having meaningful activities in life
- ❖ Developing positive relationships with others and your environment
- ❖ Understanding your illness, mental health and general well-being
- ❖ Actively engaging in strategies to stay well and manage set-backs

External

- ❖ Having friends and family who are supportive, but do not undermine narrators self-determination
- ❖ Being told that recovery is possible
- ❖ Having contributions recognized and valued
- ❖ Having formal support that is responsive and reflective of changing needs
- ❖ Living and working in a community where other people could see beyond your illness
- ❖ Having life choices accepted and validated

Developing self-confidence, self-belief and self-determination were amongst the key factors in recovery. Recovery usually followed an acceptance of illness, rejection of the stigma associated with mental illness and a determination that the illness will not ruin one's life. Refining and re-defining sense of self was considered as important as symptom alleviation. In a booklet to support this document, "Routes to Recovery", the following themes were highlighted as important in achieving recovery: -

- ❖ Building a good base for recovery
- ❖ Believing that recovery is possible
- ❖ Being in control of your own recovery
- ❖ Looking for the positives in life
- ❖ Finding the right support and treatment
- ❖ Keeping busy and finding meaning and purpose

The findings of this research can be compared with international research carried out by Andresen, Oates and Caputi (2003), in their stage model of recovery and psychosis. They conducted a comprehensive review of published experiential accounts, consumer articles, qualitative studies and theoretical literature. In their review of the literature, they focused on two psychological dimensions of recovery in schizophrenia. These two dimensions were, *component processes* and *stages of recovery*. Four component processes of recovery were salient: *finding hope; redefining identity; finding meaning in life* and *taking responsibility for recovery*. The authors presented a five-stage model of recovery, based on qualitative studies they had reviewed. The first stage was referred to as *moratorium* and was characterised by denial, confusion, hopelessness, identity confusion and self-protective withdrawal. The second stage was *awareness*, where the person has a first glimmer of hope of a better life, and that recovery is possible. It involves an awareness of a possible self other than that of 'sick person' – a self that is capable of recovery. The third stage was referred to as *preparation*, which involves awareness of core values, strengths and weaknesses, and further involves

learning about mental illness, services available, recovery skills etc. The fourth stage was *rebuilding*. This stage involves taking responsibility for managing the illness² and taking control of one's life. The final stage of recovery is referred to as *growth*, where the individual may not be free of symptoms, but knows how to manage the illness and to stay well. Andresen et al. (2003) state the individual in this stage, has a positive sense of self, feeling that the experience has made them a better person than they might otherwise have been.

3.3 Recovery focused research and Psychosis : what are the main aspects of recovery from psychosis?

Bonney and Stickley (2008) carried out a systematic review of the literature on recovery and mental health. The authors stated that the objective of the study was to highlight the notion of recovery from the user's perspective. Search terms included schizophrenia, psychosis, recovery, mental illness and mental health. The authors reviewed 170 studies. Six dominant themes were identified in this review and were:-

- 1.) ***Identity*** – that individuals, having experienced serious mental health problems expressed a need to redefine their identity and to accept their experiences as being part of who they are. This was considered an essential component of recovery;
- 2.) ***Service provision agenda*** – this referred to how services can “shape” and operationalise the concept of recovery but that this might not always be in keeping with service user's perceptions of recovery. For example, services may highlight the importance of symptomatic reduction as an essential component of recovery, or might view treatment success as reduced admissions to hospital, neither of which may relate to the individual's experience of recovery'
- 3.) ***The social domain*** – this item refers to individuals placing emphasis on being valued members of society; of being employed, contributing to society and being able to engage in and access mainstream activities. This is also crucial to helping shape up identity as being part of the wider social domain improves sense of self due to experiences of being accepted and included;
- 4.) ***Power and control*** – this theme refers to individuals having a degree of choice and autonomy over their care and treatment but also being given responsibility for this too;
- 5.) ***Hope and optimism*** – Hope is considered to be a key ingredient in recovery. In this review, the authors reflected on studies demonstrating that many people with schizophrenia describe positive aspects of their experience, for example, becoming

more creative and understanding, becoming mentally stronger and feeling more grounded and part of their environment. Hope has also been described as being able to lead a meaningful and fulfilling life, despite ongoing mental health experiences.

- 6.) ***Risk and responsibility*** – this theme refers to the balance that services and carers need to be aware of when enabling individuals to fulfil recovery potentials. Often, services work within a philosophy of risk reduction and to an extent, become risk averse. This can have the disabling effect of individuals with psychosis not being able to take on more responsibility for themselves for fear that it may result in their harm or harm to others.

Pitt, Kilbride, Nothard, Welford and Morrison (2007) conducted a unique study of recovery from psychosis by having interviews with service users carried out by a service user. Seven interviews were analysed using Interpretative Phenomenological analysis. The findings of this study were consistent with those in the above review. Three key themes were identified; “Rebuilding self”, “Rebuilding life” and “Hope for a better future”. Within the themes “Rebuilding self”, individuals reported recovery involved the process of them learning and understanding about themselves; understanding their mental illness and the distress they had experienced. However the process of rebuilding self also involved empowerment and gaining control, developing self-esteem and motivation and developing the confidence to be able to challenge mental health services, where necessary.

The second theme of “Rebuilding life” referred to the process of becoming integrated in society, and developing socially valued roles. For example, sub-themes of re-building social support and being an active participant in life were identified. Finally, the third theme identified in this study was “Hope for a Better Future”. This involved “a process of change” and “desire for change”. In essence, this involved individuals developing the confidence to be able to take more responsibility for themselves, to feel empowered in doing this and to be able to challenge other’s perceptions of mental illness. As summarised, “the recovery journey involves a process from social exclusion to social inclusion” (pg 58).

It may therefore be concluded that recovery from psychosis involves many processes and stages (although not necessarily having to work through one stage before achieving another). Recovery seems to be about re-defining and developing a sense of self, but feeling empowered by this and developing the ability to take on responsibility for oneself and to be able to challenge services where appropriate. Recovery is also about developing hope and optimism about the future, and importantly, this does not appear to be contingent on symptomatic reduction, but on feeling positive about self and future possibilities.

3.4 What are the challenges to adopting a recovery focused approach?

Recovery and the individual

Recovery style has been identified as an important factor in adjustment to psychosis. Sealing over or avoidance coping (McGlashan et al., 1997; McGlashan, 1987; Drayton et al., 1998) tends to be associated with poor social functioning and quality of life and high levels of depression (McGlashan, 1987; Drayton et al., 1998; Thompson et al., 2003). Research has shown that sealing over may reflect the individual's psychological vulnerability (Drayton et al., 1998). Tait, Birchwood and Trower (2004) found that participants with sealing over recovery styles reported lower levels of parental care during early childhood than those with an approach or integrated style of recovery. Furthermore, such individuals reported higher levels of abuse from parents in their childhood than those with an integrated style of recovery. This is further evidenced by research that has shown that individuals with psychosis have life histories that are characterised by disrupted attachments, experiences of trauma through physical, sexual and emotional abuse, exposure to violence in the home and quite often social exclusion (Boswell, 1996; van Os et al, 2004; Read & Gumley, 2008). Sealing over styles have implications for the individuals engagement with services and hence, their recovery. Tait et al. (2004) have argued that individuals with sealing over styles may disengage from services that are perceived as demanding and forcing compliance with treatment. They have argued that therapeutic attention should focus on raising self-esteem through the use of non-intrusive activity and through staff having an interpersonal style characterised by low self-expressed emotion. Therefore, although an individual may present with a particular style of recovery, this is not a stable trait (Tait et al., 2004) and therefore can change according to the therapeutic environment. This turns our discussion now to the role of the system in shaping the individual's experience of recovery.

Recovery and the system

The context and client group in a forensic mental health setting poses challenges to the adoption of a recovery-focused approach. Nearly all patients are detained under the Mental Health Care and Treatment (Scotland) Act (2003) with a significant majority also coming under the Criminal Procedures (Scotland) Act (2005). As a result, individuals are not receiving treatment on a voluntary basis and are therefore not necessarily willing participants in their care and treatment. This immediately poses a challenge to the concept of recovery being a journey that the individual has ownership and control over (Anthony, 1993). Furthermore, being detained in a high secure environment adds to the stigma already experienced by an individual with severe and enduring mental health problems.

The restricted environment of the institution also has a bearing on the application of recovery in forensic mental health. Where the average length of hospitalisation is being reduced in general adult mental health settings for the recognition that lengthy admissions are not good for recovery (HEAT Targets, 2007-2009), the converse is the case in forensic mental health. Within a high secure environment, the length of admission range from 3 months up to 40 years (The State Hospitals Board for Scotland Annual Review, 2007). Furthermore, individuals detained in secure environments lose access to many freedoms that are considered important for recovery. For example, having meaningful activities in life, having friends and family who are supportive, living and working in a community where other people see beyond illness, having life choices accepted and validated (SRN, 2007) – all of these aspects to recovery are more difficult to achieve within a secure environment. The driving force behind such restrictions is risk management (Forensic Mental Health Services Managed Care Network, 2004); therefore individuals residing in such settings will have limited access to relatives, limited opportunity to exercise control over their care and treatment – factors considered conducive to promoting recovery (Anthony, 1993; SRN, 2007).

Much has been written about the role of the institution and the dynamics that exist within this. (Campling, 2004). Patients within institutions are all potentially vulnerable due to the unique power relationship that exists between staff and patients. Goffman (1961) in his seminal work, “Asylums” developed the theory of the “total institution process” wherein it takes efforts to maintain predictable and regular behaviour on the part of both the staff and the clients, suggesting that many features of such institutions serve the ritual function of ensuring that both staff and clients know their function and social role. Goffman argued that that total institutions possess the following characteristics:

- A barrier to social intercourse with the outside and to departure, which is often built-in (e.g. high walls);
- All aspects of life are conducted in the same place and under a single authority;
- Each member’s daily activity is carried out in the company of a batch of others;
- All phases of the day’s activities are tightly scheduled;
- The activities are brought together in a single rational plan purportedly designed to fulfil the official aims of the institution;
- A basic split between a large managed group (inmates) and a small supervisory staff;
- Grossly restricted social mobility between the two strata;
- The staff control information, decision-making and access to the institution’s hierarchy;
- Being resident in an institution is incompatible with family life.

Our understanding of Social Mentality Theory (see chapter one, pg 15-16 for outline) and in particular Social rank theory (Gilbert, 1992; Price et al., 1994) can be used to develop Goffman's original concept of roles in the institution, by helping us to understand the psychological impact of the interpersonal dynamic created by such roles. Social rank theory argues that various mental mechanisms evolved within the context of social hierarchies. In these contexts those with superior strengths/ skills were able to threaten, attack or intimidate those less able, and those in subordinate positions would defend themselves by escaping, fleeing and submitting. The consequences of low social rank include low self-esteem, submissiveness, shame, humiliation, anxiety and depression (Birchwood, Meaden, Trower and Gilbert, 2003). Submissive interpersonal styles have further reaching implications. Such strategies are associated with responding to auditory hallucinations, particularly command hallucinations (Birchwood, Meaden, Trower and Gilbert, 2003). This chapter has already highlighted the evidence that many individuals with psychosis have histories that are characterized, interpersonally by them being subordinate or submissive to others through those experiences of abuse. The experience of psychosis and the stigma attached to this can further compound this submissive role (SRN, 2007). For example, being admitted to hospital or being a patient in a community mental health team can be a disempowering experience. By the nature of being a patient, individuals experience a lower social rank compared with staff. Therefore there is a risk that the environment in which people are brought in to facilitate their recovery and to offer care and treatment, can also be the environment that contributes to the maintenance of their psychosis by the nature of the social roles and interpersonal styles that exist.

The concept of "malignant alienation" (Watts & Morgan, 1994) is also relevant when considering the forensic mental health environment. Malignant alienation is dynamic that can hinder the recovery process. It is described as "*A progressive deterioration in [patient's] relationship with others, including loss of sympathy and support from members of staff, who tended to construe these patient's behaviour as provocative, unreasonable, or over dependent. Such alienation between patient and other appeared to be malignant in that it gained momentum and was associated with a fatal outcome*" (Watts & Morgan, 1994, cited in Davies, 2008, p.g. 22). Patients who present with complex histories and challenging behaviour are more likely to engender this sense of alienation in staff (Watts & Morgan, 1994). This is likely therefore to be more commonplace in a forensic mental health establishment. Contributing to malignant alienation is staff being unable to express negative feelings. This can be much greater in forensic mental health where staff have to cope with the impact of hearing patients' offending histories, which can illicit negative feelings and anger.

Not all aspects of institutional life have to be negative or negate the potential for recovery. If we take a closer look at attachment with this population then we can understand the function of the institution as a secure base, upon which recovery becomes an actual possibility. Both dismissing and unresolved attachment patterns are over-represented among offenders and individuals with psychosis, compared to normal populations (Adshead, 2004; Read & Gumley, 2008). When an individual is admitted to a secure hospital, it is likely that they draw upon past attachment behavioural strategies to manage their sense of threat or fear. Adshead (2001) refers to “toxic” attachments, which are “*attachment patterns characterized by dismissing feelings of need or tenderness, and dissociation at times of threat.....Such toxic attachments are also associated with an acute sensitivity to discrepancies of power and control, so that other people are assessed in terms of their threat/ control potential, or their vulnerability/ exploitation potential*” (Adshead, 2004 p.g 154-155). This last point is particularly salient in terms of the previous discussion around the low social rank of patients in institutions. It is possible however for forensic institutions to create a secure base for attachment and to hence promote recovery, through for example, establishing firm boundaries; monitoring staff and patient affect regulation; managing separations and losses to name a few (Adshead, 2004). The secure base facilitates the development of positive relationships with staff and peers, improved emotional regulation and mentalisation in order to reflect on one’s own experiences and those of others.

It may be argued that the potential for tension exists within a forensic mental health environment. There is the tension between offering care and treatment, against the needs to ensure a safe environment and promote risk management. Tension exists between staff and patients in that staff have to manage and deal with the negative feelings they may have for patients, whilst maintaining a therapeutic stance. Patients have to cope with the restrictions on their freedom, the shame and stigma of being a patient in forensic mental health. All of this poses a challenge to the application of a recovery-focused model in this setting.

3.5 Fostering a recovery focused therapeutic environment.

Cognitive models of psychosis

Fostering a recovery focused approach to care and treatment can be developed through the delivery of psychological interventions. For example, current research into psychological models of psychosis has challenged the view that treatment is about symptom reduction, providing further support for the recovery-focused approach (Tai & Turkington, 2009). Consistent with this it has been argued that CBT for psychosis is not a “quasi-neuroleptic” (Birchwood & Trower, 2006) and that the focus of treatment should be on reducing distress associated with experiences of psychosis. Furthermore, research has shown that CBT can

bring about a reduction in compliance with command hallucinations and distress without a reduction in voice frequency (Trower et al., 2004). Abba, Chadwick and Stevenson (2008) also talk about responding differently to symptoms of psychosis –they refer to responding mindfully to distressing psychosis. This builds upon the work of Chadwick, Birchwood and Trower (1996) who argue that cognitive therapy for psychosis should not be aimed at trying to control psychotic symptoms such as voices, images and paranoid intrusions, but at alleviating the distress associated with them.

Garety et al. (2001) present a cognitive model for the positive symptoms of psychosis, covering both delusions and hallucinations. In this model, they provide an explanation for the cognitive processes that lead to the formation and maintenance of the positive symptoms of psychosis. This model is integrated with social factors (such as early life experiences, interpersonal variables etc.) and how these factors may contribute to the origins, maintenance and recurrence of symptoms. Garety et al. (2001), place significance in the role of emotion in this process.

This model explains how individuals are vulnerable or pre-disposed to the development of psychosis. This predisposition is considered to be of a bio-psychosocial origin. Garety et al. (2001) argue that onset of psychosis follows life events, leading to emotional changes and disruptions in cognitive processes, such as attention, perception and judgement. Such basic cognitive disturbances lead to anomalous experiences (hyper-vigilance to threat, racing thoughts), which lead to emotions arousal. It is this emotional arousal, which Garety et al. (2001) argue feedback into the processing of anomalous experiences. The attempt to understand the cause of these experiences – to find meaning in them, leads to biased appraisal processes. This cognitive model is supported by previous research into cognitive processing (Garety & Freeman, 1999) that shows an information processing style characterised by jumping to conclusions, externalising attributional biases, deficits in understanding social situations and the intentions of others. These processing biases are exacerbated by the experience of anxiety. It is further argued in this model that social background factors such as trauma, loss etc lead to negative self-schemata, predisposing the individual to such experiences.

Further evidence for predisposing vulnerability comes from research by Birchwood, Meaden, Trower, Gilbert and Plaistow, (2000) in to auditory hallucinations. In their model, they apply social cognition to understand the nature of the relationship between the individual and their auditory hallucination. They argue that the distress arising from the activity of the voice can be understood by reference to the individual's relationship with the voice rather than the voice

content. This relationship is usually characterised as one of involuntary subordination to a power or omnipotent other. Core interpersonal schemata, reflecting past experiences (the predisposing vulnerability), particularly powerful caregivers, influence how this voice is interpreted. Furthermore, such early experiences have implications for the development of self-esteem, which research has shown is commonly low in people with psychosis and plays a role in the development and maintenance of psychosis.

As mentioned above, Garety et al. (2001) place significant emphasis on the role of emotion and its relationships with cognitive processing in their cognitive model. Birchwood and Iqbal (1998) found that residual symptoms of both hallucinations and delusions are more common in depressed people with psychosis, and they propose that feelings of hopelessness and uncontrollability contribute to symptom maintenance. Meta-cognitive beliefs, such as beliefs concerning the uncontrollability of one's thoughts, can also increase the distress caused by psychosis (Freeman & Garety, 1999).

Morrison et al. (1995) and Morrison, (2001) argued that auditory hallucinations are experienced when intrusive thoughts are attributed to an external source in order to reduce cognitive dissonance, which may be caused by the incompatibility of certain intrusive thoughts and meta-cognitive beliefs, particularly beliefs about controllability. Therefore, this model argues that voices, thought broadcasting and passivity phenomenon may be misattributed intrusion.

CBT for Psychosis

Early forms of CBT for psychosis focused on improving coping skills, functional outcomes such as improved social and independent living skills and treatment compliance (Tarrier, 1992; Wieden et al., 1995). Recent research developments have shown that hallucinations and delusions can occur when anomalous experiences that are common to the majority of the population are misattributed in a way that has extreme and threatening personal meaning. Subsequently, this has led to a shift in focus in CBT to that of distress resulting not necessarily from difficult experiences but the meaning placed on those experiences. Therefore in CBT for psychosis, it is the individual's personal meaning, understanding and coping with symptoms that are the focus of treatment, not symptom reduction (Tai et al., 2009). Importantly, this process is a collaborative one with the client and with those involved in their care. The aim of therapy is to develop a shared understanding of experiences and a shared understanding of goals and desired outcomes. Furthermore, therapy is about normalising experiences in order to demystify psychosis and make it seem less frightening (Kingdon &

Turkington, 1994). This is supportive of a recovery-focused approach in that it helps to promote autonomy, self-efficacy and collaboration (Anthony, 1993; SRN, 2007).

Furthermore, developments in our understanding of cognitive models of psychosis have led to other aspects of its presentation being targeted in therapy, as opposed to thinking styles and reasoning biases. For example, our knowledge of the role of self-esteem in the development and maintenance of psychosis has led to self-esteem interventions (Hall & Tarrier, 2006), which have shown to lower positive symptoms. Research that highlights the developmental and interpersonal factors involved in the development of psychosis, for example attachment histories, experiences of trauma, abuse, (Read & Gumley, 2008) have also led to interventions that have more of a focus on interpersonal aspects of the individuals experience (Gumley & Schwannauer, 2006).

3.6 What is the evidence base for CBT for Psychosis?

The chapter will now present a selection of some of the studies that have been carried out in CBT for psychosis. This will consider outcomes for chronic groups, acute and first episode psychosis groups and relapse prevention. This will be followed by a discussion of some of the most recent reviews into CBT for psychosis.

Chronic and medication resistant group

Anti-psychotic resistant symptoms constitute a significant problem because a substantial number of patients and their families are affected. Approximately 20-40% of patients with schizophrenia continue to experience symptoms that interfere with their functioning (Rathod et al., 2008).

Tarrier et al. (1993) carried out the first controlled trial into medication resistant psychosis. In this study a comparison was made between the effectiveness of CBT for medication-resistant psychotic symptoms with a general cognitive intervention aimed at improving problem solving skills. Patients in this trial were randomly assigned to receive intensive therapy of 10 sessions offered over 5 weeks. They were reassessed at 6 months follow-up. There were various problems with this study. Namely, there was a high drop-out rate and a failure to use intention to treat methodology. The results showed that those in the CBT group improvements were noted on measures of symptomatology and overall symptom severity as measured by the Brief Psychiatric Rating Scale.

Kuipers, Garety, Fowler, Dunn, Bebbington and Hadley (1997) carried out the London East Anglia Randomised controlled trial for CBT for Psychosis. Participants in the study had to

have experienced at least one positive and distressing symptom of psychosis that was considered medication resistant. Participants were randomly allocated between a standard care condition and CBT group. Sixty participants in total were included in the trial. Individuals were offered nine months of individual therapy. Multiple assessments of outcome were carried out and showed that over the nine months there was a significant between group difference. Participants in the CBT group experienced a 25% reduction in the BPRS, but no other clinical, symptomatic or functioning measure changed significantly.

Garety et al. (1997) carried out a controlled trial of CBT for drug resistant psychosis with non-random allocation of participants. An average of 16 sessions of cognitive therapy was provided. In the cognitive therapy group there was a significantly greater effect on reducing delusional conviction, overall symptoms on the BPRS and levels of depression as measured by the Beck Depression Inventory. Garety et al. (1997) also carried out predictors of outcome study. This was based on a randomised controlled trial for medication resistant psychosis. Changes were assessed with the BPRS. Key predictors of outcome were a response indicating cognitive flexibility concerning delusions and the number of recent admissions.

Sensky et al. (2002) provided 19 sessions of CBT to patients allocated to either CBT or the control group – befriending. At post-therapy, both groups improved, however at nine-month post treatment follow-up, the CBT group continued to make considerable gains whereas the befriending group did not.

Rector, Seeman and Segal (2002) carried out a controlled study of patients with a diagnosis of schizophrenia experiencing persistent positive and negative symptoms. Forty-two patients were randomly allocated to either CBT plus enhanced treatment as usual, or enhanced treatment as usual. They received CBT on an individual basis for 6 months (20 sessions). Significant clinical effects observed for positive, and negative symptoms and a reduction on symptoms severity compared with treatment as usual. However, no statistically significant differences were found between the groups post-treatment.

Turkington et al. (2008) recently reported their five-year follow-up findings. It was reported that CBT showed evidence of a significantly greater and more durable effect on symptom severity and level of negative symptoms compared with the Befriending group. However, no difference was found between the groups on either overall symptoms of schizophrenia or depression

CBT for Acute and First Episode Psychosis

The aim of providing CBT during the acute phase of psychosis is to shorten the experience of psychosis and reduce residual symptoms. Shepherd et al. (1989) demonstrated that in over one third of patients, impairment and residual symptoms worsened after each acute episode. Furthermore, experiences of acute psychosis are linked to post-traumatic stress disorder, post psychotic depression and an increase in the risk of suicide (McGlashan, 1994).

Drury, Birchwood, Cochrane and MacMillan (1996) carried out a randomised controlled trial into cognitive therapy in the acute phase of psychosis. Individuals were randomised to either the CBT condition (offering both group and individual CBT) or the control group, which consisted of a therapist providing structured activities and informal support. At the nine month follow-up both groups showed a decline in positive symptoms although this was more marked in the CBT group. Furthermore, at nine months, five percent of the CBT group and fifty-four percent of the control group showed moderate or severe residual symptoms. Drury et al. (2000) carried out a five year follow up of this trial. No statistically significant differences between the groups were found in relapse rates, positive symptoms or degree of insight. However, in those patients who had experienced one relapse or less, the CBT group did show evidence of significantly less residual positive symptoms – that is the effects of CBT had endured.

Lewis, Tarrier, Haddock, Bentall, Kinderman, Kingdon et al. (2002) looked at acute phase outcomes in the SoCRATES trial (Study of Cognitive Alignment and Therapy in Early Schizophrenia). In this study, a five-week CBT programme plus routine care was compared with supportive counselling plus routine care and routine care alone in a multi-centre trial randomising 315 people with schizophrenia. The aim was to deliver 15-20 hours of therapy within a five-week treatment envelope. The results showed that the CBT intervention accelerated resolution from positive symptoms but in the intent to treat analysis, these results were not significant.

Jackson et al. (2008) recruited sixty-two participants with a first episode of psychosis and randomly assigned them to either CBT known as Active Cognitive Therapy for Early Psychosis (ACE) or befriending (the control group). Participants could not receive more than twenty sessions of CBT over a fourteen-week period. Four primary outcome measures of symptoms and functioning were taken at pre-treatment, mid-treatment, end of treatment and one year follow-up. Both groups showed improvement over time. At the mid-treatment point, ACE significantly outperformed befriending on functional measures only. At the one year

follow-up there was no significant differences between the groups on any of the outcome measures or on hospital admissions.

Relapse prevention

Gumley, O'Grady, McNay, Reilly, Power and Norrie (2003) reported on a randomised controlled trial of early intervention for relapse in schizophrenia – results of a 12-month follow-up. All participants met DSM-IV criteria for schizophrenia and were receiving anti-psychotic medication and were considered 'relapse prone'. Participants were considered to be relapse prone if they had a history of relapse in the last two years; their key-worker viewed them as living in a stressful environment (e.g. a home with high expressed emotion); they were living alone or socially isolated; non-adherence to anti-psychotic medication, and being on a neuroleptic dosage reduction programme. One hundred and forty four participants were randomised to receive either treatment as usual (TAU) or CBT plus TAU. At twelve months, 15.3% of participants in the CBT group were admitted to hospital compared to 26% of the TAU. 18.1% in the CBT group relapse compared to 34.7% in the TAU. In addition, the CBT group showed significantly greater improvement on positive and negative symptoms as well as global psychopathology, performance of independent functioning and pro-social activity.

In one of the most significant trials to date, Garety, Fowler, Freeman, Bebbington, Dunn and Kuipers (2008) did not find that CBTp reduced relapse rates or improved rates of remission at 12 or 24 months compared with family therapy or treatment as usual. Two reasons have been considered for those disappointing findings. First of all, this was a trial of generic CBTp and the trial therapists reported that it was sometimes difficult, in the absence of symptoms or of distress, to maintain a clear focus on positive symptoms. Furthermore, in terms of sampling, those randomised were all in hospital following an acute relapse or exacerbation, many of whom were responsive but non-adherent to medication and therefore showed a rapid response to re-instating treatment. Further implications of this study for relapse prevention will be discussed in chapter seven.

Group CBTp

Group CBT for psychosis has been found to have similar effects sizes as CBT delivered on an individual basis (Wykes et al., 2008). There has been an increase in the availability of group interventions for psychosis in order for CBT to be more accessible to more people. Group therapy is advantageous where there are limited resources as it helps to improve availability of access to a larger group of individuals. It also allows individuals to socialise, which is a significant positive factor for a group of individuals who have traditionally been socially

isolated and excluded. Furthermore, groups allow individuals to share experiences, which may aid in the restructuring of beliefs.

Lawrence (2006) recently conducted a review of group cognitive behavioural therapy for psychosis (GCBT). Five studies met inclusion criteria for the review (Wykes, Parr & Landau, 1999; Wykes, Hayward, Thomas, Green, Surguladze, Fannon, & Landau, 2005; Halperin, Nathan, Drummond & Castle, 2000; Kingsep, Nathan & Castle 2003; Bechdolf, Knost, Kuntermann, Schiller, Klosterkotter, Hambrecht & Pukrop, 2004). The primary outcome measures for the studies included social anxiety, auditory hallucinations and relapse and re-hospitalisation. The review concluded that GCBTp is more effective than treatment as usual in reducing levels of social anxiety. The effect upon depression was found to be greater than that observed for social anxiety. The effects compared with treatment as usual may be reduced when the interventions are compared with an active control group. This review further concluded that these studies were limited by methodological weaknesses, such as poor statistical power, and inadequate blinding of assessors to treatment allocation.

Other GCBTp studies have been published which were not included in the above review, but are nonetheless important to consider (Barrowclough, Haddock, Lobban, Jones, Siddle, Roberts & Gregg, 2006; Penn, Piper, Evans, Wirth, Cai & Burchinal, 2009). Both these studies looked at reduction in positive symptomatology as their primary outcome measures. Barrowclough et al. (2006) found that compared with treatment as usual, CBT did not significantly improve symptomatology or functioning, but it did result in reductions in feelings of hopelessness and in low self-esteem. In contrast, Penn et al. (2009) found that GCBTp significantly reduced psychotic symptoms. Johns, Sellwood, McGovern and Haddock (2002) conducted a pilot group intervention for negative symptoms. Initially six participants were recruited but four completed the intervention. The group intervention focused largely on reduced motivation, targeting both the objective aspect (levels of activity) and the subjective aspect (associated distress). Following the group there was a significant reduction in patients' level of avolition and a trend for reduction in overall level of negative symptoms.

Reviews and Meta-analyses

There have been several reviews into CBT for Psychosis carried out in the last ten years (Pilling et al., 2002; Rector and Beck et al, 2001; Dickerson, 2000), which have indicated that CBTp is effective in reducing the positive symptoms of psychosis. Tarrier and Wykes (2004) reviewed twenty randomised controlled trials into CBT for psychosis. Although the majority of the studies reviewed focused on alleviating medication resistant symptoms in chronic patients, it also reviewed preliminary work into recovery in acute psychosis; relapse

prevention and early intervention. This review concluded that CBT for psychosis is beneficial to patients, with the strongest evidence available for chronic patients (however, 17 out of the 20 studies were from a chronic group).

Zimmerman et al. (2005) reviewed fourteen studies published between 1990 and 2004 and carried out a meta-analysis of the results to measure the efficacy of CBT in the treatment of positive symptoms in psychosis. This review concluded that CBT is a promising approach for adjunctive treatment of positive symptoms of schizophrenia. Furthermore, this review found a more promising effect on acute patients than chronic patients, although concluded that this may have been due to the inclusion of the Drury et al (1996) study presenting methodological limitations that led to an over-estimation of the effect size in acutely unwell patients.

In perhaps the most comprehensive review to date, Wykes (2008) reviewed thirty-four studies of CBTp. This included twenty-seven individual treatment studies and seven studies of group CBT. The studies were rated with the Clinical Trial Assessment Measure. This review critiqued existing studies, reported that few of the studies adequately described the process of assessor blinding; that more than half of the studies did not use a statistical method that was judged to take satisfactory account of drop outs from treatment (such as intention to treat analysis); although all studies used “CBT” there were variations in this that would have affected the outcome. Furthermore, not all studies reported on the number of sessions provided in the intervention. Wykes (2007) has argued that outcome may be influenced by different amounts of therapy, and there needs to be some measure of the ‘effective dose’ of a specific therapy. This review concluded that CBT for psychosis has a modest effect on outcome for positive symptoms. However, it also concluded that CBT for psychosis may have an effect on other outcomes, even if these were not the specific targets of therapy. No significant differences were found on whether CBT was delivered in a group or individual format.

The evidence for CBT for psychosis has resulted in existing practice guidelines supporting the use of cognitive behavioural therapy as a potentially effective psychosocial intervention (NICE, 2002). The strongest recommendation is for the use of CBT to alleviate persistent, distressing residual positive symptoms, such as auditory and visual hallucinations. Although these can reduce distress in the patient, it is noted that there is no clear evidence that such treatment reduces relapse rates. NICE also suggests that CBT be offered as a treatment to increase adherence to pharmacological intervention, and should be considered as a means of increasing insight for patients into their illness. NICE also recommends that a greater duration of treatment is likely to lead to more positive outcomes for the patient,

recommending that an 'adequate' treatment with CBT would be expected to last more than six months and contain more than ten treatment sessions.

3.7 CBTp research in Forensic Settings

In preparing this review, a thorough search was carried out using OVID databases (MEDLINE and PsycINFO, 1987-2009) to review published research studies carried out in the field of psychological interventions for psychosis in forensic mental health settings. Only two studies were found (Haddock et al, 2004 and Haddock et al 2009). The limited number of studies into psychosis in forensic settings suggests the importance of further research being conducted in this area to develop interventions that meet the complex mental health and risk management needs of this population.

One published case series was carried out evaluating the feasibility of cognitive-behaviour therapy for the treatment of psychotic symptoms and anger in patients with a diagnosis of schizophrenia that were living in a low secure unit in a North West England health trust. The results showed benefits for the patients involved and demonstrated that the approach was feasible to implement within such a setting (Haddock et al., 2004).

PICASSO (Psychological Interventions for Coping with Anger and Schizophrenia: a study of outcomes) is a randomised controlled trial evaluating the effectiveness of CBT and Social Activity therapy for clients with schizophrenia and problems with anger and/ or aggression. This is the first randomised controlled trial of psychosis in this population. PICASSO has recruited patients from in-patient (n=58) and out-patient mental health services (n=19), including forensic mental health establishments. The CBT intervention included motivational strategies to aid engagement, strategies to reduce the severity and distress of psychotic symptoms and strategies to reduce the severity of anger linked to aggression and violence. The Social Activity Programme aimed at helping patients identify activities they enjoyed and helping them to carry these out. Both treatments consisted of 25 sessions carried out by therapists trained in the protocol and undergoing supervision. The interventions were manualised. Primary and secondary outcome measures were used to measure change in this study. The primary outcome was aggression and violence measured with the Ward Anger Rating Scale. Secondary outcomes included staff rated aggression and anger (using the ward anger rating scale); self-reported anger (the Novaco Anger Scale and Provocation Inventory); symptom assessment (PANSS and the PSYRATS) and risk, which was measured using the Historical, Clinical, Risk Management-20 (HCR-20) scale. Overall, 38 people received CBT and 39 received SAT. The findings from this study demonstrate significant benefits for CBT compared with control group, both over the course of the intervention and over the follow-up

period on violence, delusions and risk management. There was no similar benefit found for anger. The authors suggested that further benefits on anger may have been achieved with a longer treatment envelope or booster sessions. In the CBT group, a notable reduction in “distress” as measured by the PSYRATS was found, which was not found in the SAT group. The authors have suggested that CBT might have given participants additional strategies to lower distress and cope with symptoms. (Haddock et al., 2009).

This study is significant as it is one of the few studies that has looked at outcome in psychosis in forensic mental health settings. However, the outcomes measured in this study reflect pre-determined notions of outcome, and hence recovery in this population. Obviously lowering of risk of violence and offending is important in this population and that has to be a central focus of the work with the group. However, it is also necessary to have an understanding of what patients themselves view as being important factors in their recovery, as this too will help to determine risk management plans that perhaps have more ecological validity as they are grounded in the user’s experience.

3.8 Summary and rationale of thesis

This chapter commenced with a summary of the literature into first episode psychosis whereby it was argued that contemporary notions of outcome as measured in such studies are limited to symptomatic and functional outcomes, which emphasise the importance of an “end-point” in an individual’s experience of psychosis. Proponents of the recovery movement have highlighted that the concept of recovery is a dynamic process that is constantly being shaped through the interplay between the individual and their environment. The environment and hence the individual, is shaped by international, national and local policies. Within this social context, exist psychological processes; the identification of which through research helps to inform the challenges and opportunities faced by the individual and the wider system in fostering a recovery focused approach to psychosis. Recent studies into CBT for psychosis have contributed to a recovery focused approach through focusing on the development of a shared understanding of experiences with the individual and by focusing on reducing distress associated with experiences. It is the individual’s personal meaning, understanding and coping with symptoms, that forms the basis of treatment (Tai & Turkington, 2009). The philosophy underpinning this confers with a recovery-focused approach that values the individual’s experience and meaning (SRN, 2007).

Over the past twenty years, there have been many controlled and randomised controlled trials into CBT for psychosis. Meta-analytic reviews have found evidence to support the use of CBT as an adjunctive therapy for both chronic and acute patients (see previous review of

studies). Although there are limitations to these studies, the findings have informed clinical practice through the development of guidelines and standards created by NICE.

There has been a considerable lack of research into CBT for psychosis in forensic mental health settings. Although there are commonalities in the presentations and histories of individuals presenting in such settings with general adult mental health, there are also notable differences. All patients admitted to forensic mental health settings are subject to some form of compulsory detention, either under the requirements of the Mental Health (Care & Treatment) (Scotland) Act (2003) or other legislation specifically related to the criminal justice system. Most, if not all, of the patients experience a high level of co-morbidity (e.g. schizophrenia or other psychosis, *plus* personality disorder, *plus* substance misuse, *plus* trauma), often linked with serious offending behaviour - thus they often have a number of co-occurring complex needs that require specialist assessment and treatment. This issue presents a particular challenge to the delivery of psychological therapies in terms of how to determine the most appropriate method for ensuring that patients have access to appropriately sequenced complex treatment interventions designed to minimise both the risk they present to others and their personal and therapeutic needs.

Research looking at interventions and treatment with patients in forensic settings has pointed to the need for an eclectic approach that delivers an integrated combination of pharmacologic and psychotherapeutic interventions from different schools. The “*What Works for Whom?*” literature (Roth and Fonagy, 2006) for this patient group suggests that interventions and therapies are most successful when they are:-

- Intensive
- Long term
- Theoretically coherent
- Well structured
- Engage the service user and make sense to them
- Take account of their hopes and aspirations
- Well integrated with other services
- Tied into follow up care

Setting of Thesis

The State Hospital is “the national centre providing high security services for patients with mental disorders (including learning disabilities) who are likely seriously to threaten others on account of their dangerous, violent and criminal propensities, and whose condition is characterized by actions outside the normal range of aggressive or irresponsible behaviour

and which can cause damage, injury or real distress to others” (*Health, Social Work and Related Services for Mentally Disordered Offenders in Scotland, 1999*).

The Psychological Therapies Service (PTS) was formally established in 2000. This service fulfils a crucial role in supporting the hospital towards attainment of its two main aims:

1. To provide care and treatment that maximises rehabilitation and the individual’s chance of an independent life and;
2. To provide care and treatment under conditions of appropriate security with due regard for public safety ;

The principle of *reciprocity* underlies both these aims in that, “where society imposes an obligation on an individual to comply with a programme of treatment and care, it should impose a parallel obligation on the health and social care authorities to provide safe and appropriate services, including ongoing care following discharge from compulsion”. *Risk assessment, risk management, and risk reduction* is central to the work of the PTS, where we aim to help patients to improve their mental health as well as reduce and manage any future risk that they may present to others.

The next three chapters present a programme of research carried out at the State Hospital. The first programme of research involved a grounded theory exploration of recovery in patients presenting with psychosis in forensic mental health. The themes of recovery from this study led to the development of two group interventions. The first, a self-esteem programme, was piloted and the findings of this, alongside the themes from the grounded theory study, led to the development of a compassion focused group intervention for recovery after psychosis. This findings of this intervention, along with the results from the two other research papers will be critically reviewed with implications for future clinical interventions and research discussed.

CHAPTER FOUR: A GROUNDED THEORY STUDY OF THE EXPERIENCES OF INDIVIDUALS WITH PSYCHOSIS RESIDING IN HIGH SECURITY

4.1 INTRODUCTION

“A person’s recovery from psychosis involves more than a reduction in symptoms. It involves the entire self, bringing all components of physical, emotional, mental and spiritual aspects of themselves into their experiences of life.” (Forchuk, Jewell, Tweedell and Steinnagel. 2003)

The concept of recovery from psychosis can be defined in many different ways. Fitzpatrick (2002) described recovery as being on a continuum, with three identifiable points: the medical model; the rehabilitative model; and the empowerment model. The medical model defines recovery as the removal of symptoms of illness to the point where the individual can function at a pre-morbid level. The rehabilitative model, which is based on the medical model, takes the view that the illness is incurable, although it is possible, through rehabilitation, for the person to resume to a life similar to the one they had prior to becoming unwell.

Advocates of the empowerment model are not satisfied with the notion of mental illness and argue that mental illness does not have a biological foundation, but is a sign of severe emotional distress in the face of overwhelming stressors (Ahern and Fisher, 2001). Therefore, how a person responds, and is responded to, plays a crucial role in their further development. Proponents of this model state therefore that through empowerment, the person can heal and resume their previous social role, avoiding the mental illness label.

Recovery appears to be a lifelong process that involves an indefinite number of incremental steps. Indeed, with reference to the user literature, there is very little consensus on the definition of recovery. The meaning of recovery depends on whom you ask. However, most definitions involve some component of acceptance of distress, having a sense of hope about the future, and finding a renewed sense of self (Davidson, 2003). Deegan (1992) suggests that recovery involves a process whereby limitations are accepted, which creates a forum for realising “unique possibilities”. Recovery in this sense is described as a way of life, and an attitude towards approaching the challenges presented in daily living.

There is a small, yet growing amount of qualitative research into the experiences of people with psychosis. Qualitative methods are particularly useful to explore perceptions and experiences of the relationship between individuals’ behaviour in the context of their social environment. Qualitative research in psychosis has helped to bring about a greater

understanding of peoples' experiences and the meaning they attach to these experiences. Furthermore, it informs us of the processes involved in these experiences. Such knowledge and understanding is important if we are to gain a greater knowledge of the factors and processes involved in recovery from psychosis.

For example, Davidson and Strauss (1992) explored sense of self in recovery and psychosis by conducting a series of interviews over a 2-3 year period with 66 participants with serious mental illness³. This study focused on the reconstruction of a sense of self and recovery. Four aspects of this process were highlighted from the study, and considered fundamental to the recovery process; discovering the possibility of a more agentic sense of self; taking stock of one's strengths and limitations; putting aspects of the self into action and; using this enhances sense of self as a resource in recovery

In a review of the literature, Andresen, Oades & Caputi (2003) focused on two psychological dimensions of recovery in schizophrenia. These two dimensions were, *component processes* and *stages of recovery*. Four component processes of recovery were salient: *finding hope*; *redefining identity*; *finding meaning in life* and *taking responsibility for recovery*. The authors presented a five-stage model of recovery, based on qualitative studies they had reviewed. The first stage was referred to as *moratorium* and was characterised by denial, confusion, hopelessness, identity confusion and self-protective withdrawal. The second stage was *awareness*, where the person has a first glimmer of hope of a better life, and that recovery is possible. It involves an awareness of a possible self other than that of 'sick person' – a self that is capable of recovery. The third stage was referred to as *preparation*, which involves awareness of core values, strengths and weaknesses, and further involves learning about mental illness, services available, recovery skills etc. The fourth stage was *rebuilding*. This stage involves taking responsibility for managing the illness⁴ and taking control of ones life. The final stage of recovery is referred to as *growth*, where the individual may not be free of symptoms, but knows how to manage the illness and to stay well. Andresen et al (2003) state the individual in this stage, has a positive sense of self, feeling that the experience has made them a better person than they might otherwise have been.

Findings of the research emanating from the user perspective therefore suggests that recovery from psychosis does not require remission of symptoms, but involves minimising, managing or overcoming the effects of being a "patient in the mental health system", adverse experiences such as loss, disruption in family relationships, peer relationships, loss of valued

³ The use of the term serious mental illness is borrowed from Davidson and Strauss (1992).

⁴ The use of the term "illness" is borrowed from Andresen, Oades and Caputi (2003)

social roles, and the loss of a sense of self as an autonomous and meaningful contributor to society.

To date there have been no published studies into the experiences of people with psychosis in maximum security. This is despite this being a population where there is a significant history of adverse life events. This population are often considered treatment resistant and high risk. Similarly there have been no published studies into what constitutes “recovery” in this population. Our understanding of recovery in this population is important in order to help develop interventions, to lower risk, and inform risk management. The current study presents a users perspective on being a patient in a high security setting, and the factors they consider important in their recovery.

4.2 Methodology

Sensitivity to Context

The State Hospital is the maximum-security hospital for Scotland and Northern Ireland and provides treatment and care in conditions of special security for individuals with mental disorder who, because of their dangerous, violent or criminal propensities, cannot be cared for in any other setting (The State Hospital Annual Review, 2005). There are 11 wards covering admissions, rehabilitation and continuing care. There are also dedicated services for women and those with learning disabilities. Patients in the hospital and participants in the study are familiar with being assessed on a regular basis by health professionals who are vigilant to issues of risk and mental health. This continued attention to risk issues may influence participants’ expectations during interviewing and thus the quality of disclosure.

Theoretical background

In constructing the methodology for this study, we attempted to pay special attention to the interplay between researcher and participants. Therefore, this study employed a grounded theory approach to analysis (Strauss & Corbin, 1990). The methodology was also influenced by the social constructivist revision of grounded theory (Charmaz, 1990) which recognises the role of the researcher’s perspective in the generation and development of theory. In particular, the social constructivist approach understands theory generation as the interplay between the researcher and the participant’s systems of meaning. In essence, the ideas and themes emergent in the method are a product of a process of meaning making within which the researcher is an active agent. In this sense there are parallels between this approach and Interpretive Phenomenology which also recognises that such an exploration must necessarily implicate the researcher’s own view of the world as well as the nature of the interaction between researcher and participant (Willig, 2001)

Reflexivity

Grounded theorists refer to *reflexivity*, which is how the researcher responds to the role that their ideological/ philosophical stance may have placed on their knowledge and how they make sense of the interview.

The researcher in this study is a clinical psychologist at the State Hospital. The identity and role of the researcher in the hospital were known by participants, which may have influenced issues regarding disclosure and confidentiality. The researcher was aware of managing the tension between trying to create a free flowing discourse enriched by autobiographical accounts of participants' experiences versus participants' concerns regarding the possible adverse consequences of disclosure. These issues were discussed in supervision with AG, which gave the opportunity to reflect on interviews with participants and how the questions posed could reduce such tensions. This process informed the style of the interview and the sampling strategy.

Interviews were in-depth, unstructured and open-ended. Careful consideration was given to the identity of the researcher and the potential power imbalance in the interview setting. It was felt that by making the interview open-ended without any set agenda, it would facilitate collaboration and also enable the participant to have control over the discussion. Therefore all participants were asked the same opening question "*what is it like for you being in the hospital*" and responses were followed up with prompts such as "*can you tell me more about that ?*" "*how have things changed for you over the years ?*" "*has it always been like that for you ?*" In order to access specific autobiographical memories, participants were asked questions such as "*can you give me a specific example of what you mean?*" "*Can you remember a specific memory to describe what you are saying?*" "*can you recall an example to describe what you mean?*" The essential component in all interviews was creating a safe environment for participants to be able to tell their story about being in the hospital and to be able to reflect on their past experiences. After interviews were completed, the interviewer arranged another meeting with the participant to discuss the emerging codes.

Participants

Participants were identified by Responsible Medical Officers (RMO) as being suitable for the study if they were capable of giving informed consent; were currently experiencing or had experienced symptoms of psychosis; and were not involved in another research study. All participants who were approached to take part in the study gave their consent. Fourteen participants were approached to participate. One participant's interview was unusable because of recording failure. Therefore the study comprised thirteen participants. Information about

participants' diagnosis was provided by their RMO. All participants recruited to the study had psychotic experiences, and all had longstanding difficulties in interpersonal relatedness. Eleven of the participants had a diagnosis of schizophrenia, and two had a diagnosis of bi-polar affective disorder.

Table 4.1: Demographic information of participants

Patient	Primary diagnosis	Duration in hospital	Index offence	Male/ female	Age (years)
1	Bi-polar affective disorder	8 years	Sexual offence	Male	45
2	Schizophrenia	2 years	Sexual offence	Male	22
3	Schizophrenia	8 years	Sexual offence	Male	45
4	Schizophrenia	2 years	manslaughter	Male	24
5	Schizophrenia	8 months	Attempted murder	Male	34
6	Schizophrenia	2 years	Assault	Male	44
7	Bi-polar affective disorder	6 months	Attempted murder	Male	42
8	Schizophrenia	1 year	assault	Female	24
9	Schizophrenia	8 years	Attempted murder	Male	43
10	Schizophrenia	3 years	assault	Male	40
11	Schizophrenia	7 months	Attempted rape	Male	43
12	Bi-polar affective disorder	10 years in TSH	Murder and sexual offence	Male	60
13	Schizophrenia	As above	Violent assault	Male	43

Procedure

Ethical approval was granted by the Local Research Ethics Committee (REC no 04/s1103/31). Participants were initially considered capable of consenting to the study by their RMO and referred to the principal investigator. Following this, each participant was provided with a participant information sheet about the study and invited to participate in the research. Upon agreeing to participate, they were asked to sign a consent form.

Each participant was interviewed for approximately 60-90 minutes. Interviews were tape recorded and then transcribed by the researcher. After each interview took place, transcripts were coded on a line-by line basis in order to identify micro-codes. The process of constant comparative analysis enabled emerging codes to be compared and contrasted. This process of comparison continued throughout the entire research study. Coding was facilitated using the QSR N 4 computer package.

After each transcript was coded, and emerging codes compared and contrasted, further participants were recruited, which was guided by emerging categories. This enabled further exploration of those categories, but also to identify cases that did not meet the emerging conceptual system. This process is referred to as negative case analysis. For example, codes emerging from early interviews related to how participants spoke about their experiences and the importance of relationships. This was discussed in supervision with AG as to whether these might be influenced by duration in hospital. This informed recruitment, with further participants being recruited from admissions and rehabilitation wards. The aim here was to create and increase the number and variance of codes and emergent themes.

As further interviews progressed, coding moved from a basic descriptive level to axial coding, whereby more abstract and higher-level categories and themes were developed. A list of all emerging codes was compiled in conjunction with memos and field notes made by the research to produce analytical categories of initial descriptive codes. Consistent with Dey (1999) theoretical sufficiency was preferred to theoretical saturation (Glaser & Strauss, 1967; Glaser, 1978; Strauss & Corbin, 1990) as the aim of this study. Two colleagues (a clinical psychologist and forensic psychologist at the State Hospital) cross-checked a sample of four transcripts, with memos and coding attached. This enabled the development of theory to be followed.

How participants spoke about their experiences – the development of themes and categories

Early in the study, after the first block of three interviews, it became clear that there were differences in how participants spoke about their experiences. This influenced the development of the interview and sampling. In the first set of interviews, participants did not readily talk about their past experiences, focusing more on their current experience of hospital. When participants did talk about their past experiences, they did so in a generalised and heavily semantic manner without providing any specific autobiographical examples to elaborate the topic being discussed. Further interviews were therefore adapted to include specific prompts to encourage participants to provide episodic memories and to enable elaboration. For example, if a participant spoke about the importance of medication in recovery, follow-up probes would aim to elicit specific experiences related to the participant's statement. As more participants were recruited, it became apparent that some participants had greater difficulty recalling accounts of specific autobiographical memories. Theoretical sampling of participants at various points in their journey through the hospital (and in their recovery) were recruited to explore whether lack of specific autobiographical memories was related to their mental state (i.e. whether actively psychotic or stable) and whether it could be related to other factors such as institutionalisation i.e. it may be that a longer duration of hospitalisation becomes associated with a more rehearsed and less reflective way of talking about one's experience. This may reflect the repeated nature of interviewing that patients are exposed to within a high secure setting.

In some of the participants' stories of their lives, there was a freshness and detail in their accounts. Participants reflected on themselves and used terms such as "*I remember*" when recalling specific memories. There was a greater flexibility in their accounts, and they incorporated the interviewer into their recall with phrases such as "*you see*". In these transcripts, there was evidence of participants reflecting on the meaning, and personal significance of such memories, which was demonstrated with comments such as "*it was as if I was being rejected*". In these autobiographical accounts, participants created visual images when describing their experiences. The following extract demonstrates the richness of this narrative⁵ with particular phrases to exemplify this highlighted in bold. When discussing feelings of worthlessness and feeling on the "outside", participant 11 described the following:-

I – it sounds as though that has been a life long trait?

⁵ The use of the word 'narrative' in this context refers to the story/ account produced by the participant, and how they told their story. It does not refer to a narrative analysis.

*P11 – yeh.. it has basically been since primary school. **I remember once with my mum, on this particular day I was to be the Captain of a 5 a side football team, and my mother, she came and took me to hospital because I had two episodes of epilepsy, and on this day she took me out of school. The way I look upon that now is that was the first start of rejection. Football was something I enjoyed, and I was the Captain of the team and she took me out of this. It was as though she was saying “you are no good” and I we will take you away from football. As if she was saying “you will only embarrass yourself, so I am taking you to hospital”. Maybe I am not explaining it right doctor. It was as if I was being rejected by her, as though she was passing judgement on me. When I went to High school I was bullied there, and for some reason my parents, when they found out I was being bullied, my mother, she did not want to know. It was ignorance, she didn’t want to know. And I repeated a year (pause) I didn’t want to repeat a year but my parents made me repeat a year eh, I was humiliated by two boys who were younger than me then, and throughout my adult life I always felt I had to struggle, but although I had a couple of friends, I wouldn’t call them proper friends. I just felt as though I was lonely that I always had to do things on my own.***

In contrast to this, there were other accounts where participants labelled their experiences in psychiatric terms. Their transcripts were shorter and their statements tended to be abbreviated. There was a sense that these participants were blocking or minimising important meanings and attempting to “seal over” significant life experiences. Although these participants did make reference to their past experiences, these references lacked specific episodic accounts, and with this, any reflection on the personal significance of such experiences. For example:-

I – do you have any specific memories of what it was like for you when you came into the hospital?

P7 – I was slightly manic, paranoid....but I am no like that anymore.

I – can you give me any examples of what you were experiencing.....what it was like for you when you came in here?

P7 – eh...it was...I didn’t like it...I felt paranoid I thought the worst of people. To be honest, I am settling in here ok.

This is also illustrated in participant 10 below:-

I – do you have any specific memories of what it was like for you when you came into the hospital?

P10 – no, I can't really remember much about when I first came into hospital. I was still on a lot of medication and that. I was on a lot of valium, but eventually they reduced it and I began to realise that I didn't need drugs in my body to be normal again.

How participants spoke about their life histories seemed to reflect the degree to which they felt able to draw upon their life experiences in order to construct an account of their experience of recovery in the context of the State Hospital. This had an *overarching* influence on the way in which common themes were expressed across participants' accounts. These accounts reflected issues related to their concept of self and how this relates to significant others (including staff and family). Participants spoke about their *relationships and a changing sense of self* in terms of two broad categories of experience; their *past experiences of adversity and recovery in the context of being in hospital*. The sub-categories that emerged from participants' accounts will now be discussed below. This construction is diagrammatically illustrated in Figure 4.1 below.

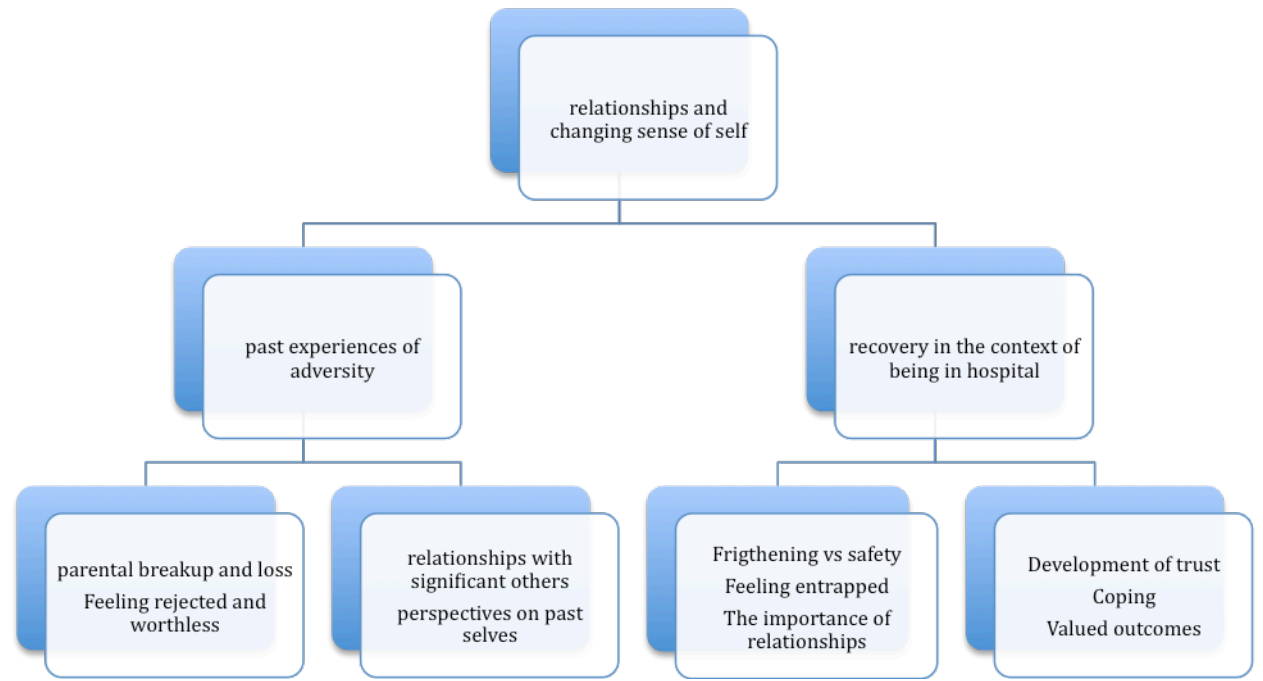


Figure 4.1: Themes and categories.

4.3 FINDINGS

PAST EXPERIENCES OF ADVERSITY

All thirteen participants spoke about the past experiences that led to them being in hospital, discussing this in terms of themselves and their relationships with others. When discussing past experiences they described parental break-up, relationship breakdown (with family and significant others) and being bullied. Participants also spoke about feeling hurt in the past and some spoke about their experiences of rejection. When talking about their past, participants spoke about the impact of those experiences on their view and development of self and how in some cases it contributed to feelings of worthlessness. Participants also spoke about their attempts to cope with difficult experiences and emotions, which appeared to derive from such negative experiences. In summary, these are reflected in the sub-categories labelled as *parental break-up; feeling rejected and worthless; relationships with significant others and perspectives on past selves*. These will now be discussed below.

Parental break-up and loss

Many participants spoke about early parental separation and divorce. Some spoke about how this had a long lasting and enduring impact on them, in terms of loss or unresolved feelings. For example, the following paragraph is a discussion with participant 5 about the impact of his father's death on his life and sense of direction.

P5 – what was I telling you about.....my father died when I was five so that kind of changed the direction away from me, although there was a step-father, it still didn't give me the direction.

I – what do you mean when you say it took away your direction?

P5- what I mean by that is that the path was no longer clear....the future was unknown and em, (pauses) I would have to look round the corner myself with no protection.

I – it sounds as though you felt quite vulnerable?

P5 –(silence)- it didn't feel like I was vulnerable, it felt like I was (pauses) it felt like (pauses) I had to protect myself.

I – why do you think you felt that way?

P5 – my dad was a protector. He would have looked after me.

I – how does it feel talking about this?

P5-it feels a little disjointed. My whole life....I never found my true vocation....I had 16 different jobs, never ever found anything I could settle into, and em, nothing that could give me eh what my

father had given me, like the, nothing could fill the gap. He died everything changed. When he died it was like being on the top of a mountain.....everything below me was still there, but everything had changed...everything seemed to be worthless. My dad loved me, and I was the best to my dad and he was the best to me”. (long silence 30 seconds)

Feeling rejected and worthless

Participants described early experiences of rejection from parental figures and/ or peers, and reflected on the significance of this in terms of current feelings of worthlessness. Some of the participants spoke about their experiences of feeling on the outside and never feeling part of things. It appeared from their discussions that these earlier experiences had a significant impact on their development of self, with many of the participants perceiving themselves at some point in their lives as worthless. In the discussion that preceded the extract below, participant 11 was talking about how he coped with difficult experiences in the past by retreating into his “shell”. He explained how this pattern of coping developed from a belief that he was worthless and stupid. He then spoke about an early memory of being bullied and feeling rejected, which he felt contributed to the development of his view of himself as worthless.

P11 – when I went into prison, that is how I dealt with things. Even before going to prison that is how I would deal with things (pause) I would just go into my shell. Some people might say I was just “stand offish” but that is just how I would deal with things. When I was at school, High school, I was bullied at school. I see myself as worthless and not good enough, andI am nervous about carrying on a conversation with someone incase I say the wrong things, or I say something that is stupid, so I will go into my shell and that is how I deal with things. I sort of shy away from people, and I am just quiet.

Relationships with significant others

When participants spoke about their past experiences, they spoke about their relationships with significant others. In many cases, participants spoke about their relationships with others with the dynamics of power and control being discussed. For example, participants spoke about feeling dominated by others, feeling helpless and lacking control. These dynamics were

reflected in different relationships including peers, teachers and parents. These experiences had an impact on participants describing a highly autonomous stance towards others, arising from the expectation that others would be domineering and controlling. In the following extract, participant 7 described a specific memory where he felt he lacked any power or control over what happened to him. This appeared to have a significant impact on him, as it made him resolute that no one else would have any power or authority over him.

I- are you able to think of an example to describe what you are saying?

P7 – well eh, you know I was 15 years old and I was scared of this guy, as I had broke his bicycle 3 years previously and he had started demanding money for it at school.....I was scared of him and I could not pay because my father just did not have that kind of spare money to fix his bicycle. He was just bullying me, but I stayed off school just to get away from him and I got referred to the psychiatrist and got taken into the psychiatric unit.

I – right

P7 – I wanted to go to the school party...and I got dressed for the school party, as that would have been the last time that I would have seen anyone from school. I wasn't allowed to go in to this school party...

I – why?

P7 - ..it was a decision eh, that wasn't mine, made by the sports staff that were providing the security for the party. That incident, that scenario, made a difference to the way I actually became, the person I became, because I wasn't allowed to do something I wanted to do, you see the aim was to get all dressed up, to get dolled up, in my suit and tie, and eh, but because the B became a dead end for me, and I had to go in a different direction.

I – and how did that experience influence you?

P7 – it made me decide that I wouldn't let everyone make the decision for me, that would stop me enjoying what I wanted to do. I did that. When I made that decision, I became who I am today.

The experiences described above illustrate a consistent picture provided by all participants of their early experiences as been characterised by a strong sense of interpersonal adversity,

illustrated through experiences of loss, family break-up, feelings of rejection and worthlessness. This appeared to influence the ease with which participants were able to form relationships with others.

Perspectives on past selves

During the interviews participants reflected on their past selves in relation to their coping style and reactions to others. For many of the participants, this involved describing their use of drugs and alcohol or the use of self-harming as a way of coping with difficult emotions and feelings.

I – those are the kinds of things that have helped you feel better about yourself..I am just wondering if there is anything different about yourself now, which makes you feel happier about yourself?

P1 – I am a lot calmer now than I used to be when I was outside. I had never been diagnosed when I was outside either. I went from being depressed and wanting to commit suicide eh to manic and cycling 35-50 miles a day...and I didn't even realise I was ill. I didn't realise that my life was spinning around so much. It was when I was manic that I was using so much cannabis, and eh without the cannabis I wasn't sleeping at all. I was using it to self-medicate, although I wasn't thinking about that at the time. I thought I was addicted to cannabis. It has given me a lot of insight into the fact that I was so unwell. It has also given me a lot of hindsight into things that have happened in the past, which I didn't understand at the time and felt very frustrated about.

In the extract below, participant three described his anxieties about moving on from the hospital as he recalled past experiences where he had found it difficult to cope with his life outside, and described using drugs and alcohol to cope.

I – What does it mean to you to be here?

P3 – eh...that I don't think it would be possible for me to live out there in the community...to live normally out there in the community and not be capable of murder, suicide, whatever. I can't see how it would be possible for me to live outside. Even though it wasn't like the jail, life was stressful – it was stressful. Having to go to work, having to be mates with everybody, all of it just became stressful.

The way I dealt with it was through smoking hash and eh that gave me voices and paranoia. The voices and paranoia were part of the drink and drugs I thought.

RECOVERY IN THE CONTEXT OF BEING IN HOSPITAL

All participants spoke about their experiences of being in hospital. This included accounts of their early experiences of being in hospital, which many participants described as being frightening. However, some participants described their admission to hospital as a positive experience, creating for them a sense of safety. Participants also spoke about feelings of being “entrapped” in the hospital and trying to adjust to hospital life. Participants discussed what helped them to adapt to the hospital and spoke about issues such as *relationships with staff and family*; the *development of trust, coping* and their *valued outcomes* in terms of recovery.

Frightening vs safety

Participants described what it was like for them coming into the hospital. For some, the experience of being admitted and being in hospital was frightening. This was mainly to do with them being extremely distressed by their voices or fearful paranoia. It seemed that for some participants, the process of being hospitalised initially exacerbated their distress. The following extract describes this participant’s early experience of the hospital:-

P4 – At first I thought, when I just came into the hospital, I thought there was a conspiracy going on or something like that....to kill me. There were patients coming in from outside, and I thought they were people coming off the street to get at me, know what I mean. It was a really frightening experience. I thought the full ward was against me to harm me.

I – what was it like for you?

P4 – it was constantly going in my head, know what I mean. Just constantly going through my head. I was waiting for someone to attack me. I never spoke to anybody once. I wouldn’t talk to anybody. I just kept myself to myself. I wouldn’t speak to the staff or the patients. I thought the staff were involved in it an all. This went on for a few months.

However, some participants also spoke about their admission to hospital as an opportunity to get “respite” from their experiences and hence felt it was a relatively positive experience for them.

I - so what led to you being in the hospital?

P9 – I was in prison as well. My cell mate says to me that I should watch this guys eyes and I did. Being in here was a rest initially.

I – when you say it has been a rest, how has it been restful for you?

P9 – nae violence, hallucinations. Quiet, quiet.

Feeling entrapped

All of the participants stated that being in hospital had made them feel “stuck” and entrapped. The main reason for this was the lack of a fixed time scale, which they would have if they were sentenced to prison. This created a sense of uncertainty and uneasiness in most of the participants, which some described as having a negative impact on their mood. Participants also stated that it was difficult to think of the future and that they had to learn to focus on the “here and now” as a way of coping. For example participant 4 described the following:-

I –whats it like for you being here in the hospital?

P4 – sometimes it is a struggle. It is hard to keep yourself motivated and keep the momentum going. There is plans for us to move on and all that, its just the time is taking too long and you just don't know where to be and all that. Theres no date to look to. You are just stuck here without knowing what is going to happen. It's hard. It's hard thinking about the future and all that.

The importance of relationships

Participants spoke about the process of “learning about themselves and how being in hospital involved a process of making sense of past experiences. However, doing this seemed to involve developing relationships with others, which participants stated being an important factor in them exploring themselves and finding out about themselves. For example, the following extract provides an example of how for participant 2, his past relationships with his family had been poor. However, he valued the development of such relationships and believed it to be an important part of his recovery.

I – tell me a bit more about your family.

P2 – (silence)...I am not really in touch with my mum's side.....because obviously because of my offence. My mum and dad come up and support me quite a lot...they give me quite a lot of support em...I am building up more of a relationship with my family. I am hoping to have a relationship with them, which I didn't have before.

I-uhhuh..

P2 em...I didn't really have a relationship with my family before I came in here. I never spoke to my mum and dad. I used to just stay in my room all the time. Ever since I have been in here I have been building up a relationship with them.

Participants also spoke about how they had changed over the years; how this change had been facilitated by their relationships with staff and family and how those relationships had also changed during their hospital admission. It appeared that such relationships, in particular those with staff, had enabled participants to acquire a language that helped them make sense of their experiences. This is described further by participant 10:-

P10 – I have a lot of insight into my illness now

I – what has helped to give you that insight?

P10 – eh, I've done groups. I've done "coping with mental illness" (A hospital education group). The doctor sat down with me and told me what my illness was and she spoke with my family. My key-worker supports me and helps me to be aware of when I am paranoid and the signs of it an all that.

Development of Trust

With regards to adapting to the environment of the hospital, participants spoke about developing a strategy of being "open-minded" and trying not to have pre-conceived ideas. This was difficult for many as coming into hospital was a frightening experience for most of those interviewed. It was marked by them experiencing extreme fearful paranoia and feeling threatened by others. Participants also spoke about their relationships with staff helping them to adapt to their new environment in the early months. However, experiences of past relationships influenced the ease at which new relationships with staff could be formed. Most

participants spoke about the need for trust and how this took time to develop. The relationships described with staff seemed to be a reciprocal process of gaining trust and mutual respect.

I – “so you say the first week you were here you compared it to the prison – what was that comparison like?”

P1 – it was a lot more....less formal. The relationships with staff was much better – more camaradery. In prison, you can not have a laugh with the prison officers...it is a case of them or us, and you have to do what you are told and call them Sir or Lordship, whatever. Here the nurses treat you as a person...that is certainly what I have found in the time I have been here in the hospital. I have built up a relationship with the staff and mutual respect for each other as well.

I – do the relationships with staff change over time at all?

P1 – well they become closer because the longer you know someone the more intimately you know them. You start talking about your friends, family activities and hobbies. I have seen people come in here who have been blinkered and it is a case of them and us kind of thinking. In time they do open up to staff, but they have to build up their trust. They are on the wards all day and they see staff who are more open with staff being treated with, lets say, more respect. You only get respect if you give it.”

This theme of trust in relationships and feeling valued was developed further and considered by participants to be a significant theme in their recovery. In particular, participants spoke about “building bridges” with their family and developing mutual respect and trust with staff.

I – can you tell me about your index offence?

P10 – I took a member of my family hostage. I regret it now you know.

I – how did that affect your relationship with your family?

P10 – well I wasn’t well at the time, and my family came up to visit me here and told me that I wasn’t well, and that they didn’t hold it against me.

I – how did you feel about that?

P10 – well I have accepted it. I just wish I hadn't done that to my family. With my brother no being here him no being here it sometimes makes it worse

P10 – sometimes you have to put things behind you. My family have been very supportive and sometimes I feel I owe them my life. The hospital has helped me so much as well.

Coping

Participants spoke about how they found it difficult to cope being in the hospital and how this was generally created by the lack of certainty regarding their stay in hospital and the effects of them being in hospital on their family. In order to tolerate this, participants spoke about coping strategies such as the use of distraction; attending placements (such as cooking, sports and recreation) and talking to other patients. However, although talking to other patients was generally considered helpful by most participants, they also communicated that discussing problems could lead to a sense of hopelessness about their circumstances. This is described by participant 4 below:-

I – you are saying you really do not know much about your plans.. what is that like for you having that sort of experience?

P 4 – eh . .I've got lots of experiences in the past that have been hard to deal with, but it is my family I feel more for. Its hard for them to deal with. They are wanting me oot, to get on with my life again. They get no information on what is happening, I am still here.I find it annoying because I want to be out there for them, I want to be there for my wee brothers and stop them from getting into trouble, and give them a bit of guidance. For me in here, you have to get things to keep you going. Do different things and all that. Sometimes you don't have the motivation for it..it is just a struggle.

I – what kinds of things do you do?

P4 – just things like going to the fitba, that takes a lot of stress out of us. Some of the placements are alright, but in a lot of them you just sit about and drink tea and have a fag, and all people talk about is being in hospital and what is happening to them. I just want to get away from all of that. That brings you doon just hearing that stuff all the time. Theres cooking sessions which are alright and the visits keep me going. Silence (10 seconds) I also turn to some of the guys

in the ward as well..that keeps you going an all. Once you start talking you start thinking 'its just no happening' and that can bring you down.

Valued Outcomes

Participants spoke about having “valued outcomes” such as achievements, gaining confidence and developing a good life as important factors in recovery. Participants spoke about developing awareness of triggers for relapse and how they learnt about these triggers from attending psychological therapies and sharing experiences with other patients. Participant 1 described his valued outcomes:-

I – how does it affect you knowing what you were like back then – is it something that concerns you about the future?

P1 – well eh.. I have had quite a few stable years now, and although I get mood swings, they are just fluctuations in my mood, like I get a bit fed up or I feel happy. I have not even been elated or depressed for quite a number of years...the medication seems to be working. It has been changed quite a few times, and before the incident I am talking about – being shaved and the mirror – I got ECT – and seemingly it was the ECT that brought me back into consciousness again.

A general mixing of the medication and care of myself such as making sure I get regular sleep and I eat properly, keeping an eye on these things...they are my triggers. I did “Coping With Mental Illness” (hospital group), the group and they eventually helped me identify early trigger signs for becoming unwell. I feel more in control now... If I am having trouble sleeping I will let staff know.

RELATIONSHIPS AND A CHANGING SENSE OF SELF

Two higher-order concepts emerged from this study and appear to be reciprocally related: *relationships and a changing sense of self*. These concepts emerged through all the participants’ narratives and are evident in their discussions about *past experiences, being in hospital* and the tasks involved in *recovery*. Participants spoke about relationships in the past as being poor and these relationships seemed to be characterised by feelings of rejection, loss

(particularly primary caregivers), and lack of trust. Being in hospital led many participants to think about their relationships in the past and to try and build relationships with staff, patients and indeed amongst some, repair relationships with family. It seems that this development in relationships was an important part of the adaptation to hospital, and recovery process, but that it was not always easy to achieve due to various limitations of being in hospital. This is evidenced by participant 4 below:-

I – “you mentioned earlier about your relationships and your family, what are your relationships like?”

P4 – I would say they are okay but I miss my family. I want to get back on my feet and get outside and be a support for my wee brother. With me being in the jail before here and then this time in hospital, we have not had time to form a real relationship. I have a good relationship with my mum who comes to see me every week, but really it is not much of a relationship with my family as I have had most of my life away from them, what with being in the jail and then a couple of weeks outside and then in hospital. I think the relationships are still strong, but I want to see my wee brother, I want to do well by my wee brother and give him help and support.”

Participants spoke about how developing relationships with those around them, helped them to learn about themselves, with there being a reciprocal relationship between learning about themselves and building relationships. Integral to this process of learning about self, was the capacity to reflect on past experiences and to recognise where things could have been different. In the extract below, participant 11 reflected on overdoses he took in the past, with the current perspective of having a greater understanding of why he carried out such behaviours: -

–“ There’s things in my life that I wish I had done differently. I wish I hadn’t taken those seven overdoses. Eh I know I was impulsive. One of the reasons I took an overdose was I was writing a book and I sent it away to get published and it got rejected and I took an overdose. I wish I hadn’t been so foolish. There was another time when my giro cheque wasn’t in on time and I took an overdose. I was so impulsive and stupid. There was things when I wish I had calmed down and hadn’t been so quick to react to things”

In the extract below, participant 10 is reflecting on how he has changed since being in the hospital:-

*I – “do you feel you have changed at all since being in the hospital?
P10 – oh yes, I am an entirely different person now. Before I came in here, I was just a junkie, and then I realised I don’t need drink and drugs to lead a normal life. I know I don’t need them. I just hope in the future I don’t fall back into the same trap. But as I say, I have looked into it a lot, and I don’t think I will fall back into the same trap. That was 23 years I was taking the drugs.”*

For some however, the process of being in hospital was a negative experience, which seemed to have exerted a negative influence on their sense of self, contributing to low self-esteem and feelings of worthlessness. This was reflected in how they spoke about themselves in the interview.

*I – so whats it like for you being in the hospital?
P8 – good most of the time. I do nothing but lie on the couch.
I – why is that?
P8 – I don’t want to do anything else. I have become so big and put on so much weight since I came in here that I can’t do much else.
All I want to do, all I want to do right now is sleep.*

Towards the end of the interview, this participant decided that she no longer wanted to be interviewed and stated the following:-

P8 “You can repeat basically what I have said which is some lonely lassie whose not got very much in her life, where she is in hospital with lots of people that she doesn’t like, perhaps eh, she doesn’t like socialising with them...social nights is not what she wants because she has put on a lot of weight”

4.4 DISCUSSION

This grounded theory study explored the experiences of patients with psychosis residing in a high security setting. The aim of this study was to generate a vivid account of the perspectives and experiences of people with psychosis residing in maximum security. The analysis produced two themes common to all participants' accounts; *past experiences of adversity* and *recovery in the context of being in hospital*. Two higher order concepts, *relationships* and *changing sense of self* emerged, which were evident across both themes. Participants spoke about the tasks involved in recovery, which included; *the importance of relationships*; *development of trust*; *coping*; and *valued outcomes* (such as achievements, gaining confidence, developing a good life).

The manner in which participants spoke about their lives, revealed a consistent and emerging process where early experiences and indeed experiences of adversity, influenced individuals' stance taken towards hospital and therefore the tasks demanded of patients during their recovery. For example, many participants described early experiences of loss and betrayal of trust in significant relationships (through parental break-up, bereavement, bullying) creating a sense of fear and insecurity. This led some to perceive hospital as a safe place, taking them away from the danger they had experienced in the past, hence generating a sense of security and protection. However, for other participants, their experience of hospital was a continuation of the danger and insecurity they had experienced in the past. For example, participant's whose early experiences were characterised by loss (through the death of a parent, the break-up of family life, the loss of trust of significant others) struggled to develop trusting and meaningful relationships with staff and family. The lack of trust resulting from early adversity influenced participants' ability to form relationships with others, which was apparent in how they spoke about their relationships with staff in the hospital. In such cases, participants spoke about the significance of developing trusting relationships with staff, and building family relationships that had disintegrated in the past. The development and repairing of such relationships appeared to have an impact on participants "*redefining and developing*" their sense of self. Therefore past experiences of loss and social fragmentation in relationships influenced the tasks involved in their recovery.

How participants spoke about their experiences and told the story of their life influenced the sampling and recruitment of further participants for the study. Some of the life histories were characterised by a freshness and detail in their autobiographical accounts. Within these transcripts, participants reflected on themselves and others when recalling specific memories. These accounts reflected a search for meaning and understanding of the significance of events

in the past, and their impact on current feelings and sense of self. Such narratives generated a sense of coherence and integration, which was absent in other participants' accounts. In contrast, other narratives were characterised by a difficulty in providing specific autobiographical memories of their experiences leaving the impression that participants had not developed a complete story of their lives whereby they managed to make sense of their experiences and conceptualise themselves in those circumstances. On the other hand, these participants had seemed to have (successfully) set aside their past experiences and maintained a focus on here and now. In this sense, therefore, their language reflected that of the hospital in that they frequently spoke in terms of illness, symptoms and risk. This may reflect a recovery process which involves identifying the language and beliefs of more powerful others in an attempt to make sense of their current and past experiences.

When discussing the narratives of participants in this study, reference is made to the growing literature on narrative style in people experiencing psychosis, the results of which have informed further research into recovery. For example, Lysaker et al. (2003) state that with impoverished narratives, people lose the contextual basis of emotions, imagined futures, and sustained intimacy. It has therefore been suggested that the construction/ recovery of a coherent narrative plays a significant role in the movement towards mental health (Davidson & Strauss, 1992) and maybe considered a potential focus of psychotherapy (Fenton, 2000; Lysaker & Lysaker, 2001). Siegal's model of "*interpersonal neurobiology*" (2001) offers an explanation of the development of narratives that lack coherence and integration, stating that coherent narratives may reflect an integrative process within the mind. Furthermore, the coherence of adult's autobiographical narrative is the most robust predictor of the child's attachment with the parent. Therefore, the development of coherent and integrated narratives may in part be influenced by attachment style, and that construction of a coherent narrative may be an essential component of the recovery process.

With reference being made to the possible role of attachment style in the development of coherent narratives, it is interesting that participants spoke about the importance of relationships in their past and in their recovery. They also discussed the interchange between relationships and the development of a sense of self. Most of the narratives included accounts of past relationships that were characterised by lack of trust, family breakdown, rejection and violence. Participants also spoke about the difficulties in maintaining relationships in adulthood – most often as a result of lengthy periods of institutionalisation. It was also evident in the narratives, the difficulties some participants had in developing trusting relationships with staff and family, which appeared to be related to past experiences in relationships. However, participants spoke about their relationships with staff as an important

factor in them getting well, which involved the process of developing mutual trust and respect. Furthermore, from their accounts it seems that the development of relationships with staff and other patients, plus the building of relationships with family, served an important role in them re-defining their sense of self (i.e. helping them to talk about their past experiences; trying to put pieces together and to see a future). Participants who had developed meaningful relationships with staff commented that this helped them to feel valued, and seemed to play an important factor in their developing sense of self. It therefore appeared that some participants perceived the hospital as a “secure base”, creating a sense of safety and possibly affective containment. This relationship with an institution/ organisation has been discussed by Adshead (1998) who states that it is possible for staff in mental health care organisations to be a positive attachment figure for individuals, especially for those who did not experience secure attachment in childhood.

In summary therefore, it appears that how participants spoke about their experiences and their ability to communicate a coherent narrative, may have been influenced by early attachments. Furthermore, early experiences of disrupted relationships appeared to influence participants’ ability to develop relationships with staff and other peers. The development of relationships was cited by participants as an important factor in their adaptation to hospital and in their recovery. The importance participants placed on relationships and their recovery can be understood by referring to the literature on Attachment Theory (Bowlby, 1988). Attachment theory provides a model of the development of the self and how we relate to others and the world around us. For the development of an autonomous self, the experience of safety within the context of an emotional relationship is crucial. Under conditions of chronic neglect and insensitivity, the development of the autonomous self is seriously threatened. This can lead to an unstable self structure where needs are accompanied by aggression if the self is to remain intact and stable. Bateman and Fonagy (2003) state that “*the acquisition of the capacity to create a ‘narrative’ of one’s thoughts and feelings – to mentalise – can overcome flaws in the organisation of the self that can flow from the disorganisation of early attachment*” (page 191). Attachment theory can therefore help us to understand the impoverished narratives generated by many of the participants, which appeared to lack *Reflective Function (RF)*, which is the awareness of the nature of mental states (Fonagy., Target., Steele & Steele, 1998). It also helps us to understand the difficulty many patients in this population experience in forming and maintaining relationships, and having the capacity to *self-soothe* when distressed. The ability to develop meaningful relationships with staff and repair relationships with family and friends may go some way to creating a secure base for patients, which may be an important factor in their recovery. It is therefore acknowledged with reference to the literature on attachment, that developing meaningful relationships may be difficult for

participants with insecure attachments, but working towards this may be an important factor in recovery.

In conclusion, this study employed a grounded theory methodology to explore the experiences and perspective of patients with psychosis in a maximum-security setting. This study was a preliminary study that has generated findings that are both clinically relevant and require further research. The author is not aware of any other research that has been conducted in this area. It has provided a greater knowledge and understanding of the important factors involved in recovery in patients in maximum security.

With regards to limitations, it is possible that the interviewer imposed her terms of reference on the interview and subsequent analysis of the results and therefore an independent researcher might have achieved a different dynamic. However various contingencies were put in place to reduce the impact of interviewer bias, for example, all interview transcripts were reviewed by two independent reviewers. Supervision with a Consultant Clinical Psychologist also allowed interview transcripts to be discussed. This reflexivity is central to qualitative research.

Participants' familiarity with the interview process may have been a factor in those narratives that appeared to reflect a rehearsed dialogue, containing medical terminology, and lacking an affective quality. However, even taking this into account, the style of the interview was developed in response to this narrative style, and encouraged participants to generate specific autobiographical accounts, which many participants were unable to do. It is therefore possible that their accounts reflected not only a rehearsed component, but also other factors, which influenced their style and content. For example, early attachment experiences, which may have influenced the development of individual's mentalising or RF abilities, may have contributed to an impoverished narrative, characterised by a lack of coherence and integration (Siegal, 2001; Fonagy et al. 1998; 2001).

Analysis of narrative style in this population has implications for further research and clinical practice. Fonagy (2001) states that a secure attachment style seems to advance mentalising or RF abilities, whereby impairment of RF (which results from insecure attachment), removes a critical barrier that might normally inhibit offending, making individuals who have suffered this impairment more likely to display violent behaviour (Fonagy, 2001). It is perhaps possible therefore, that analysing the narratives of this population provides an indication of their RF, which may be associated with their propensity to violently offend and also their recovery. Therefore, Fonagy (2001) hypothesises that increasing RF, leads to greater

mindfulness and self-agency, which may reduce the risk of violent behaviour. Further research might therefore explore changes in RF over the course of psychotherapy, and whether this can be used as a marker of recovery and inform risk management.

**CHAPTER FIVE: SELF-ESTEEM AND PSYCHOSIS. A PILOT STUDY
INVESTIGATING THE EFFECTIVENESS OF A SELF-ESTEEM PROGRAMME
ON THE SELF-ESTEEM AND POSITIVE SYMPTOMATOLOGY OF MENTALLY
DISORDERED OFFENDERS**

5.1 INTRODUCTION

Self-esteem

Self-esteem refers to the evaluation that an individual makes regarding himself or herself; it reflects one's sense of individual competence and personal worth in dealing with the challenges of life (Mruk, 1999). It is an emotional process of self-judgement and can range from feelings of self-efficacy and respect, to a feeling that one is fatally flawed as a person (Brandon, 1983). Self-esteem results from the interaction between self-evaluation and social feedback, therefore, from this perspective, social stigma, family care and negative family interactions can all be detrimental to self-esteem (Lecomte, Corbiere &Laisne, 2006)

Self-Esteem and Psychosis

Research into self-esteem and psychosis has shown that low self-esteem is a common problem (Bowins & Shugar, 1998; Freeman et al., 1998; Lecomte, Cyr, Lesage, Wilde & Leclerc, 1999; Silverstone, 1991), which may be related to poorer clinical outcomes. Low self-esteem has been implicated in the formation of persecutory delusions (Bentall, Kinderman & Kaney, 1994) and in the maintenance of delusions and hallucinations in patients diagnosed with schizophrenia (Garety et al., 2001, Smith et al., 2006).

The relevance of self-esteem in the treatment of psychosis is perhaps not surprising given that the process of developing psychosis and the sequelae that follows can be traumatic with significant implications for the development of negative self concept. It has therefore been recommended that self-esteem is considered an important outcome measure in therapy, and is specifically targeted in the course of treatment. Barrowclough et al. (2003) have proposed that interventions that target negative self-worth may have a beneficial impact on positive symptoms. Psychological interventions have therefore developed with self-esteem being the specific target of therapy (Hall & Tarrier, 2003; Lecomte et al., 1999). The findings of studies that have evaluated these interventions have produced mixed results, with some finding an increase in self-esteem, and a decrease in positive symptomatology (Hall & Tarrier, 2003). However, other studies have found that the self-esteem intervention resulted in an increase in the use of active coping strategies and a decrease in positive symptoms, but no direct effect on

self-esteem (Lecomte et al., 1999). Conflicting results may be due to different methodologies (e.g. group therapy or individual therapy) and different measures of self-esteem.

Recovery models refer to the development of a fulfilling life and positive sense of identity and how this enables individuals to develop self-determination and hope (SRN, 2007). Studies employing qualitative methodologies have also demonstrated the importance that individuals place on developing their sense of self and reconstructing their sense of self, as part of their recovery journey (Humberstone, 2001; Koivisto et al., 2003; Andresen et al., 2003; Davidson & Strauss, 1992). The findings of a grounded theory study into recovery amongst individuals residing in a high security forensic mental health setting similarly found that such individuals considered development of sense of self to be at the heart of their recovery (Laithwaite & Gumley, 2007a). This would therefore suggest that an intervention that focuses on helping individuals to increase their self-esteem may facilitate their recovery.

Little research has been conducted into self-esteem and psychosis in mentally disordered offenders. This population present with issues that make them distinct, which may pose particular challenges to conducting clinical work in this group. For example, clinical experience suggests that mentally disordered offenders generally present with more long-standing, complex, and co-morbid mental health difficulties. Furthermore, these service users have the double stigma of having both psychosis and a history of offending behaviour. Detainment in hospital means that service users do not have readily available access to family or friends, they are not in employment, and are unable to easily access many resources that might have a beneficial effect on their self-esteem.

Given the emerging importance of self-esteem in the treatment and outcome of psychosis, it seemed important to explore self-esteem in this group of service users. Therefore the aim of this study was to pilot a self-esteem group with service users with a background of offending behaviour who were detained in a high secure hospital and to investigate the impact of this group intervention on measures of self-esteem and psychiatric symptomatology.

5.2 AIMS

The principle aim of this pilot evaluation was to test the following hypotheses:-

1. Participants in the self-esteem group intervention will show an improvement in their self-esteem as measured by the Rosenberg Self-Esteem Questionnaire, the Robson Self-Concept Questionnaire and the Self-Image profile for Adults.
2. Participants in the self-esteem group intervention will experience a reduction in psychiatric symptomatology as measured by the PANSS and the PSYRATS.

3. Participants in the group intervention will experience a reduction in depressed mood as measured by the BDI-II.

5.3 METHOD

Design

A within-subjects design was used. Participants were assessed at baseline, mid-way (5 weeks) through the programme, at the end of the programme (10 weeks) and at 3-month post group follow-up.

Participants

Participants were considered eligible for the group if they had a primary diagnosis of schizophrenia, schizo-affective disorder or bi-polar affective disorder and experienced low self-esteem. Potentially eligible participants were excluded from the study if they had an organic illness, severe intellectual disability, and were not able to provide informed consent. Participants were also excluded if they were involved in other research. All participants in this study had a primary diagnosis of schizophrenia.

Procedure

Ethical approval was given by the Local Research Ethics Committee (LREC number 05/s1102/15). Participants were recruited from a high security inpatient NHS setting. Letters were sent to Responsible Medical Officer's and Clinical Psychologists in the hospital in order to identify potential participants. Prior to seeking informed consent from potentially eligible patients, the respective patient's Responsible Medical Officers were asked to provide consent for their patient to be approached. Following consent, patients were approached by a Chartered Clinical Psychologist (HL), and following a full description of the study, patients were invited to participate.

Assessments

Assessments were administered to participants at baseline, mid-group (5 weeks), post-intervention (10 weeks) and three-month post group follow-up. All the clinical outcome measures were standardised measures, either self-report questionnaires or structured interviews with acceptable psychometric properties.

Self-esteem

Three self-esteem measures were used. This decision was made due to there being a lack of self-esteem measures that have been specifically developed for this patient population. The measures chosen have been routinely used with other patient populations and for research purposes. Three measures were used in order to ensure that where changes in self-esteem occurred, this was reflected in more than one measure, thus increasing the robustness of findings.

The Rosenberg Self-Esteem measure (RSE, Rosenberg, 1965; Rosenberg et al, 1995) is a 10-item self-report measure of self-esteem. Higher scores (range 0-30) are indicative of higher self-esteem.

The Robson Self-Concept Questionnaire (RSCQ, Robson, 1989) is a 30-item self-report measure of self-esteem on which each item is scored on a 0-7 point scale. The scale provides a composite measure of self-esteem based on the dimensions of self-worth and significance, attractiveness, competence and ability to satisfy aspirations. The range of self-esteem scores for individuals with no evidence of psychological disorder is 132-142 (mean 137) with higher scores indicative of good self-esteem (Hall & Tarrier, 2003).

The Self-Image Profile for Adults (SIP-AD; Butler & Gasson, 2004) consists of 30 self-descriptions and is a self-report questionnaire. Participants are invited to rate both themselves as they are and how they would like to be (ideal) along each self description. A self-image score (SI) represents how the individual feels about themselves. A high self-image score suggests the person has a positive view of themselves. Self-esteem (SE) reflects an individual's evaluation of themselves. On the SIP-AD this is operationalised as the discrepancy between how the person sees themselves and how they wish to be (ideal). A high score reflects a wide discrepancy and therefore lower scores are interpreted as reflecting high self-esteem.

Psychiatric Symptomatology

Psychotic symptomatology was measured by interview using the Positive and Negative Syndrome Scale (PANSS; Kay, Fiszbein & Opler, 1987) and the PSYRATS (Haddock; McCarron; Tarrier & Faragher, 1999).

The PANSS measures 32 symptoms on 7 point Likert Scales, deriving three composite subscales: Positive, Negative, and General Psychopathology. Higher raw scores indicate more

severe symptomatology. The PANSS Depression Scale II is a single item from the PANSS general psychopathology scale and was used to measure depression (score range = 1-7).

The PSYRATS consists of two scales designed to rate auditory hallucinations and delusions. The auditory hallucinations subscale is an 11-item scale. The delusions subscale is a six-item scale, which assesses dimensions of delusions. A five point ordinal scale (0-4) is used to measure both scales. A higher score reflects greater levels of symptomatology.

The Beck Depression Inventory II (Beck, Steer & Brown, 1996) was used as a self-report measure of mood (score range 0-63).

Inter-rater reliability

Assessments were conducted by four raters. The same four raters evaluated their participants from baseline through to the 3 month follow-up. Three of the raters were involved in facilitating the self-esteem programme. A rater separate from the programme administered the PANSS assessments. All PANSS raters had undergone training using video assessment (with reliability at $r > 0.80$).

Treatment

The self-esteem programme was delivered by a Chartered Clinical Psychologist (HL), a Clinical Nurse Specialist in Cognitive Behaviour Therapy, and an Assistant Psychologist. The self-esteem programme was based on Hall and Tarrier's self-esteem intervention (2003). The group programme was adapted for the forensic environment by one of the authors (AB). The principle emphasis of the programme was the acquisition of skills in monitoring, noting and rehearsal of evidence of positive qualities. Additionally co-facilitators encouraged group members to recognise what they have done well within each group session.

The programme also involved cognitive restructuring of negative self-evaluations or self-criticism. To achieve this, the programme helped develop skills in awareness of self-criticism, weighing of evidence for such criticism, and the reappraisal of negative self-critical thoughts. Group members were also coached using the same method to cope with criticism from others.

Repeated rehearsal of skills was used to promote learning. The skills were modelled by co-facilitators so that group members were able to observe the component skills in action. The reliance on collecting evidence for positive qualities ensured that improvements in self-esteem were grounded in real life experiences. The programme ran for 10 weeks (one session per week, lasting approximately 2 hours 30 minutes).

TABLE 5.1 SELF-ESTEEM PROGRAMME SESSION CONTENT

Session	Content
One	<p>Introduction to Improving Self-Esteem. Objectives: to establish group rules and contract; establish aims and intended outcomes for group; agree what self-esteem is; identify how low-self-esteem develops; introduce three skills that can improve self-esteem; identify positive qualities.</p>
Two	<p>Collecting and using evidence for positive qualities – 1. Objectives: In this session, reinforce skills of noticing and noting positive qualities; identify any difficulties completing the exercise and develop methods for completing the task in the future</p>
Three	<p>Collecting and using evidence for positive qualities – 2. Objectives: Reinforce skill of noticing and noting positive qualities and develop skill in rehearsal and examples of positive qualities.</p>
Four	<p>Collecting and using evidence for positive qualities – 3. Objectives: Reinforce skill of noticing and noting positive qualities and develop skill in rehearsal and examples of positive qualities. In this session, there is also a focus on identifying achievements as a child, adolescent and young adult. Participants are asked to talk about a time at school when someone told them they did something well, or a time when they felt good. Positive Feedback to Group Members is also provided. Group members are given cards and asked to write down something about each group member giving an example of something that group member has done well. The feedback should be positive and anonymous.</p>
Five	<p>Challenging self-criticism -1. Objectives: To discuss what self-criticism is and what the impact of it is. Exploring strategies to combat self-criticism and how to recognise and question self-critical thoughts and to produce realistic alternatives. Questioning self-critical thoughts involves these stages: <i>What is the evidence for this?</i> <i>What is the evidence against this?</i> <i>Am I confusing a belief with a fact?</i> <i>Am I jumping to conclusions?</i> <i>Am I noticing my weaknesses and forgetting my strengths?</i></p>
Six and seven	<p>Challenging self-criticism – 2: Objectives. Combating self-criticism on a daily basis. Within the group, each participants provides an example of a self-critical thought they have experienced during the week and with other group members, they work through the stages involves in challenging this thoughts and producing realistic alternatives. All group members do this.</p>
Eight and Nine	<p>Challenging criticism from others – 3: Objectives: How can criticism from others be challenged and how does criticism from others affect us? In these sessions draw out impact upon emotions and behaviour.</p>
Ten	<p>Review session: Objectives: Rehearsal of Key skills, establishing the use of key skills and identifying follow-up needs.</p>

5.4 RESULTS

Participant characteristics

Two groups were run in the hospital. There were 15 (all male) participants in total. All participants completed the programme. The mean age of the participants was 35.27 years of age (S.D 8.8) and the mean duration in hospital was 7 years. All participants had a psychiatric diagnosis of schizophrenia.

Outcome measures

Analyses were carried out using SPSS for Windows (Version 12). Descriptive statistics were conducted and further analyses were carried out using non-parametric tests. Friedman's analysis was carried out to test for any overall effects. Where a significant effect was identified, follow-up analysis using Wilcoxon signed ranks test was conducted to identify specifically where the effects were located.

Self-esteem measures

As shown in table 5.2, Friedman's test demonstrated an overall significant effect for improvements in self-esteem as measured by the Rosenberg Self-Esteem Inventory, the Self-Image and Self-Esteem components of the SIP-AD. No overall significant effects were found on the Robson Self-Concept questionnaire. Further analysis using the Wilcoxon signed ranks test showed significant effects on the Rosenberg Self-Esteem inventory at the end of the group ($Z=2.45$, $n\text{-ties}=15$, $p<0.05$) and at three month follow-up ($Z=2.43$, $n\text{-ties}=14$, $p<0.05$). Significant effects were found at the end of the group for Self-Image ($Z=2.48$, $n\text{-ties}=13$, $p<0.05$) and on the Self-Esteem components of the SIP-AD ($Z=2.67$, $n\text{-ties}=14$, $p<0.01$). This effect was not maintained at 3 month follow-up.

Psychiatric Symptomatology

There were no significant overall effects found on the PANSS positive or PANSS negative scales. Friedman's analysis revealed an overall effect on the delusions rating scale of the PSYRATS, but not on the auditory hallucinations scale. Specific effects were found on the PSYRATS delusions scale between the start of the group and mid treatment ($Z=2.023$, $n\text{-ties}=15$, $p<0.05$).

An overall effect was found on the BDI II and on the PANSS depression scale. Significant effects were found on the BDI II between baseline and mid treatment ($Z=2.25$, $n\text{-ties}=15$, $p<0.05$), baseline and end of treatment ($Z=2.89$, $n\text{-ties}=14$, $p<0.05$) and baseline and 3 month follow-up ($Z=2.84$, $n\text{-ties}=15$, $p<0.05$). A significant effect was found for the PANSS

depression scale between baseline and end of treatment ($Z=2.59$, $n\text{-ties}=13$, $p<0.05$). The effect was not maintained at follow-up.

Table 5.2: Change in assessment measures over course of treatment (Mean, Median and Friedman’s analysis)

Measure	Pre-treatment Mean,Median and S.D	Mid Group Mean, Median and S.D	Post- treatment Mean, Median and S.D	3 month- follow up Mean, Median and S.D	X ² ¹ (d.f)	P
Rosenberg	14.60, 16.00 (5.48)	16.53, 16.00 (5.78)	18.53, 19.00 (5.91)	17.93, 18.00 (5.47)	9.04 (3)	.03*
Robson SCQ	101.53, 105.00 (29.68)	114.40, 109.00 (32.79)	117.20. 112.00 (31.65)	115.47, 115.00 (26.02)	4.64 (3)	.20
Self- Image Profile (SI)	109.40, 108.00 (25.82)	113.67, 113.00 (30.44)	120.53, 120.00 (30.39)	118.33, 122.00 (28.72)	9.80 (3)	.02*
Self-Image Profile (SE)	46.60, 48.00 (20.36)	39.73, 39.00 (22.75)	35.87, 26.00 (25.64)	35.67, 26.00 (26.62)	12.16 (3)	.007*
PANSS** positive	13.27, 10.00 (6.56)	No mid group assessment	10.67, 12.00 (3.02)	11.20, 9.00 (4.62)	3.59 (2)	.17
PANSS** Negative	16.27, 16.00 (6.42)	No mid group assessment	12.87, 12.00 (4.61)	12.80, 13.00 (4.31)	4.53 (2)	.10
PANSS** depression	10.07, 11.00 (3.15)	No mid group assessment	7.20, 8.00 (2.30)	8.56, 8.00 (2.80)	11.58 (2)	.003*
PSYRATS AH	7.40, 0 (14.22)	6.93, 0 (12.67)	2.40, 0 (7.37)	1.93, 0 (6.03)	6.07 (3)	.10
PSYRATS DR	5.67, 0 (8.69)	1.20, 0 (3.36)	3.47, 0 (6.51)	2.13, 0 (5.46)	9.72 (3)	.02*
BDI II	24.20, 25.00 (12.97)	17.47, 16.00 (10.50)	15.47, 15.00 (11.27)	15.07, 15.00 (10.26)	12.85 (3)	.005*

* significant results ** raw scores are reported for the PANSS scales ¹Friedmans ANOVAPSYRATS AH – Auditory Hallucinations scale

5.5 DISCUSSION

This preliminary study aimed to explore the effectiveness of a group intervention for self-esteem in patients with psychosis living in a forensic setting. The primary aim of the study was to evaluate whether the group programme would improve self-esteem in participants at the end of treatment and at three-month post group follow-up. A secondary objective was to evaluate the effect of the programme on participants' psychiatric symptomatology and depressed mood.

The findings demonstrated an overall treatment effect for self-esteem at the end of treatment on the Rosenberg Self-Esteem Inventory and the Self-Image and Self-Esteem components of the SIP-AD. These effects were only maintained at three-month post group follow-up on the Rosenberg Self-Esteem Inventory. No significant effects were found on the Robson Self-Concept Questionnaire. This is an interesting finding especially since the Robson Self-Concept Questionnaire has items that require participants to reflect on quality of interpersonal relationships. Therefore, this measure may tap into measures of self-concept not targeted by the programme. Given this, overall the findings suggest that particular aspects of self-esteem were improved at the end of treatment compared with baseline. The evidence for maintenance of effects at three-month follow-up was less convincing with only the Rosenberg Self-Esteem Inventory revealing significant effects at follow-up.

Significant results were found for the Beck Depression Inventory II (BDI II). These effects were maintained at three-month post group follow-up. It is noteworthy that there were strong correlations between the self-esteem measures and the BDI II. That is lower self-esteem was associated with more severe depressed mood. Therefore it is unclear whether changes in self-esteem were related to changes in depressed mood or vice versa. It is noteworthy that a large component of the self-esteem programme focused on identifying and challenging self-critical thinking. Self-critical thinking biases have been shown to be influential in the development and maintenance of psychopathology, in particular, depression (Gilbert et al. 2006). Therefore it is entirely understandable that a programme which focuses on participants developing skills in monitoring, identifying and challenging self-criticism, would lead to an improvement in mood in addition to self-esteem.

The study conducted by Hall and Tarrier (2003) demonstrated a reduction in patient symptomatology as a result of the self-esteem intervention. These findings were maintained at follow-up. The present study did not find a significant reduction on psychiatric symptomatology as measured by the PANSS, although there was a significant reduction

found on the delusions rating scale measured by the PSYRATS. Most of the patients who entered the study were categorised as “below average” on the PANSS positive and PANSS negative scales. Subsequently, a significant improvement in these ratings would perhaps not be expected.

There were several limitations to this study. In particular, this study was conducted with a small sample of patients, without any matched control group. Future research should incorporate a larger sample size and include a matched control group, which would improve the reliability and generalisability of the findings.

Furthermore, self-report measures of self-esteem and patient symptomatology were used. Such measures have not been validated with a forensic population or those experiencing psychosis. This may indeed explain why changes were not found on the RCSQ at the end of the group intervention. Future research could therefore include a measure that has been developed to assess perceptions of sense of self and others (aspects of self-esteem) in individuals with psychosis. For example the Brief Core Schema Scale (BCSS; Fowler et al, 2006) is a new measure, which looks at schemata exploring self and others in psychosis and preliminary findings demonstrate that it has good psychometric properties.

Facilitators involved in the delivery of the group intervention also aided participants in the completion of psychometric assessments. To reduce bias, an external rater who was not involved in delivering the programme administered the PANSS assessments. Future evaluation of the programme would be improved by using raters independent of the treatment programme.

Although significant treatment effects were found for self-esteem at the end of the group programme, it is less certain whether these treatment effects were maintained at three-month post group follow-up. There may be several reasons for this. This is a population with highly complex needs, which may suggest that a more prolonged intervention is necessary for long-term effects. Furthermore, as suggested by Knight, Wykes and Hayward, (2006), an intervention focusing on core schema might be necessary for long-term change. Participants in this group had limited access to resources and experiences that might enhance their self-esteem, making a group of this kind more challenging. Future groups may need to adapt the content and structure of the programme to take into account the limitations faced by participants in accessing experiences that improve self-esteem.

A large component of the programme focused on participants developing rational alternatives to their self-critical thoughts, in order to improve their self-esteem. Lee (2005) however states that although some individuals can generate alternative thoughts to self-criticism, they rarely feel reassured by such efforts and may continue to experience shame and low mood. A further development to the current self-esteem programme would therefore be to incorporate elements of Compassionate Mind Training (Gilbert & Irons, 2005) to facilitate participant's understanding of self-criticisms, and criticism from others.

In conclusion, the current study evaluated a self-esteem group intervention for patients with psychosis residing in a high security setting. The findings demonstrated an improvement in self-esteem over the course of the intervention, with a parallel improvement in depressed mood. Future replication of this study could involve a waiting list control group and independent rating of change in outcome. The programme content could be enhanced by inclusion of techniques developed from compassionate mind training techniques.

CHAPTER SIX: RECOVERY AFTER PSYCHOSIS (RAP). A COMPASSION FOCUSED PROGRAMME FOR INDIVIDUALS RESIDING IN HIGH SECURITY SETTINGS.

6.1 INTRODUCTION

In social mentality theory (Gilbert, 1989, 2001, 2005) the interplay in social situations between emotional, motivational, cognitive, and behavioural processes is conceptualised as reflectioning underlying evolutionary derived systems that shape relationships between the self and others. Social mentalities are implicated in care-giving, care-eliciting, formation of interpersonal alliances, social rank and sexual behaviour. They have a critical role in appraising threat, enhancing safeness, and in *regulating the affect* associated with these fundamental evolutionary challenges (MacBeth, Schwannauer and Gumley, 2008). According to whether the environment is threatening or safe, all organisms must co-ordinate a range of internal processes in order to pursue goals, enact strategies and co-create social roles (Buss, 2003; Gilbert, 1989, 1992). Whether environments are threatening or safe, humans have (often rapid) access to an evolved menu or suite of strategic responses (ways of attending, feeling, behaving and thinking) to aid adaptive responding (Gilbert, 2005).

Social mentality theory refers to the development of the “*human warmth syndrome*” whereby human beings develop, through secure attachments with primary care givers, the ability to have compassion towards themselves and others. A secure attachment facilitates the development of internal working models of others as “safe, helpful and supportive”. The internalisation of this helps the individual to develop self-soothing and compassionate behaviours towards themselves and others. This activates the *safe(ness)* social mentality. The *threat-defence* mentality is activated in situations of perceived and actual threat. For example, social rank may provide a source of threat, whereby dominant individuals will issue commands and hold power, whilst subordinates will take those commands and be submissive. Social mentality theory states that the role relationships that exist between people can also exist *within* people and arise from internal working models of early relationships. Therefore, human beings can internalise the voice of a critical other and develop a submissive/subordinate response to this. This model can help to explain the occurrence of command hallucinations. It has been demonstrated that people who experience auditory hallucinations often relate to them as though they were relating to real external others. In particular, the voices are commonly experienced as malevolent, derogating, shaming and self-critical (Legg & Gilbert, 2006).

Developmental theory helps us understand the impact of early attachments on adult psychopathology and hence the development of safe(ness) or threat focused social mentalities. Previous research shows that early attachment experiences influence the ability to develop safe, and secure adult relationships (Bowlby, 1988). Gilbert (2004) refers to two consequences that result when parents are unable to create (and stimulate) safeness, are threatening or shaming and do not convey warmth. First the *under-stimulation* of positive affect and warmth systems; and second, the child is more likely to be *threat focused*, seeing others as a source of threat. Subsequently, they are more social rank focused, especially on the power of others to control, hurt or reject them. Sloman, (2000); Sloman, Gilbert & Hasey (2003) has shown that those who have not been able to internalise a sense of warmth (able to stimulate positive affect in the mind of others) and who feel unloved by others, can set out on quests to earn their place, becoming excessively seeking, competitive and sensitive to rejection (Gilbert, 2004).

People with psychosis who also commit offences often come from backgrounds that reduce the safe(ness) mentality and result in an activation of the threat focused mentality. Read et al. (2004); Read and Gumley (2008) has demonstrated a correlation between a very high incidence of childhood trauma (emotional, sexual and physical abuse or neglect) and a diagnosis of schizophrenia that is not attributable to chance. Experiences of bullying, shame, and other humiliation experiences (Bebbington et al. 2004, Campbell & Morrison, 2007) trauma and loss (Romme & Escher, 1989) are also associated with increased risk of developing psychosis. Such traumatic life experiences can lead to the collapse and disorganisation of attachment characterised by impaired mentalisation and theory of mind, fragmentation, dissociation and segmentation of episodic memories; and use of competing and inconsistent coping responses (Liotti & Gumley 2008., Read & Gumley, 2008). Such early experiences may compromise the development of inner warmth. We know that many people who have psychosis and who have also offended have had such life experiences (Boswell 1996; Fonagy et al, 1997) and we understand that this has an impact on attachment organisation and increases propensity for a threat focused social mentality or “paranoid mind” (Gumley & Schwannauer, 2006).

The potential importance of developing inner warmth came from observations that some high self-critics could understand the logic of cognitive behavioural therapy, and could generate alternative thoughts to self-criticism, but rarely felt reassured by such efforts (Lee, 2005). Similar observations were made when a self-esteem programme was piloted with a group of patients with psychosis in a high security hospital (Laithwaite & Gumley, 2007a). The findings of this preliminary study were encouraging and demonstrated an improvement in

self-esteem, and depression. A noticeable change in positive symptomatology was not evident, due to most participants being remitted of their positive symptoms prior to the group commencing. Furthermore, participants in the group spoke about their early adverse experiences and how this contributed to the development of low self-esteem. However, it was clear that many participants were able to challenge their self-criticism on an “intellectual level” but continued to report feelings of worthlessness and low self-esteem.

The participants in both the above studies (Lee, 2005; Laithwaite & Gumley 2007a) came from traumatised backgrounds. It is postulated by Gilbert (2004) that individuals with such experiences are compromised in their ability to generate a model of compassion, and hence the ability to self-soothe. Further studies have demonstrated that a lack of self-compassion is associated with increased vulnerability to a number of indicators of psychopathology (Neff, 2003). We know this is relevant because compassion helps to tap into safeness mode, which helps to regulate affect. This is significant with regards to relapse and recovery after psychosis as a key aspect in relapse is high levels of emotional distress and affective dysregulation in the period before, during and following the acute phase of psychosis. For example, findings from retrospective and prospective studies have shown that the most commonly reported early signs of relapse are fearfulness, anxiety, poor sleep, irritability, tension, depression and social withdrawal (Herz & Melville, 1980; McCandless-Glimcher et al., 1986; Birchwood et al., 1989). In terms of recovery, studies by Birchwood et al (1993) and Rooke and Birchwood (1998) has shown that patients with depression following an acute psychotic phase were more likely to have experienced more compulsory admissions and loss of, or drop in employment status. Gilbert formulates this according to social rank theory, whereby schizophrenia is a major life event that leads to significant loss in social status and role in society. Those who experience post-psychotic depression may indeed have greater insight into such losses and fear subsequent relapse for this reason.

Gilbert and colleagues (Gilbert, 1992, 1997, 2000; Gilbert & Irons, 2005) have developed compassionate mind training (CMT) to help people develop compassion and the ability to self-soothe, regulate affect and hence provide an antidote to the threat mode. This model is based on the premise that self-criticism is significantly associated with shame-proneness and that self-criticism is associated with lifetime risk of depression (Murphy, 2002). CMT proposes that some people have not had the opportunity to develop their abilities to understand sources of their distress, be gentle and self-soothing in the context of set-backs and disappointments, but are highly (internally and externally) threat focused and sensitive. CMT seeks to change an internalised dominating-attacking style that elicits a submissive response to one that elicits a caring and compassionate response.

There is a poverty of published research carried out into people with psychosis in forensic clinical settings. This is despite the fact that this is a population with complex and long-term needs. This population have generally experienced past trauma; poor relationships with significant others, disrupted attachment histories and have the double stigma of experiencing severe mental health problems and being offenders (Laithwaite & Gumley 2007b; Boswell, 1996; Fonagy et al, 1997). Recovery in this population is not just about reduction of symptoms or distress, but reduction/ management of risk of violent offending. It is therefore important that therapies that have been researched in general mental health settings are adapted and piloted with this population. A recovery programme that draws on CMT is attractive as it has a developmental perspective that focuses on the effect of disrupted attachment histories on the current functioning of the individual and their ability to respond to self-criticism, self-soothe, and modify distress. Hence a programme that focuses on developing a compassionate understanding of those vulnerabilities, may promote recovery and help seeking safety strategies, which in turn may reduce the risk of violent re-offending.

6.2 AIMS

The aim of this group intervention was to evaluate the specific aims of the Recovery After Psychosis Programme. The hypotheses of this study were as follows:

- Completion of the recovery after psychosis programme will improve self-esteem and self-compassion;
- Completion of the recovery after psychosis programme will lead to a reduction in depression;
- Completion of the recovery after psychosis programme will improve social comparison and reduce experience of shame.

6.3 METHODOLOGY

Design

A within-subjects design was used. Participants were assessed at the start of group, mid group (5 weeks) the end of the programme and at 6 week follow-up.

Participants

Setting

The State Hospital is the maximum-security hospital for Scotland and Northern Ireland and provides treatment and care in conditions of special security for individuals with mental disorder who, because of their dangerous, violent or criminal propensities, cannot be cared for

in any other setting (The State Hospital Annual Review, 2005). There are 11 wards covering admissions, rehabilitation and continuing care. Patients in the hospital and participants in the study are familiar with being assessed on a regular basis by health professionals who are vigilant to issues of risk and mental health.

Inclusion/Exclusion criteria

Participants were considered eligible for the group if they had a primary diagnosis of schizophrenia, schizo-affective disorder or bi-polar affective disorder (those with bi-polar affective disorder had a history of psychotic features). Potentially eligible participants were excluded from the study if they had an organic illness, severe intellectual disability, and were not able to provide informed consent. Participants were also excluded if they were involved in other research. All participants in this study had a primary diagnosis of schizophrenia, or bi-polar-affective disorder.

Procedure

Ethical approval was given by the Local Research Ethics Committee (LREC number 06/s1103/76). Participants were recruited from a high security inpatient NHS setting. Letters were sent to Responsible Medical Officer's and Clinical Psychologists in the hospital in order to identify potential participants. Prior to seeking informed consent from potentially eligible patients, the respective patient's Responsible Medical Officers were asked to provide consent for their patient to be approached. Following consent, patients were approached by a Chartered Clinical Psychologist (HL) and following a full description of the study, patients were invited to participate.

Assessments

Assessments were administered to participants at the start, at 5 weeks (mid group) and at the end of the programme with a 6 week follow-up. All the clinical outcome measures were standardised measures, either self-report questionnaires or structured interviews with acceptable psychometric properties.

Inter-rater reliability

All psychometric assessments were carried out by the assistant psychologists who had both received in-house training in the delivery of such assessments. Both were trained to use the Positive and Negative Syndrome Scale (PANSS) using video assessment (with reliability at $r > 0.80$).

Primary outcomes

Social comparison scale (SCS) (Allan & Gilbert 1995). This is an 11 item scale which taps global comparisons to others in the domains of attractiveness, rank and group fit (feeling similar or different to others). A lower total score reflects relative inferiority compared with others, whereas a higher total score indicates relative superiority.

External Shame (the Other as Shamer Scale;(OAS) (Goss, Gilbert & Allan, 1994; Allan, Gilbert & Goss1994) This scale was developed to measure external shame (how an individual thinks others see him/her). The scale consists of 18 items asking respondents to indicate the frequency of their feelings and experiences to items such as, “I feel insecure about others opinion of me” and “other people see me as small and insignificant” on a 5 point Likert scale (never, seldom, sometimes, frequently, almost always). A total score is given by adding up the items. A higher score indicates greater experience of external shame.

Self Compassion Scale (SeCS) (Neff, K, 2003). This scale is a self-report measure that explores self-compassion in individuals. It is a 26 items scale that measures self-compassion (13 items) and coldness towards the self (13 items). There are six subscales, three measure self-compassion: common humanity, self-kindness and mindfulness. There are also three subscales to measure coldness towards the self: self-judgment, over identification and isolation. Responses are given on a 5 point Likert scale ranging from 1='almost never' and 5='almost always'. Subscale scores are computed by calculating the mean of subscale item responses. To compute a total self-compassion score, reverse score the negative subscale items - self-judgment, isolation, and over-identification - then compute a total mean. The higher the total score, the greater the self-compassion (n.b this is recommended scoring by Neff, but not scoring of original 2003 paper).

The Beck Depression Inventory II (BDI II) (Beck, Steer & Brown, 1996) was used as a self-report measure of mood (score range 0-63). Higher scores reflect increase in self-reported low mood.

The Rosenberg Self-Esteem measure (RSE) (Rosenberg, 1965; Rosenberg, Schooler, Schoenbach & Rosenberg, 1995) is a 10 item self-report measure of self-esteem. Higher scores (range 0-30) are indicative of higher self-esteem.

The Self-Image Profile for Adults (SIP-AD) (Butler & Gasson, 2004) consists of 30 self-descriptions and is a self-report questionnaire. Participants are invited to rate themselves as they are and how they would like to be (ideal) along each self-description. A self-image score

(SI) represents how the individual feels about him/ herself. A high self-image score suggests the person has a positive view of him/ herself. Self-esteem (SE) reflects an individual's evaluation of him/ herself. On the SIP-AD this is operationalised as the discrepancy between how the person sees him/herself and how they wish to be (ideal). A high score reflects a wide discrepancy and therefore lower scores are interpreted as reflecting high self-esteem.

Secondary outcomes

The Positive and Negative Syndrome Scale-(PANSS) (Kay, Fiszbein, & Opler,1987) measures 32 symptoms on a 7 point likert scale, deriving three composite subscales: Positive, Negative, or General Psychopathology. Higher raw scores indicate higher symptomatology.

Intervention

The Recovery After Psychosis Programme (RAP) was developed by authors H.L and A.G. and based on Compassionate Mind Training (Gilbert, 2001). The Recovery After Psychosis programme was delivered by a team comprising of two Chartered Clinical Psychologists (HL and PC), an Advanced Practitioner (M O'H), a trainee clinical psychologist (LA) and two assistant psychologists (SP and PD). The group was delivered by three therapists (due to security reasons). The first group was facilitated by HL, M O'H and SP and the last two groups were facilitated by HL, M O'H, PC and LA. SP and PD provided between group session individual support. AG provided the group facilitators with clinical supervision. The programme ran for 10 weeks (20 sessions). This involved two sessions a week. The programme was divided into the following 3 modules:-

Module one: understanding psychosis and recovery – the aim of this module was to help patients conceptualise the holistic nature of psychosis and the impact of this on various aspects of their lives. Patients were encouraged to think about psychosis in relation to their emotions, their cognitions, their behaviour, relationships and environment (see Figure 6.1). This model was then used to understand recovery. Therefore, patients were encouraged to think beyond recovery as symptom reduction, but also to view recovery in terms of their emotions, feelings, relationships with others and their environment. To help patients with this, the metaphor of the “pebble in water” was used, so that they could understand how recovery or progress in one area of their life can have an impact on another area. Another group exercise involved using the metaphor of “recovery as a journey” helped create a visual experience of the many difficulties that they may face in the future, and the “tools” they need to take with them on their journey to help with this.

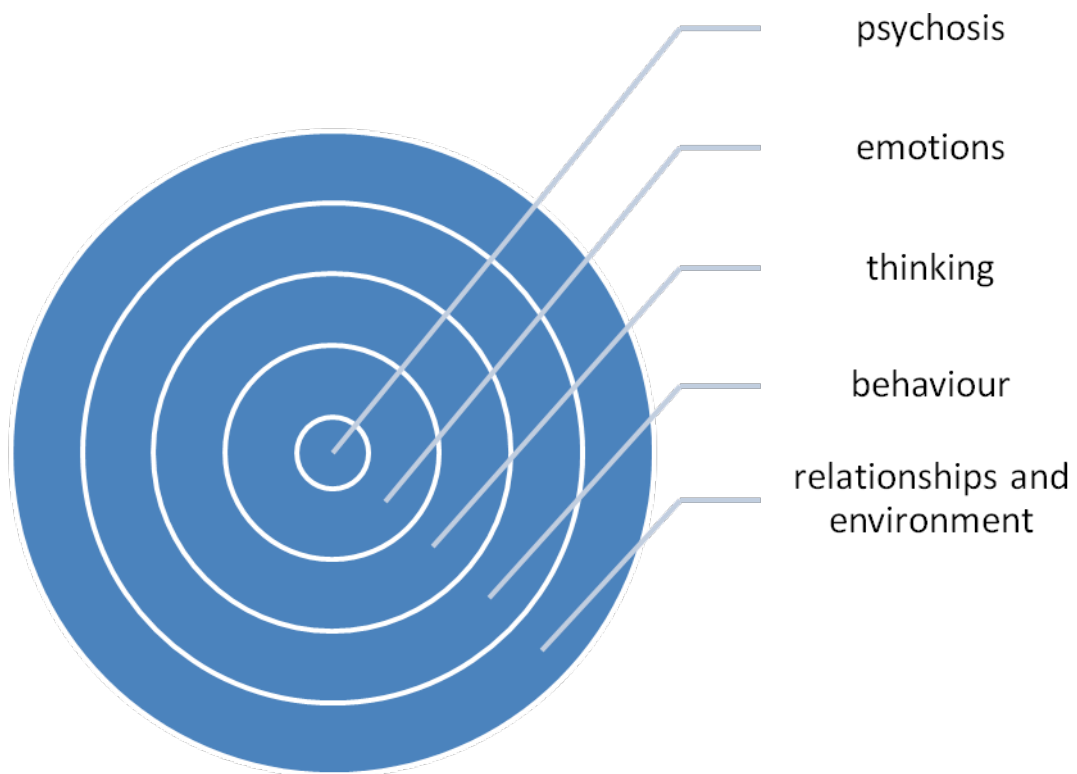


FIGURE 6.1 “Pebble in the water” metaphor.

Module two: Understanding compassion and developing the ideal friend – in this module the group explored the concept of compassion and the many features of this (strength, forgiveness, acceptance, trust, non-judgemental). The strengths and weaknesses of these characteristics were discussed in depth. This exercise progressed to the creation of the “ideal friend”. The intention of creating this ideal friend is for patients to be able to refer to “someone” who is compassionate and over time, it is anticipated that they will internalise the characteristics of this ideal friend, to develop their own compassionate responses towards themselves and others. Guided discovery techniques were used to illicit an image of this ideal friend, and patients were encouraged to focus on characteristics such as voice tone, facial expressions, body posture etc. Throughout the remainder of sessions, the programme referred to the ideal friend, and used exercises to help develop compassionate responding. Participants were asked to keep a diary of any negative emotions and self-critical thoughts they experienced during the week, and how they responded to this using their “ideal friend.”

Module three: Developing plans for Recovery after Psychosis – this part of the programme involved the development of a Recovery After Psychosis plan (focusing on triggers, early warning signs, use of safety behaviours, action plan and agreed coping strategies). This information was used to create a compassionate letter, which involved participants writing a letter to themselves (as written by their ideal friend). This letter contained encouragement and support in relation to how to respond to set-backs and how to seek help in the future.

TABLE 6.1 RECOVERY AFTER PSYCHOSIS PROGRAMME CONTENT

	Session	Content
MODULE ONE – Understanding psychosis and recovery	Session one: This is how we understand Psychosis	Impact of psychosis on emotions, thinking, behaviour, relationships and environment (using pebble metaphor)
	Session two: How can we understand recovery?	What recovery means in terms of emotions, thinking, behaviour, relationships and environment (using the pebble metaphor)
	Session three: Recovery as a journey	What is the journey like? Use the metaphor of hill walking, what are the difficult times, when is it easier? Encourage participants to reflect on their own journey of recovery.
	Session four: What do you take on your journey of recovery?	Introduce notion of taking a friend on this journey.

MODULE TWO – Understanding compassion and developing the ideal friend	Session five: Ideal friend	The creation of a unique ideal, compassionate friend
	Session six: What is compassion?	Draw out different components of compassion such as strength, forgiveness, acceptance, trust, and non-judgemental. Consider the strengths and weaknesses of each.
	Session seven - eight: Compassionate responding	Consider difficult experiences of the last week, such as feeling anxious, angry etc and think of compassionate responses
	Session nine: Developing flashcards of the ideal friend	Characteristics of ideal friend are put onto a card (such as physical appearance, tone of voice, smell etc) along with prompts to help create imagery.
	Session ten: Compassion and forgiveness	Group to consider concept of forgiveness, what that means in relation to self, and in relation to others. Also to consider the experience of forgiving and what it is like to be forgiven (using role plays and imagery)
	Session eleven: Compassion and Trust	Trust is discussed in the group. This is important given interpersonal histories and experiences of paranoia. Role plays are used to characterise trust and behaviours and the associated feelings.
MODULE THREE – Developing plans for Recovery after Psychosis	Session twelve: Compassion and acceptance	Acceptance of life histories and current circumstances.
	Session thirteen-fifteen: RAP plans	Developing an understanding of the problems that led to being admitted to hospital. Increasing awareness of coping strategies and unhelpful behaviours.
	Session sixteen: The importance of responsibility and future directed responsibility	Participants are presented with various cards outlining different potential future scenarios and asked to discuss in small groups. The purpose of this task is to consider future responsibilities and choices.
	Session seventeen - Nineteen: Compassionate letter writing	The focus of letter is for it to be written by ideal friend and to consider circumstances leading to being in hospital. Taking a compassionate re-frame of this but taking responsibility for actions and for future. Encouraged to think about potential relapse in future and strategies to seek help.
	Session twenty: Feedback and closure	

6.4 RESULTS

Participant characteristics

Three groups were run in the hospital. There were 19 (all male) participants in total and 18 participants completed the programme. The mean age of the participants was 36.9 (SD 9.09). The mean duration in hospital was 8 years. Five participants had received a diagnosis of schizophrenia; 10 paranoid schizophrenia and 3 bi-polar affective disorder (the 3 participants had experienced auditory hallucinations when elated, although at the time of the group, these had remitted). Eight of the participants also had a co-morbid personality disorder, namely anti-social personality disorder. One participant was considered to be in the “borderline” intellectual disability range.

Outcome measures

Analyses were carried out using SPSS for windows (version 14). Descriptive statistics were conducted and further analyses were carried out using Friedman’s ANOVA. Significant overall effects were followed up with Wilcoxon signed ranks (two-tailed). Effect sizes based on Wilcoxon signed ranks are provided for all outcome measures for the purposes of transparency. It should be noted that p measures were not adjusted for multiple comparisons. This was a pilot study and thus we did not want to potentially miss significant outcomes by restricting p values.

Overall significant changes were found on the Social Comparison Scale, Other As Shamer Scale and the Beck Depression Inventory II, the Rosenberg Self-Esteem measure and the Self-Image profile for Adults. Further analyses using Wilcoxon signed ranks test found significant changes on the Social Comparison Scale between the start and end of the group ($Z=1.96$, n -ties=11, $p<0.05$, $r=0.3$) and this change was maintained at follow-up ($Z=2.148$, n -ties=10, $p<0.05$, $r=0.36$). A small change was found on the Other as Shamer scale between the start of the group and 6 week follow-up ($Z=.801$, n -ties=11, $p>0.5$, $r=0.15$). Significant changes on the Beck Depression Scale were found at the end of treatment ($Z= 2.332$, n -ties=15, $p<0.05$, $r=0.38$) and at 6 week follow-up ($Z=-2.825$, n -ties=16, $p<0.01$, $r=0.47$). An overall significant change was found on the Rosenberg self-esteem questionnaire. Further analyses using Wilcoxon signed ranks test demonstrated a significant change at 6 week follow-up ($Z=-2.80$, n -ties=15, $p<0.01$, $r=0.47$) from baseline. Significant changes were not found on the Self-compassion scale, the Robson self-concept questionnaire or the Self-image profile for adults.

Primary Outcomes measures

Table 6.2: Primary Outcome Measures: Change in assessment measures over course of treatment (Median, IQR and Friedman's analysis)

Measure	Pre-treatment Median and IQR	Mid Group Median and IQR	Post-treatment Median and IQR	6 week - follow up Median and IQR	X ² ¹ (d.f)	P	Effect Sizes (r) (t1- t3)** (t1-t4)
Self-compassion Scale	3.30 (3.1-3.7)	3.57 (3.3-3.9)	3.48 (3.2-4.2)	3.63 (3.1-4.1)	4.87(3)	.18	0.22 0.28
Social Comparison Scale	36.00 (29-39)	35.00 (33-40.5)	38.00 (32.5-43.5)	35.00 (33.5-43)	8.54(3)	.036*	0.30 0.36
Beck Depression Inventory (11)	9.00 (4.5-15.5)	6.00 (3.0-16)	4.00 (3.0-8.0)	4.00 (1.5-10)	10.05 (3)	.018*	0.38 0.47
Other As Shamer Scale	33.00 (23--41.5)	36.50 (25.5-48)	32.50 (22.5-36.3)	31.50 (18.8-46.7)	8.35 (3)	.04*	0.04 0.15
Rosenberg self-esteem questionnaire	19.00 (18-22)	19.00 (18--22)	20.00 (18.5-23)	22.00 (19-26)	12.5 (3)	.006*	0.14 0.47
Robson self-concept questionnaire	126.50 (120-142)	128.50 (120-144.25)	127.50 (115-140.6)	127.50 (112.6-149.7)	1.85 (3)	.603	0.01 0.24
SIP-AD-SI	132 (102-150)	129 (109.5-144)	131 (114-149.5)	126 (111-142)	5.09 (3)	.165	0.14 0.06
SIP-AD-SE	24 (16.5-37)	25 (17.5-45.5)	20 (12.5-38.5)	22 (14-41)	2.03 (3)	.566	0.02 0.07

* significant results

** t1-t3 (pre-treatment to end of treatment)

T1-t4(pre-treatment to 6 week follow-up)

Effect sizes calculated on Wilcoxon signed ranks.

Secondary outcomes

Table 6.3: Secondary Outcome Measures

Measure	Pre-treatment Median and IQR	Mid Group Median and IQR	Post-treatment Median and IQR	6 week - follow up Median and IQR	X21 (d.f)	P	Effect Sizes (r) (t1- t3)** (t1-t4)
PANSS Positive	9.00 (8-10)	No Mid group	9.00 (8-10)	8.00 (7-10)	2.79 (2)	.248	0.1 0.24
PANSS Negative	10.00 (9-13)	No mid group	10.00 (9-16.5)	9.00 (8-12)	5.79 (2)	.055	0.02 0.3
PANSS General Psychopathology	24.00 (20.5-26)	No mid group	21.00 (18.5-23.5)	19.00 (16.5-21)	7.61(2)	.022*	0.38 0.41
PANSS Depression	8.00 (6-11)	No mid group	7.00 (5.50-8)	6.00 (4.5-7)	5.76 (2)	.056	0.26 0.31

* significant results

** t1-t3 (pre-treatment to end of treatment)

T1-t4(pre-treatment to 6 week follow-up)

Effect sizes calculated on Wilcoxon signed ranks.

Significant changes were found on the PANSS general psychopathology score at the end of the group ($Z=2.23$, $n\text{-ties}=14$, $p<0.05$, $r=0.38$) and this was maintained at follow-up ($Z=2.75$, $n\text{-ties}=12$, $p<0.01$, $r=0.41$). Significant changes were not found on the PANSS positive, negative or depression scales.

6.5 DISCUSSION

This was a pilot, pre-trial study. This was the first time that a compassion focused group intervention has been run at the State Hospital and to our knowledge, the first time that it has been run with a forensic clinical population. The primary objective of this study was to evaluate whether the programme would improve depression, improve self-esteem, develop self-compassion and social comparison and lower the experience of shame compared with others, and hence improve how an individual perceives others see him/ her.

The findings of this study demonstrated a large magnitude of change for levels of depression, and self-esteem as measured by the Beck Depression Inventory II, and Rosenberg Self-Esteem Inventory. A moderate magnitude of change was found for the social comparison scale and general psychopathology, with a small magnitude of change for shame, as measured by the Other as Shamer Scale. These changes were maintained at 6 week follow-up. Gilbert

(2005) has shown that self-critical thinking biases are influential in the development and maintenance of psychopathology, therefore a programme such as this recovery programme, that focuses on developing compassionate responses to shame, self-critical and self-attacking thoughts will likely lead to a reduction in depression, shame and an increase in self-esteem. Much of the research on psychopathology has focused on depression, however we know that self-critical thinking, shame and low self-esteem also play a role in the development and maintenance of psychotic experiences (Bentall, Kinderman & Kaney, 1994; Garety et al., 2001; Smith et al., 2006). We observed changes on the general psychopathology scale which may be associated with a reduction in shame and self-critical thinking. However, in a larger scale study, investigating the mediating effects of changes in compassion, shame and self-critical thinking on general psychopathology might be interesting. Furthermore, anger is a common response to rejection from others, shame and feeling inferior (Gilbert & Miles, 2000; Baumeister, Smart & Boden, 1997), therefore an intervention that focuses on reducing shame, and improving comparison with others, may have an impact on reducing anger and possibly risk of violent offending. This again could be explored in a larger scale trial of a compassion focused group on shame, anger and risk reduction. There is limited published research carried out on interventions for psychosis with a mentally disordered population. However, although this study drew from patients in a high security setting, the results sit favourably with a case series study of three patients with psychosis, anger problems and substance misuse in a low security environment (Haddock et al 2004) and with a self-esteem group intervention carried out in high security (Laithwaite & Gumley 2007a).

A significant change was found on the Rosenberg self-esteem questionnaire but not on the other measures of self-esteem. In the self-esteem group evaluation (Laithwaite & Gumley, 2007a) self-esteem was found to be strongly correlated with scores on the BDI II. That is lower self-esteem was associated with more severe depressed mood. Therefore it was unclear whether changes in self-esteem were related to changes in depressed mood or vice versa. Although correlations between scores on the BDI II and the Rosenberg self-esteem measure were not carried out in this study, it is possible that a similar relationship was present. Indeed, Rosenberg and colleagues have found that the negative correlation between the two variables “*seems to be due somewhat more to the effect of depression on self-esteem than to the effect of self-esteem on depression*” (Rosenberg et al., 1995, p. 145). Furthermore, the findings from Birchwood and Iqbal (1998) draw attention to the fact that depression in psychosis is particularly common, with prevalence estimates ranging from 22% to 75%, depending on criteria used.

Significant changes were not found on the self-compassion scale. However, the median score on this measure is comparable with norms developed on a general student population (Neff, 2003). It may be that the self report of compassion is different for individuals who have lacked the experience of compassion from others during critical periods of their development. This would be consistent with the proposals of social mentality theory. There were several challenges to delivering this programme. The concept of compassion is one that is not usually discussed in forensic clinical settings where notions of symptom reduction and risk management prevail. Participants were able to describe the characteristics of compassion but struggled to relate these characteristics to themselves. For example, acceptance and forgiveness generated much discussion in the group, with many participants reportedly feeling uncomfortable about self-forgiveness as it may be interpreted as lack of remorse or empathy for their victims. The programme focused on developing acceptance for past behaviours but responsibility taking for future possible outcomes. This seemed to empower many of the group participants as there was some hope of moving on from the stigma and shame of the past to being positive about the future. This change in looking at future possibilities also helped participants respond to self-attacking thoughts that seemed to be mainly past orientated. There is a movement to promote forgiveness in violent offenders and to promote the potential to develop a “good life” (Ward and Marshall, 2004) with this being seen as a more positive approach to offender rehabilitation as it helps to engage individuals in therapy, and subsequently may reduce risk of future violent offences (Day, Gerace, Wilson and Howells, 2008).

Many of the participants initially found it challenging to generate a compassionate image. This was not just simply that participants in the group found it difficult to access early memories, as some could clearly describe memories of inconsistent care-giving – it was that they could not relate to personal experiences of compassion, and therefore found it challenging to generate an internal working model of a compassion. The research on attachment theory may help to explain this. When early attachment experiences are compromised, this may result in insecure adult attachment states of mind. We know from research that individuals with psychosis and with violent offending histories often have experienced disrupted attachment histories (Boswell, 1996; Read and Gumley, 2008). For example, limited early experiences of care giving conducive to secure attachment and limited experience of mirroring, where needs of the infant are reflected on by their care-giver (Fonagy et al 2002). Such early attachment experiences have an effect on the development of mentalisation and subsequent regulation of affect (Liotti and Gumley, 2008). Therefore individuals’ ability to reflect on their own emotional mental states, and memories may be compromised (Bowlby, 1988; Fonagy, 2002). Such early attachment histories might also

have been associated with avoidant/ dismissive coping styles. The compassion focused therapy encouraged participants to reflect upon episodic memories, which may have resulted in some participants feeling anxious or distressed and using avoidant coping styles so as not to think about an image. Furthermore, individuals operating in a threat focused social mentality may have experienced a degree of fear when generating a compassionate image (Gilbert, 2003). To overcome some of these challenges, group facilitators offered support and helped the group to generate a group compassionate image, and also suggested that they could think of a place or non-human object that generated feelings of warmth and safety.

There are several limitations to this study. In particular, the study was conducted with a small sample of participants without any matched control group. We therefore cannot be fully confident that the changes observed over time are fully attributable to the effects of the intervention. Future research could incorporate a larger sample size, and randomization to an appropriate control condition, which would improve the reliability and generalisability of findings. In addition, many of the measures used in the study do not have published norms and have not been validated with a forensic clinical population. However, comparisons can be drawn with previous studies that have used these measures. We know that patients in the forensic clinical population score higher on external shame and lower on social comparison compared with a student population (Goss, Gilbert and Allan, 1994; Gilbert et al 2003). Gilbert and Proctor (2006) developed a group intervention for six patients with major/ severe long term and complex difficulties. At the start of this group, the mean score for participants was much higher on external shame than the forensic clinical population. However, at the end of the intervention, the scores on external shame and social comparison were comparable with the forensic clinical population. It is also important to recognise that Bonferonni corrections were not used in the analysis. One limitation of the study is the accepted p value was not corrected for the number of multiple comparisons and small sample size. However, we considered that and given the pilot nature of the study that the increased risk of type I errors was acceptable. This was because we wished to estimate which outcomes were more important to measure in a larger randomised study. Facilitators involved in the delivery of the group were also involved in the completion of psychometric assessments. To reduce bias, future evaluation of the programme would be improved by using raters independent of the treatment programme.

In conclusion, this preliminary study evaluated a compassion focused group intervention for patients with psychosis residing in a high security setting. The findings demonstrate an improvement in depression, self-esteem, and rating of self compared with others, and a reduction in shame, and general psychopathology. Further replication of this study could

involve a waiting list control group, a larger sample size and independent rating of change in outcome. Further research could also involve extending this protocol to non-forensic populations.

CHAPTER SEVEN: DISCUSSION OF FINDINGS

7.1 GENERAL DISCUSSION

This thesis will be discussed in two parts. First of all, I will present a summary of the results of chapters four, five and six. These results will be discussed in the context of the preceding three chapters. Secondly, the remainder of the discussion will focus on the implications of the thesis in terms of advancing our theoretical and clinical understanding of recovery and psychosis.

Overview of studies

The first study in this thesis explored the recovery narratives of individuals with psychosis residing in a secure forensic mental health environment. The findings of this study produced two themes common to all of the participant's accounts; past experiences of adversity and recovery in the context of being in a hospital. Two higher order concepts, relationships and changing sense of self emerged, which were evident across all the themes. In this study, participants spoke about the tasks involved in recovery, which included, the importance of relationships; development of trust; coping and valued outcomes. These findings were consistent with the findings of previous qualitative studies of recovery and psychosis (Davidson & Strauss, 1992; Humbertson, 2004; SRN, 2007). However, this is the first study, to the authors' knowledge, that has focused on recovery and psychosis in a forensic mental health setting.

This grounded theory study also found differences in the quality of the recovery narratives produced by individuals. Some of the narratives were more coherent and more developed than others. The development of a coherent adult narrative maybe a reflection of early attachment experiences (Bateman and Fonagy, 2003), suggesting therefore that many of the participants interviewed in this research may have disrupted early attachment experiences. This is consistent with the literature on offenders with mental health problems as discussed earlier in this thesis (Pfafflin and Adshead, 2004). Furthermore Paul Lysaker and colleagues (2001, 2003) have argued that the construction of a coherent recovery narrative plays a significant role in the movement towards mental health. Indeed such ideas have been taken on board by current mental health policies and practices, which promote the development of recovery focused narratives in individuals with severe and enduring mental health problems with interventions such as the Tidal Model (Barker, 1999).

The findings of this qualitative study are largely consistent with findings of other similar recovery-focused reviews and studies (Andresen et al., 2003; Davidson & Strauss, 1992; Bonney & Stickey 2008; Pitt et al., 2007), for example redefining sense of self, improving relationships and achieving valued outcomes are common themes across the recovery literature. However notable differences were found in this study, which are important to recognise and understand. Participants in this study did not emphasise the importance of hope and optimism, or taking responsibility and empowerment, despite this being a consistent theme in other recovery studies. Several explanations for this may be offered. This study employed a grounded theory methodology to explore patients' experiences of residing in high security. As such the initial objective was not to explore recovery, although this emerged as a theme, and the tasks involved in recovery, through the narratives of patients. Other user-focused studies have explicitly explored recovery, most often using semi-structured interviews to guide the process and to identify recovery focused themes. The context of this study may also have had a bearing on the themes that emerged. Most of the recovery-focused research has interview patients who are residing in the community, either through supported accommodation, with carers, or even with intermittent period of hospitalisation. This study interview patients residing in a maximum-security inpatient hospital. Therefore, it may be difficult to be optimistic and hopeful about the future when residing in a high secure environment with no sense of when you will be released. Furthermore, it is difficult to be empowered and to take on responsibility for yourself when you are for example, a restricted patient in a high secure setting. The environment, by its very mere nature, does not encourage responsibility taking or empowerment.

The recovery study emphasised the importance of the development of sense of self in recovery. This finding is perhaps consistent with research that has shown that self-esteem is low in patients with psychosis (Freeman et al., 1998). Studies investigating the impact of psychosis on an individual's well-being have found that low self-esteem may be a product of the individual's experiences of psychosis and it's negative social context, exposure to traumatic events (Garety et al., 2001) including hospitalisation, and loss of social role and rank, and increasing the individual's vulnerability to post-psychotic depression (Birchwood and Iqbal, 1998; Iqbal et al., 2000). In general, it is recognised that for many, the process of developing psychosis and the sequelae that follows is very traumatic and can significantly influence the person's perception of self. It has been suggested that given the potential for reinforcement of negative views of the self from internal factors such as depression, hopelessness and suicidal ideation, and external factors such as critical and hostile family members/ carers, stigma and impoverished social relationships, it is perhaps not surprising that self-esteem fails to improve if not specifically targeted in therapy (TARRIER, 2001). It has

therefore been recommended that self-esteem is considered an important outcome measure in therapy, and is specifically targeted. Indeed, Barrowclough et al. (2003) have proposed that interventions that target negative self-worth may have a beneficial impact on positive symptoms, and that interventions continue to take the social context into account and for family/ care- worker to pay particular attention to helping relatives to develop less negative appraisals of patient behaviour. The second study in this thesis therefore involved the development of a self-esteem group intervention for patients with psychosis residing in a forensic mental health setting.

This group intervention was based upon the individual therapy for self-esteem and schizophrenia carried out by Hall and Tarrrier (2006). The aim of this group intervention was to improve self-esteem, reduce psychiatric symptomatology and alleviate depressed mood. Fifteen participants completed two group interventions. The findings demonstrated an overall treatment effect for self-esteem at the end of the intervention, which was maintained at three month follow-up (only maintained on the Rosenberg Self-Esteem Questionnaire). Significant effects were found on the Beck Depression Inventory II (BDI-II) and were maintained at three-month follow-up. Furthermore, associations were found between self-esteem and low mood, therefore changes in low mood may have been related to changes in low self-esteem or vice-versa. Consistent with this, is that a large component of the programme was focused on challenging self-critical thinking. Gilbert et al. (2006) has shown that a large contributory factor of depression is self-critical thinking. Unlike the Hall and Tarrrier (2006) study, the findings of this group intervention did not show a reduction in symptomatology as rated by the PANSS, although a reduction in distress, as rated by the PSYRATS was found. Many of the participants recruited into this study were considered to be “below average” on the positive and negative symptom scales of the PANSS, therefore one would not expect there to be a significant reduction in those scales. As stated earlier, a large component of the self-esteem programme focused on individuals developing cognitive behavioural strategies to challenge self-critical thoughts. Lee (2005) has stated that although individuals may be able to generate alternatives to self-criticism, they rarely feel reassured by this and may continue to experience shame and low mood. It was considered at the end of this study, therefore that the intervention may be developed by incorporating elements of Compassionate Mind Training (CMT) (Gilbert & Irons, 2005).

This led to the development of a compassion-focused approach to recovery after psychosis. This was developed to help people develop compassion and the ability to self-soothe, regulate affect and move individuals away from operating in a threat-focused manner. It proposes that some individuals have never had the opportunity to develop their abilities, to understand

sources of their distress, be gentle and self-soothing in the context of set-backs and disappointments, but are highly threat focused and sensitive. CMT seeks to change an internalised and dominating attacking style that elicits a submissive response to one that generates a caring and compassionate response. In the third study, a compassion-focused recovery group intervention, based on social mentality theory was developed. The primary focus of this intervention was on the development of compassion towards self and others and with this, to improve sense of self in comparison with others, and to reduce sensitivity to put down and reduce shame. This group aimed to improve depression, improve self-esteem, develop compassion towards self and improve social comparison and reduce external shame. This was a pilot, pre-trial study, and the first time that a compassion focused group has been run with a forensic clinical population. The findings of this study demonstrated a large magnitude of change for levels of depression and self-esteem as measured by the Beck Depression Inventory II and the Rosenberg Self-Esteem Inventory. A moderate magnitude of change was found for the Social Comparison Scale and General Psychopathology subscale (PANSS), with a small magnitude of change for shame, as measured by the Other as Shamer Scale. These effects were maintained at 6 week follow-up. There is a limited evidence base for Compassion Focused Therapy although the findings of those studies are encouraging (Gilbert & Proctor, 2006; Mayhew & Gilbert, 2008). These studies are pre-trial and do not have a control group. It is interesting to compare the findings of this study with the previous two studies. In the Gilbert and Proctor (2006) study, a group intervention based upon compassionate mind training was delivered to six patients attending a day centre. Those individuals experienced chronic difficulties and all experienced self-critical thinking and shame. The study found a significant impact upon depression, anxiety, self-attacking, feelings of inferiority, submissive behaviour and shame, but not a significant effect on self-correcting self-attacking. Mayhew and Gilbert (2008) carried out a single case series of Compassionate Mind Training with three psychotic voice hearers. The objective of this study was to explore the extent to which participants were able to access and experience warmth and contentment in order to become more self-compassionate. Furthermore, they explored the effect of CMT on the experience of hearing hostile voices, anxiety, depression, paranoia and self-criticism. The study found that CMT had a major effect on participant's hostile voices, and that they were perceived as less malevolent, and hence participants responded with less submissive strategies. Participants also reported a decrease in depression, anxiety and paranoia. Therefore, the findings of the current Recovery After Psychosis programme are consistent with the two previous studies that have explored the use of Compassion Focused Therapy with patients who have chronic mental health difficulties and have experience of shame, and self-attacking thoughts. The findings from these preliminary studies are encouraging and suggest that CFT helps individuals to develop more compassionate responding.

Weaknesses of the studies

There were several limitations to the methodologies employed in this thesis, which will now be discussed. These limitations are important to consider in light of reviews, which have demonstrated that studies of poorer methodological rigour are more likely to produce larger effect sizes (although this relationship tends to be quite weak) (Wykes et al. 2008).

Qualitative study

As stated in Chapter Four, it is possible that an independent researcher carrying out the interviews with the participants may have led to a different dynamic and hence different results. Interview bias was however reduced by all interview transcripts being coded by two independent reviewers and supervision with a Consultant Clinical Psychologist, which allowed for the interview transcripts to be discussed.

Self-esteem study

It has been argued that randomised controlled trials (RCTs) provide the best evidence on the efficacy of health care interventions, and that trials with inadequate methodological approaches are associated with exaggerated treatment effects (Moher, 1998; Altman, Schulz, Moher, Egger, Davidoff, Elbourne, Gotzsche & Lang, 2001). A group of scientists and editors developed the CONSORT (Consolidated Standards of Reporting Trials) statement to improve the quality of reporting of RCTs. The group interventions reported in this study, were not randomised controlled trials. The self-esteem and recovery after psychosis group interventions were pre-trial studies. However, given this, their methodological weaknesses must be noted. In order to consider their limitations, the standards as reported by CONSORT will be reflected upon.

This study was carried out on a small sample of patients without any matched control group, or randomisation to treatment, thus reducing the reliability and generalisability of the findings. Furthermore, facilitators involved in the delivery of the group intervention also aided participants in the completion of self-report psychometric assessments, introducing bias. In addition participants understood that they were receiving treatment as part of their standard care, but also knew that it was a research study. They were therefore not blind to this, and hence, this may have introduced an acquiescence response bias on the self-report questionnaires.

The Recovery After Psychosis Programme

Like the self-esteem group intervention, The Recovery After Psychosis intervention was limited by small sample size and a within subject design. Therefore there was no matched control group or randomisation to treatment. A further limitation to the study was that there was no extended baseline upon which to compare the findings at end of treatment. Therefore it is not possible to be fully confident that the changes observed are fully attributable to the effects of the intervention. Furthermore, many of the measures used do not have published norms and have not been validated on a forensic mental health population. Facilitators involved in the delivery of the intervention were also involved in the completion of psychometric assessments, possibly introducing further bias.

A further limitation in the study was the self-reporting of compassion, which may not equate with an increase in the experience of self-compassion. For example, “Individuals with a dismissive attachment style tend to constrict rather than contain their emotional experience, and who are strangers to feelings, motivations, or inner life” (Slade, pg 585; 1999). Similar to those with dismissing states of minds (which, it maybe hypothesised that many of the individuals in the recovery group had) – they dismiss the importance of attachment and these individuals produce pseudo secure ratings. It is therefore possible that individuals with dismissive attachment styles did not accurately reflect on the development of their self-compassion, producing false ratings.

The recovery after psychosis programme aimed to improve self-compassion. However, with hindsight, the focus on self-compassion was a limitation in the study design. As with previous discussions on recovery in forensic mental health, it is difficult to improve compassion in individuals, without looking at the system’s (i.e. the institution’s) capacity to tolerate compassion. What an individual learns about compassion within the group therapy setting has to be tested out within their environment. The capacity for compassion within forensic mental health is an interesting, but provocative concept, which is influenced by society, and the wider legal context. Most individuals would concur that the primary role of a forensic mental health establishment is public safety. This is in contrast to what is perceived as the role in other mental health settings – which is client well-being. What we have seen within forensic mental health over the past decade, however, is a shift in this paradigm, which has largely been driven by psychological models such as Good Lives (Ward, 2002). This model proposes a recovery-focused approach to working with offenders. The traditional approach emphasises risk management, whereby the primary aim of treating offenders is to avoid harm to the

community rather than to improve their quality of life (Andrews & Bonta, 1998). Ward and Hudson (2004) argue that a second approach to treating offenders is to attend to their human needs and levels of well-being. This model is concerned with the enhancement of offenders' capabilities in order to improve the quality of their life, and by doing so, reduce their chances of committing further crimes against the community. Essentially, the Good Lives Model assumes that offenders typically share the human needs and aspirations of the rest of the community and that their offending occurs as a consequence of the way in which they seek the primary human goods emerging from these needs (Ward & Hudson 2004). Therefore, what this has emphasised is that by focusing on offenders working towards a hopeful and meaningful, rewarding existence, i.e. working towards client well-being, that this serves towards maintaining public safety. Adopting a compassion focused approach to the care and treatment of offenders with mental health problems supports and compliments the Good Lives Model Approach.

Alternative explanation for noted effects

It is possible that the positive effects generated in both the self-esteem and the recovery programme was a result of the group effect – that is, the experience of being in a group with supportive individuals and facilitators, may have created an effect. However, it may be argued that this effect could have been generated through processes similar to those created by compassion-focused therapy. The experience of being in a group may have facilitated the sense of “common-humanity” that is, “that others have had similar experiences to me” which may have enabled individuals to be more forgiving and compassionate towards themselves. Furthermore, the experience of common humanity may also have had an impact on social rank – the perception that others are better or that “I am inferior”. It is possible that such group processes exist in any form of group therapy, whether this be guided by CBT, psychodynamic etc. However, the explicit focus on compassion in this group may have helped to foster this and to guide compassion focused responses to self and others, which may not have been so apparent in other forms of groups.

Complexities of carrying out clinical work and research with this population

Carrying out clinically focused research in this setting has highlighted the complexities of this population, but also of working in this environment and the implications this has for treatment. As discussed throughout this thesis, the most significant difficulty with this work was piloting a compassion focused recovery approach within a forensic mental health population. As mentioned previously, the notion of compassion and forensic mental health has not been typically equated and was one that patients and staff alike had reservations about. Furthermore, patients were limited in their opportunities to test out new skills acquired

through interventions, due to the restrictions on their liberty placed upon them by clinical teams and the Scottish Government. This had implications for research methodology as it was not possible to employ randomisation or waiting list control groups, as the time in which the studies were carried out coincided with the new Mental Health Care and Treatment Scotland Act (2003) and patients appealing against excessive levels of security. It would have been considered unethical to delay treatment to patients at this point in time.

7.2 THEORETICAL AND CLINICAL IMPLICATIONS

The development of compassion-focused approach to promoting Recovery after Psychosis

The theoretical and clinical implications of this thesis are wide reaching. This thesis has argued that recovery is a *dynamic* process that exists between the individual and the environment in which they live. The hopes and aspirations of an individual can only be realised if the system that they live in recognises this and is willing to tolerate it. Most of the research into outcome and psychosis refers to outcome of the individual, most notably, outcome as measured by functional and symptomatic outcomes (chapter two). However, what I hope has been successfully argued in this thesis is that recovery means more to the individual than reduction in symptomatic and functional outcomes. Recovery to the individual with psychosis is varied but involves achieving goals and hopes that many people who do not experience psychosis aspire to. These recovery-focused goals are not unique or unusual, they are about developing a sense of self; meaningful relationships with others; being valued and respected (chapter four). However, for many the achievement of such aspirations is difficult, due to early life experiences that interfere with their capacity to recovery and also due to the environment/ system in which they reside, which may have its own capacity for recovery.

The research carried out in this thesis led to the development of a group intervention that was developed on the basis of the recovery narratives of individuals with psychosis in forensic settings. This group intervention was also based on compassionate mind training, which derived from social mentality theory. It has been argued in this thesis that social mentality theory helps us understand the particular needs of individuals in forensic mental health with regards to early attachment experiences and how this impacts upon the development of a threat focused interpersonal strategy (or mentality), which may interfere with recovery goals. The application of compassionate mind training helps to counteract the threat-focused social mentality to encourage a sense of security, safety and self-soothing. Now, this thesis will turn to a discussion of the development of a compassion focused model of psychosis which can be applied across the therapeutic modalities, from the development of a compassion focused system, to compassion focused therapy for the individual and compassion focused group

therapy. Before describing what this will look like, it is necessary to first review the essential components of social mentality theory and the application to compassion focused therapy.

Social mentality theory (Gilbert, 1989, 2001, 2005) helps us understand the interplay in interpersonal situations between emotional, cognitive, and behavioural processes. These processes are conceptualised as reflecting underlying evolutionary derived systems that shape relationships between self and others. Social mentality theory also helps us understand the *relationship* between attachment and the development of and capacity for compassion. “*Compassion is associated with what Bowlby called the ‘care-giving behavioural system’ – an innate behavioural system in parents and other caregivers that responds to the needs of dependent others, especially, (but not limited to) children. This behavioural system is thought to have evolved mainly to complement the ‘attachment behavioural system’, which governs people’s especially young children’s, emotional attachments to their caregivers.*” (Gillath, Shaver and Mikulincer, pg 121, 2005).

Interactions with attachment figures that are available and responsive in times of need facilitate optimal development of the attachment system, promote a *sense of connectedness* and security, and enable people to rely more confidently on support seeking as a distress regulation strategy. In contrast, when a person’s attachment figures are not reliably available and supportive, a sense of security is not attained and strategies of affect regulation other than proximity seeking (secondary attachment strategies, characterised by avoidance and anxiety) are developed. Attachment theory helps us to understand an individual’s capacity to have compassion for themselves and others. Without an internal working model of compassion, which has developed through the experience of other’s compassion towards us, the ability to show this to others is compromised. This may be more so the case in individuals in this population.

Care-giving in the individual is shown for example in their response to child’s distress, so it provides a safe haven, but also through enabling the child to optimally develop through creating a safe base. This care-giving response is required in order to produce a secure attachment style in others. The ability to care-give is also dependent on the individual having a secure attachment style. The ability to help others is a consequence of having witnessed and benefited from good care-giving on the part of one’s own attachment figures and promotes the sense of security as a resource and provides models of care-giving.

Early developmental and interpersonal experiences

Essentially, this model of compassion-focused recovery is grounded in the early developmental experiences of the individual and how this influences their attachment and hence interpersonal style of relating to self and others, and subsequently, the development of their social mentalities. This interpersonal style is relevant to both experiences of mental health and offending behaviours. It has already been discussed in this thesis how early experiences of impoverished relationships with others, either through trauma, abuse or neglect, impacts upon the development of a secure attachment style (Read & Gumley, 2008; Liotti & Gumley, 2008). Secure attachment is the “*psychological immune system*” (Holmes, 2001) of our emotional well-being, without it, we are vulnerable to emotional and psychological difficulties. People with psychosis and co-morbid offending histories often come from backgrounds that reduce the *safe(ness) mentality* (this helps individuals develop self-soothing and compassionate behaviours towards themselves and others) and results in an activation of the *threat focused* mentality (this is activated in situations of perceived threat and actual threat, for example feeling submissive and dominated by another). The activation of the threat-based social mentality can result in the development of safety behaviours/strategies such as avoidance in order to prevent or reduce the sense of threat (this may be apparent in psychosis in order to prevent and reduce stigma and sense of shame). However, it has been argued that such avoidance or safety strategies may lead to unintended consequences, which serve to reinforce and maintain problems and in particular sense of threat.

The experience of psychosis can maintain and add to that sense of threat. The stigma and shame associated with psychosis can lead to the activation of the threat-focused mentality. Furthermore, the experience of developing psychosis, being hospitalised and the trauma associated with this can also contribute to the maintenance of this mentality. It was also discussed in Chapter Three that the “therapeutic environment” may serve to reinforce an individual’s lower social rank through the position of being a patient and receiving treatment from the system. It was argued that this is particularly significant in a forensic mental health environment where an individual’s ability to exert their autonomy and to take responsibility for their every day behaviour is limited.

The implications of social mentality theory and hence the rationale for advocating a compassion focused approach to recovery after psychosis, is relevant when we consider the findings of a recent CBTp randomised controlled trial into relapse prevention for psychosis (Garety et al., 2008). In this trial, Garety et al. (2008) did not find that CBTp reduced rates of relapse or improved rates of remission at 12 or 24 months (although for those individuals living with the support of a carer there was improvement in distress related to delusions and

social functioning). Sampling and therapy are the two possible reasons for these largely negative findings. In terms of sampling, those randomised were all persons in hospital following an acute relapse or exacerbation, many of whom were responsive but non-adherent to medication and thus showed a rapid response to reinstating treatment. In addition, many did not particularly wish psychological therapy and may have had a tendency to “seal-over” (Tait et al., 2003) their experiences. Furthermore, this was a trial of generic CBTp (Fowler, Garety and Kuipers, 1995) based on a general psychological model of psychotic symptoms (Garety, Kuipers, Fowler, Freeman & Bebbington, 2001) and the trial therapists reported that it was sometimes difficult, in the absence of symptoms or of distress, to maintain a clear focus on the positive psychotic symptoms and indeed Garety et al., (2008) found that the therapy did not influence the predicted mediators of change, such as specific core beliefs or reasoning biases.

It might be argued that the focus on positive symptoms and their underlying mechanisms (e.g. core beliefs and reasoning biases) are not the correct target for effective relapse prevention. As discussed earlier in this thesis, research has shown that the emergence of affective symptoms, are often the first signs of relapse and hence the development of positive symptoms may reflect the end stage of the relapse process. Furthermore, there may well be systemic and organizational responses that will impede successful relapse prevention based on a model with positive symptoms as the main focus. Gumley and Park (2009) have recently made reference to the “relapse dance” to describe the cycle of unsuccessful, thwarted or aborted help seeking and relapse. Given the traumatic and distressing nature of psychosis, help-seeking itself may produce fearful expectations. For instance, individuals with psychosis may fear increased medication, re-hospitalization, and involuntary procedures. Individuals might also experience feelings of shame, guilt, and embarrassment in relation to disappointing or letting down their key-worker. Furthermore, many individuals find help seeking a challenge and may have experienced their relationships and previous interactions with others (including clinicians) as unhelpful, aversive, rejecting or threatening. Thus, by focusing on detection and prevention of psychotic experiences, clinicians may inadvertently create expectations of individuals to seek help in the context of high levels of distress, a context that for some individuals can outstrip their internal and external resources. This is particularly relevant for those individuals who are experiencing a more protracted, difficult, and complex recovery. This may result in a defensive but understandable delay in help-seeking. Delayed help-seeking may unintentionally result in service providers adopting more crisis driven and coercive responses to the threat of relapse, thus confirming the person’s negative expectations of help-seeking and increasing feelings of lack of control and entrapment in illness. This may particularly be the case in forensic mental health services where it is feared that relapse in

mental health may also be associated with an increase in risk of violence – therefore early signs of deterioration in mental state is commonly followed by recall to a secure hospital. It is therefore argued that if individuals can learn strategies to help them self-soothe and manage the distress associated with potential relapse (by adopting compassionate mind principles), then this may enable them to seek help in the early stages. However, it is also important that services take on board such principles to support and enable individuals to manage signs of relapse and to adopt a less crisis driven approach in order to reduce fear and sense of threat in individuals.

The outline of this compassion focused service delivery model will now be described in relation to compassionate responding, group and individual therapy. Future research will then be discussed.

Compassionate responding

Compassion focused therapy (CFT, Gilbert, 2009) was developed with and for people who have chronic and complex mental health problems linked to shame, self-criticism, and who often have experienced traumatic backgrounds. The roots of CFT have their origins in an evolutionary, neuroscience and social psychology approach, linked to the psychology and neuropsychology of caring – both giving and receiving (Gilbert 1989, 2000, 2009). Feeling cared for, accepted and having a sense of belonging and affiliation with others is linked to a particular type of positive affect regulation system that is associated with feelings of contentment and well-being.

Gilbert (2009) has outlined compassionate attributes and skills, which are required to counteract feelings arising from threat-based social mentalities and their unintended consequences. These include:

1. The motivation to be more caring and sensitive to oneself and others reflected in an attentional bias towards a helpful and balanced perspective;
2. A sensitivity to the feelings and needs of oneself and others;
3. Sympathy, being open and able to be moved and emotionally in tune with our feelings, distress and needs of those and others;
4. The ability to tolerate rather than avoid difficult feelings, memories or situations;
5. An empathic understanding of how our mind works, why we feel what we feel, how our thoughts are as they are – and the same for others;
6. An accepting, non-condemning, non-submissive orientation to ourselves and to others.

These attributes can be incorporated into psychological therapies provided for individuals, groups and families and can provide a basis for service organisation and therapeutic milieu. These will now be discussed and the proposed service structure is shown in Figure 7.1 below.

Advocating a compassionate systemic approach

If we look at the system's capacity for compassion, we must consider factors such as staff's attachment style, capacity for care-giving and how this influences their ability to be responsive care-givers. In his writings on attachment, Bowlby (1988) emphasised how the therapeutic relationship led to an activation of the patient's attachment style – that is, it would mirror their early parental relationship. What was less emphasised was how the therapist's attachment style would influence therapy. A therapist who is secure is likely to be able to focus on the patient's problems, remain open to new information and maintain compassionate and empathic rather than be overwhelmed by personal distress (Gillath, Shaver & Mikulincer, 2005). Dozier and colleagues (Dozier, Cue and Barnett, 1994) have also demonstrated that caseworkers' own attachment security has a bearing on how attuned they are with the individual's attachment based affect regulation strategies. We know however that working in very difficult environments, with patients who have complex needs, that this can lead to a sense of withdrawal, depersonalisation, loss of boundaries with patients, and possibly to the phenomena described earlier in chapter three – “*malignant alienation*” (Morgan, 1996). Research has demonstrated that lack of support is a major factor in staff burnout. Therefore it is important that in such working environments, staff are supported through supervision and reflective practices.

It is argued, that in order to promote a compassion-focused approach to recovery, it is necessary to train staff, and hence target the wider system. Therefore, this model of service delivery proposes that staff working in forensic mental health, be exposed to the principles of compassionate responding. The goal of this phase is to help services to develop the capacity to provide a secure base to promote exploration and autonomy amongst service users whilst providing a safe context for help seeking during times of distress and increased risk. It may also be necessary to educate staff on the processes underlying relapse and how a focus on identifying the emergence of positive symptoms, may be counter-productive and indeed increase a sense of threat in individuals.

Training and educating staff could be delivered through reflective practice sessions that focus on the development of compassion-focused formulations of patients. The development of such formulations may avert malignant alienation of patients, improve staff morale, reduce compassion fatigue and staff burnout. Consistent with this, research carried out by Berry,

Barrowclough and Wearden (2009) into the use of formulations found that there was a significant increase in staff perception of the degree of control service users and themselves had over problems, an increase in the degree of effort they felt service users were making in coping, reductions in blame, and more optimism about treatment. Staff also reported an increase in understanding of service user's problems, more positive feelings towards service users, and an increase in confidence in their work. In terms of further research, this could be extended to look at compassion in staff and how this influences their attitudes towards patients.

Group Interventions

The grounded theory study emphasised the importance participants placed on the development of positive relationships in their sense of self and hence their recovery. The ability to develop meaningful relationships was challenging for many due to early attachment experiences and poor relationships with significant others. The findings from this qualitative study, despite being carried out on a unique population, were remarkably similar to the findings of other recovery-focused studies, namely the Scottish Recovery Network paper in 2007. The challenge therefore was in developing an intervention that would enable participants to foster meaningful relationships, but also to develop awareness of the obstacles facing them in this, such as poor self-concept, shame, submissiveness etc.

Findings from this thesis support the view that a crucial process in recovery is creating a secure base for individuals to express, clarify, reflect on and explore their own and others experiences of recovery. Yalom (1995) postulated the central curative factors active in group psychotherapy include instillation of hope, self-understanding, altruism, universality, catharsis and various aspects of interpersonal learning. Leszcz, Yalom and Norden (1985) state that group therapy is an important and valuable component of inpatient therapy. A group format provides an important environment upon which to contextualise, normalise and destigmatise experiences as well as developing reciprocity, support, co-operation and validation. A group format also provides a context for individuals to express their own individuality and autonomy and for the group to support and explore these processes. The open group format also enhances individuals' insight and reflective capacity as they observe others and naturally compare others' narrative to their own experience. The group also provides the chance for modelling of expression as it generates positive and negative emotional reactions. It is understood that any group format will recreate aspects of each individual's social functioning and past interpersonal experience. The group process and people's experiences in the group can provide as rich a learning experience as what they hear whilst attending the group.

Group therapy also provides the ideal platform for compassionate responding. This is demonstrated to others through modelling by peers and facilitators and is internalised towards oneself over time. The goal of compassionate responding, as described above is to reduce sense of shame, humiliation and embarrassment, activate positive affects and promote adaptive coping and self-organisation.

Individual Interventions

It is argued that individual therapy for psychosis that is focused on compassionate mind principles will help the individual develop the ability to self-soothe and manage distress and promote help seeking and reduce sense of threat in light of potential relapse. This may improve outcome and might have an impact on relapse and psychosis. Therefore the focus of individual therapy would be less so about identifying early signs of relapse, but more about the emotional effects of relapse and compassionate approaches to reduce stress associated with this.

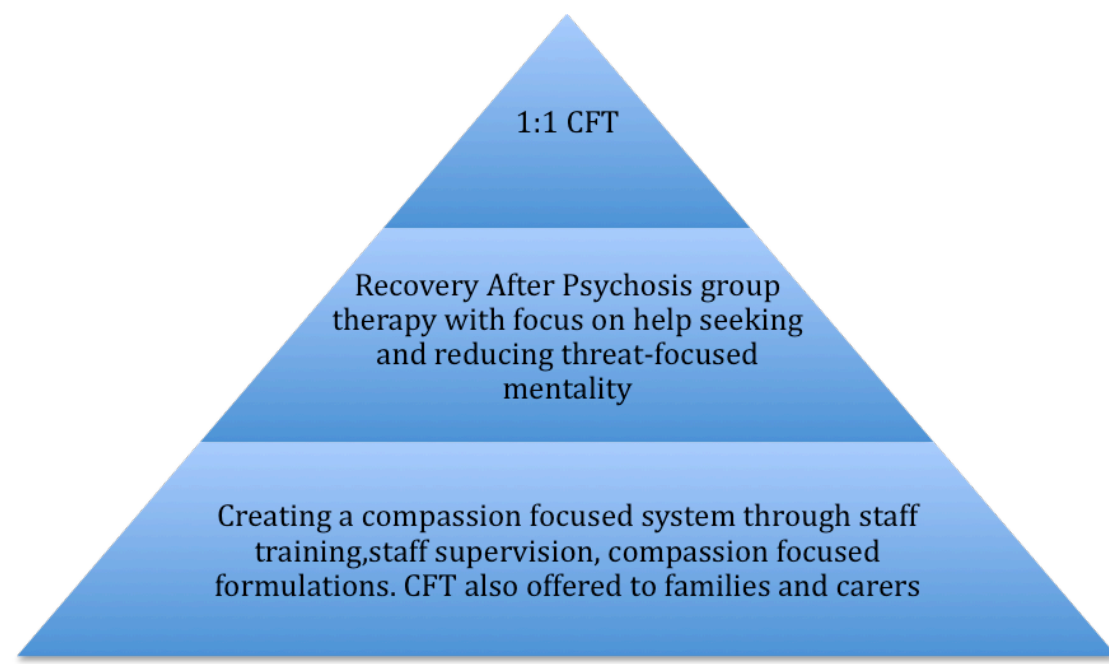


FIGURE 7.1: SERVICE DELIVERY MODEL OF COMPASSION FOCUSED THERAPY FOR PROMOTING RECOVERY AFTER PSYCHOSIS

7.3 RESEARCH IMPLICATIONS

The recovery after psychosis programme was a pre-trial pilot of this group intervention. It has been developed into a randomised controlled trial (RCT) of Recovery After Psychosis. Colleagues in NHS Ayrshire and Arran are currently carrying out a randomised controlled

trial with a general adult mental health population. It is recommended however that this be developed further in a forensic mental health population with the implications of CFT for reducing violence and lowering risk of violence assessed. For example, it would be beneficial to carry out a RCT of RAP across the forensic estate, recruiting participants close to discharge to the community. In addition to the outcomes measured in the RAP pre-trial study, additional outcomes such as relapse/ re-admission, measures of anger and assessment of risk (as measured on the HCR-20) could be looked at. Follow-up would be over a twelve-month period. This RCT would add further to our knowledge of relapse and psychosis, the effects of CFT on this and whether CFT has an impact on reducing violence (by reducing the threat-focused mentality).

Future research could also focus on the development of a compassion focused outcome measure that is sensitive to change. It has been discussed that narrative coherence may be influenced by early attachment experiences and may also be an indication of the individual's recovery. It is suggested that compassion towards self and others may also be reflected in such narratives. Therefore, the development of a narrative coding scale that is able to identify and rate compassion focused narratives would enable more sensitive assessment of outcome in therapy. This narrative approach would also reduce bias brought about through self-reporting. The development of a narrative coding scale could also be used to raise awareness of compassion-focused narratives in staff working with patients. This would help to identify the development of compassion focused responding in staff following milieu training and the effect of this in the staff/ patient therapeutic relationship.

In summary, this thesis has argued for a recovery-focused approach to psychosis. This was achieved in this thesis through the development of a recovery after psychosis programme, which was developed from the recovery themes identified by patients in the qualitative study. The group programme was based on CFT, the philosophy of which promoted a recovery focused approach. This approach deviated from traditional approaches in that the primary outcomes were not symptomatic reduction, but interpersonal outcomes and outcomes relating to sense of self and the development of relationships – outcomes generated by recovery narratives. It is proposed that the continued practice of adopting outcomes into clinical practice that reflect the outcomes that matter to an individual's recovery will lead to more meaningful clinical interventions for people with psychosis and will lead to enhanced recoveries.

Open your eyes with hope within,

Open the door, let light reach in,

If you believe, then you'll win

Siddharth Anand

CHAPTER EIGHT: REFERENCES

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Lothian NHS Board
01 August 2007

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Dear Dr Laithwaite

Study title : Recovery after Psychosis [RAP]: A recovery focused programme for patients with psychosis in forensic mental health settings
REC reference : 06/S1103/76
Amendment number : 1
Amendment date : 19 July 2007

The above amendment was reviewed on behalf of Lothian Local Research Ethics Committee 03 by a sub-committee comprising the Chair, Dr Christine West, and Dr Yann Maidment.

Ethical opinion

The sub-committee gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

Approved documents

The documents reviewed and approved by the sub-committee were:

- Notice of Substantial Amendment No. 1, dated 19 July 2007
- Protocol, version 3, dated July 2007
- Revised application form, version AB/115630/1
- Patient Information Sheet, version 3, dated 1 August 2007

Research governance approval

All investigators and research collaborators in the NHS should notify the R&D Department for the relevant NHS care organisation of this amendment and check whether it affects research governance approval of the research.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

REC Reference Number 06/S1103/76 **Please quote this number on all correspondence**

Yours sincerely

Liz Harden
Committee Co-ordinator
Lothian Local Research Ethics Committee 03

Copy to: R&D Department for NHS Lothian

INVESTOR IN PEOPLE

SL32 Favourable opinion of amendment
Version 3, June 2005

Lothian NHS Board

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24 May 2005

Dear Dr Laithwaite

Study title : Sense of Self, Adaptation and Recovery in patients with psychosis in a Forensic NHS Setting
REC reference : 04/S1103/31
Amendment number : 3
Amendment date : April 2005

The above amendment was reviewed by a Sub-Committee of the Lothian Local Research Ethics Committee 03.

Ethical opinion

The members of the Sub-Committee gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

Approved documents

The documents reviewed and approved were:

Document type	Version	Dated	Date received
Notice of Substantial Amendment			29 April 2005
Covering letter		26 April 2005	29 April 2005
Research Protocol	3	April 2005	29 April 2005
COREC Application Form		25 August 2004	
Patient Information Sheet	4	May 2005	19 May 2005
Consent Form	3	25 April 2005	29 April 2005
Management approval from The Orchard Clinic, Edinburgh		19 April 2005	29 April 2005

Membership of the Committee

The members of the Sub-Committee comprised the Chair, Dr Christine West, and Professor Lindsay Sawyer.

Management approval

All investigators and research collaborators in the NHS should notify the R&D Department for the relevant NHS care organisation of this amendment and check whether it affects local management approval of the research.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.



SL32 Favourable opinion of amendment
Version 2, October 2004

REC reference number: **04/S1103/31** Please quote this number on all correspondence

Yours sincerely,



Liz Harden
Committee Administrator
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R + D Copy



Lothian Local Research Ethics Committee 02

25 May 2005

Dr Heather M Laithwaite
Chartered Clinical Psychologist,
Honorary Research Fellow, University of Glasgow
The State Hospitals Board for Scotland
The State Hospital
Carstairs
Lanark

Dear Dr Laithwaite

Full title of study: *Self-Esteem and Psychosis: A Pilot Study investigating the effectiveness of a self-esteem programme on the self-esteem and positive symptomatology of mentally disordered offenders.*
REC reference number: 05/S1102/15
Protocol number:

Thank you for your letter of 26 April 2005, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

Please note the chair has expressed a couple of points:

- Please forward a copy of supporting documentation to the Committee for their files.
- The chair was concerned that this is 'considered part of your care and treatment', however as long as it is made clear the study is voluntary as stated in the Consent Form this is ok.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

Conditions of approval

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document Type:	Version:	Dated:	Date Received:
Application	2	14/03/2005	29/04/2005
Investigator CV		14/03/2005	17/03/2005



Clinician Information Leaflet

Title of Study: Sense of self, adaptation and recovery in patients with psychosis in a forensic NHS setting.

What is the study about?

I am a Chartered Clinical Psychologist working at the State Hospital. I am interested in studying self-esteem and psychosis and how this is related to recovery. Research has demonstrated that self-esteem is often low in patients with psychosis and may be related to poor clinical outcomes. In general, it has been recognised that for many, the process of developing psychosis and the sequelae that follows is traumatic and can significantly influence the individual's sense of self. Self-esteem has therefore been recommended as an important outcome measure in therapy and is specifically targeted.

Given the emerging importance of self-esteem in the treatment and outcome of psychosis, it seems important to explore this in mentally disordered offenders. This study proposes to explore what is important to patients in terms of their self-esteem, and factors such as their offending behaviour, their social environment, their patient-hood and interpersonal relationships will be explored, and how they contribute to the patient's sense of self. The processes involved in self-esteem, adjustment and recovery in psychosis will also be explored. It is anticipated that the results of this study will contribute towards the development of a valid and reliable measure of self-esteem in this patient population, and will further be used to develop service provision in this area.

What will participants be asked to do?

Participants who agree to be involved in the study, will be interviewed for approximately 40-60 minutes. The interview will be tape recorded. The duration of the interview is flexible and can take place over a couple of sessions if the participant prefers. It is not anticipated that the interview will create distress, however, participant distress levels will be monitored on a 10 point scale at regular intervals. If there is cause for concern, the interview will be terminated, and appropriate measures taken to reduce distress.

Participants will be asked open-ended questions around themes to do with their experience of being a patient in the hospital, their experience of psychosis, their self-esteem, and what factors contribute to this.

How can you help?

As Responsible Medical Officer, I would be grateful if you could identify participants from your ward that you feel are suitable for this study. Exclusion/ inclusion criteria are as follows:-

Inclusion criteria

- Able to give informed consent
- Primary diagnosis of schizophrenia, schizo-affective disorder, bi-polar disorder.
- Fluent in English and able to converse in an interview setting.

Exclusion criteria

- Unable to give informed consent.
- Unstable mental state.
- Unable to speak English.
- Involved in a concurrent research project.

On identifying potential participants for the study, I will approach them with a participant information leaflet, and a consent form (see attached). They will have around a week to decide if they want to participate in the study, and you will be informed of their decision.

Where will the study take place?

The interview will take place in one of the interview rooms in the ward.

What will happen to the information?

All information provided by the patient is confidential and will not be included in any aspect of their care and treatment. Participants will, however be informed that if they disclose information that causes concern regarding their safety or the safety of others, appropriate professionals will be informed.

The findings of this study will be written up and submitted to a peer reviewed journal. The findings will be used to develop services in the hospital and to help meet the needs of patients.

Thank you for taking the time to read this information leaflet. If you have any questions, please do not hesitate to contact me. I am also willing to attend core group meetings to explain the research further if necessary or of interest.

Dr Heather M Laithwaite, BA (Hons); D.Clin.Psy; C.Psychol.

Chartered Clinical Psychologist

The State Hospital Carstairs

Participant consent form

“Self-Esteem and Psychosis: A pilot study investigating the effectiveness of a self-esteem programme on self-esteem and positive symptoms of psychosis.”

Principle Investigator: Dr Heather Laithwaite, Chartered Clinical Psychologist

Name of Participant

(printed).....

(delete as appropriate)

- I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions. **YES/NO**

- I understand that my participation is voluntary and that I am free to withdraw at any time, without giving reason, without my medical care or legal rights being affected. **YES/NO**

- I understand that sections of any of my medical notes may be looked at by responsible individuals from the Psychosocial Interventions for Psychosis team. I give permission for these individuals to have access to my records. **YES/NO**

- I understand that the results of the group will be written up
For submission to a peer reviewed journal. **YES/NO**

- I understand that a written end of treatment report will be forwarded
to my RMO and clinical team upon completion of the programme. **YES/NO**

- I understand that if I disclose information that causes concern about my
well-being or the well-being of others, that this will be shared with my RMO
and clinical team **YES/NO**

- I wish to receive a summary of the study results **YES/NO**

- I understand that anonymised findings will be published **YES/NO**

(details that identify you will not be published)

- I agree to take part in the above study **YES/NO**

Participant's signature:.....

Date:.....

Principal Investigator's signature:.....

Date.....

1 for participant; 1 for researcher; 1 to be kept with hospital notes.

Patient Information Leaflet (Version 2 26th April 2005) will be on headed note-paper

Self-Esteem and Psychosis: An investigation of the effectiveness of a self-esteem group in improving self-esteem and the experience of positive symptoms in Psychosis.

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Thank you for reading this.

What is the purpose of this study?

Self-esteem reflects the way we feel about ourselves, and the overall opinion we have about who we are. Recent research studies have shown that people who have had distressing experiences of hearing voices, feeling threatened and persecuted by others, experience poor self-esteem, and may generally have a low opinion of themselves. Some studies have shown that by improving self-esteem, distressing experiences relating to hearing voices and feeling threatened may reduce. The aim of this research study is to invite participants who have experienced hearing voices, feeling threatened, and who also experience low self-esteem to take part in a programme aimed at improving self-esteem. The group, which will be delivered in the hospital, runs over 12 weeks, and will involve attending once a week.

Why have I been chosen?

A letter was sent out to all Responsible Medical Officers in the hospital inviting them to select potential participants. You may have also recently been referred to the Psychosocial Interventions for Psychosis service, where we are also looking for potential participants.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at anytime and without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not affect the standard of care you receive.

What will happen to me if I take part?

If you decide to take part, a member of the Psychosocial Interventions Team in the hospital will come out to give you a brief interview. In this, you will be asked about your experiences of hearing voices, feeling threatened/ persecuted. You will also be asked to fill out some questionnaires that relate to self-esteem. If the interview and the questionnaires show that you experiences self-esteem problems, you will be accepted onto the group.

The group consists of 12 sessions run over 12 weeks. You will be in the group with 7 other participants. In the group you will cover work relating to your self-esteem, and will be encouraged to develop skills to help improve your self-esteem. Throughout the course of the group you will be asked to fill out the questionnaires you completed at the initial interview. This is so we can see if the group is benefiting you.

Will my taking part in this study be kept confidential?

If you choose to take part in this study, your RMO, ward manager and ward psychologist will be notified. Your attendance at the group is considered part of your care and treatment in the hospital. Therefore there will be written report regarding your attendance and engagement in the programme submitted to your RMO and Clinical Team upon completion of the group. Similarly, if you disclose information during the group that causes concern about your well-being, or the well-being of others, this information will be shared with your RMO and Clinical Team. When the study is written up to be submitted for publication, all names and identifiers will be removed so there is no possibility of you being identified.

What will happen to the results of the research study?

He results will be written up for submission to a journal, and the results will be used to develop patient services in the hospital.

If you have any further questions, please do not hesitate to contact me.

Dr Heather Laithwaite
Chartered Clinical Psychologist
Department of Psychology
The State Hospital

RMO consent letter for RAP

Dear RMO

The CBT for Psychosis service has developed a recovery after psychosis programme for patients in the State Hospital. The rationale for this programme is based on research that has recently been carried out in the Psycho-social Interventions Service. This will now be discussed.

A preliminary qualitative study was carried out exploring the views of offenders with psychosis with regards to recovery (Laithwaite and Gumley, submitted). The findings of this study demonstrated the importance of developing trusting relationships in patients' recovery. However, challenges to the development of trusting relationships included stigma (exacerbated by experiences of being in hospital, and in particular, admission to the State Hospital) and the influence of past adverse experiences. Furthermore, experiences of impoverished relationships in the past influenced the ease at which patients could develop trusting relationships with others.

A self-esteem programme was piloted in the State Hospital earlier this year. The principal aim of this group was to help patients improve their self-esteem (through increased awareness of positive qualities, and challenging self-criticism), and it was further hypothesised that this would bring a reduction in positive symptomatology. The findings of this preliminary study were encouraging and demonstrated an improvement in self-esteem, and depression. A noticeable change in positive symptomatology was not evident, due to most participants being "symptom" free prior to the group commencing. Qualitative findings from the group were also of interest. Participants spoke about their early adverse experiences and how this contributed to low self-esteem. Many displayed self-critical attitudes, and lacked a sense of "warmth" towards themselves. Participants also demonstrated a lack of self-awareness (which improved over the course of the programme), but initially found it difficult to provide examples of self-critical thoughts and reflect on the impact of this on their feelings. There was a significant shift in their awareness of this over the course of the programme.

Most recently, the PSI service have piloted a Staying Well After Psychosis Programme. This was based on cognitive behavioural therapy principles, and introduced work on compassion

based therapy, to help patients identify self-critical thinking, and processes that sabotage help-seeking.

The proposal to run a recovery after psychosis programme is to base this on the findings of the above research, and to develop this further by placing more emphasis on compassion based therapy, and in particular, strategies for challenging self-critical thinking, which can be an obstacle in the way of help seeking. Compassionate approaches also focus on the development of acceptance, and non-judgemental attitudes toward self, which it is hypothesised, will help with help-seeking.

Referral criteria

- The programme is designed to focus on recovery after psychosis with an emphasis on help-seeking behaviour. Patients who are currently symptom free, but with a history of psychosis will be considered suitable for the group.
- As the programme is also being run as a research study, patients will be asked if they want to consent to being involved in the study. Therefore, patients need to be capable of providing informed consent.
- Patients need to be fluent in English, and motivated to engage in group work.
- Patients with a severe intellectual disability will be excluded from the programme.

I would be grateful if you could inform me by the 18th December 2006 as to whether you have patients on your ward that you think could benefit from attending the programme.

Yours Sincerely

Dr Heather M Laithwaite
Chartered Clinical Psychologist

Cc Ward Clinical Psychologist

I, (RMO name) give permission for Mrto be approached regarding the recovery after psychosis programme.

Signed.....

Date.....

Recovery programme (will be on State Hospital headed paper)

Participant consent form

“Recovery after Psychosis”: An investigation of a group programme for recovery after psychosis”

Principle Investigator: Dr Heather Laithwaite, Chartered Clinical Psychologist

Name of Participant

(printed).....

(delete as appropriate)

- I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions. **YES/NO**

- I understand that my participation is voluntary and that I am free to withdraw at any time, without giving reason, without my medical care or legal rights being affected. **YES/NO**

- I understand that sections of any of my medical notes may be looked at by responsible individuals from the Psychosocial Interventions for Psychosis team. I give permission for these individuals to have access to my records. **YES/NO**

- I understand that the results of the group will be written up for submission to a peer reviewed journal. **YES/NO**

- I understand that a written end of treatment report will be forwarded to my RMO and clinical team upon completion of the programme. **YES/NO**

- I understand that if I disclose information that causes concern about my well-being or the well-being of others, that this will be shared with my RMO and clinical team **YES/NO**

- I wish to receive a summary of the study results **YES/NO**

- I understand that anonymised findings will be published **YES/ NO**

(details that identify you will not be published)

- I agree to take part in the above study **YES/NO**

Participant's signature:.....

Date:.....

Principal Investigator's signature:.....

Date.....

1 for participant; 1 for researcher; 1 to be kept with hospital notes.

RECOVERY AFTER PSYCHOSIS (RAP)

Laithwaite & Gumley



RECOVERY AFTER PSYCHOSIS (RAP): A COMPASSION FOCUSED PROGRAMME FOR INDIVIDUALS RESIDING IN HIGH SECURITY SETTINGS.

Introduction

A grounded theory study was carried out exploring the views of offenders with psychosis with regards to their recovery (Laithwaite & Gumley, 2007a). Amongst the many factors that individuals cited as being important in their recovery, developing meaningful and trusting relationships was reported as one of the most significant. Despite this however, patients described the barriers to developing trusting relationships. These included stigma and shame (exacerbated by experiences of being in hospital, experiences of mental health problems and shame associated with index offence) and the influence of past adverse experiences. In addition, many of the adverse experiences discussed included past and current impoverished relationships with significant others, which subsequently influenced the ease at which patients could develop trusting relationships.

The main themes identified in this grounded theory study of recovery add to our understanding of the contributory factors in a patients' pathway into and recovery from psychosis. The above study highlighted the importance of trusting relationships in recovery. We know from previous research that early attachment experiences influence the ability to develop safe, and secure adult relationships (Bowlby, 1988). Gilbert (2004) refers to two consequences that result when parents are unable to create (and stimulate) safeness, are threatening or shaming and do not convey warmth. First the under-stimulation of positive affect and warmth systems; and second, the child is more likely to be threat focused, seeing others as a source of threat. Subsequently, they are more social rank focused, especially on the power of others to control, hurt or reject them. Sloman, (2000); Sloman, Gilbert & Hasey (2003) has shown that those who have not been able to internalise a sense of warmth (able to stimulate positive affect in the mind of others) and who feel unloved by others, can set out on quests to earn their place, becoming excessively seeking, competitive and sensitive to rejection (Gilbert, 2004).

Social mentality theory (Gilbert, 1989) provides an evolutionary/ developmental account of the origins of self-criticism (which can be used to explain the development of derogatory auditory hallucinations). In this theory, reference is made to the development of the "*human warmth syndrome*" whereby human beings develop, through secure attachments with primary care givers, the ability to have compassion towards themselves and others. A secure attachment facilitates the development of internal working models of others as "safe, helpful

and supportive”. The internalisation of this helps the individual to develop self-soothing and compassionate behaviours towards themselves and others. Social mentality theory also provides an account of the development of role relationships (for example, attachment, sexual, dominate-subordinate type of self-self relating that comes in the form of self talk or voices). Dominant individuals will issue commands and hold power, whilst subordinates will take those commands and be submissive. Social mentality theory states that the role relationships that exist between people can also exist *within* people and arise from internal working models of early relationships. Therefore, human beings can internalise the voice of a critical other and develop a submissive/ subordinate response to this. This model can help to explain the occurrence of command hallucinations. It has been demonstrated that people who experience auditory hallucinations often relate to them as though they were relating to real external others. In particular, the voices are commonly experienced as malevolent, derogating, shaming and self-critical.

Observations of critical and self-derogating thoughts were made when a self-esteem programme was piloted with a group of patients with psychosis in a high security hospital (Laithwaite & Gumley, 2007b). The principal aim of this group was to help patients improve their self-esteem (through increased awareness of positive qualities, and challenging unhelpful self-criticism), and it was further hypothesised that this would bring a reduction in positive symptomatology. The development of this programme was based on previous research, which has demonstrated that self-esteem is implicated in the formation of persecutory delusions (Bentall & Kaney, 1996; Bentall, Kinderman & Kaney, 1994; Kinderman & Bentall, 1996) and in the maintenance of delusions and hallucinations in patients with schizophrenia (Garety et al, 2001). The findings of this preliminary study were encouraging and demonstrated an improvement in self-esteem, and depression. A noticeable change in positive symptomatology was not evident, due to most participants being “symptom” free prior to the group commencing. Qualitative findings from the group were also of interest. Participants spoke about their early adverse experiences and how this contributed to the development of low self-esteem. However, it was clear that many participants were able to challenge their self-criticism on an “intellectual level” but continued to report feelings of worthlessness and low self-esteem.

The potential importance of developing inner warmth came from observations that some high self-critics could understand the logic of cognitive behavioural therapy, and could generate alternative thoughts to self-criticism, but rarely felt reassured by such efforts (Lee, 2005). This research also found that such individuals were likely to come from traumatised backgrounds. It is postulated by Gilbert (2004) that individuals with such experiences are

compromised in their ability to generate a model of compassion, and hence the ability to self-soothe. Further studies have demonstrated that a lack of self-compassion is associated with increased vulnerability to a number of indicators of psychopathology (Neff, 2003).

Gilbert and colleagues (Gilbert, 1992, 1997, 2000; Gilbert and Irons, 2005) have developed compassionate mind training (CMT) to help people develop compassion and the ability to self-soothe. This model is based on the premise that self-criticism is significantly associated with shame-proneness and that self-criticism is associated with lifetime risk of depression (Murphy, 2002). The basic idea behind CMT is that some people have not had the opportunity to develop their abilities to understand sources of their distress, be gentle and self-soothing in the context of set-backs and disappointments, but are highly (internally and externally) threat focused and sensitive. The components of compassion are understanding, forgiveness, and acceptance. CMT is not about targeting specific core beliefs or schema but seeks to alter a person's whole orientation to self and relationships. It seeks to change an internalised dominating-attacking style that elicits a submissive response to one that elicits a caring and compassionate response.

There is a poverty of research carried out into people with psychosis in forensic clinical settings. This is despite the fact that this is a population with complex and chronic needs. This population have generally experienced past trauma; poor relationships with significant others and have the double stigma of experiencing severe mental health problems and being offenders. Recovery in this population is not just about reduction of symptoms or distress, but reduction/ management of risk of violent offending. It is therefore important that therapies that have been researched in general mental health settings are adapted and piloted with this population. A recovery programme that draws on CMT is attractive as it has a developmental perspective that focuses on the effect of disrupted attachment histories on the current functioning of the individual and their ability to respond to self-criticism, self-soothe, and modify distress. The preliminary studies discussed above have demonstrated that this population is characterised by past trauma, poor relationships, high expressed emotion, self-criticism, vulnerability to relapse and avoidance of seeking help. Hence a programme that focuses on developing a compassionate understanding of those vulnerabilities, may promote recovery and help seeking behaviour and in turn, reduce the risk of violent re-offending.

Aims

The aim of this group intervention was to evaluate the specific aims of the Recovery After Psychosis Programme. The aims of this programme were:

- To improve depression

- To improve self-esteem
- To develop compassion towards self
- To improve social comparison

Methodology

Design

A within-subjects design was used. Participants were assessed at the start of group, mid group (5 weeks) the end of the programme and at 6 week follow-up.

Participants

Setting

The State Hospital is the maximum-security hospital for Scotland and Northern Ireland and provides treatment and care in conditions of special security for individuals with mental disorder who, because of their dangerous, violent or criminal propensities, cannot be cared for in any other setting (The State Hospital Annual Review, 2005). There are 11 wards covering admissions, rehabilitation and continuing care. Patients in the hospital and participants in the study are familiar with being assessed on a regular basis by health professionals who are vigilant to issues of risk and mental health.

Inclusion/ Exclusion criteria

Participants were considered eligible for the group if they had a primary diagnosis of schizophrenia, schizo-affective disorder or bi-polar affective disorder. Potentially eligible participants were excluded from the study if they had an organic illness, severe intellectual disability, and were not able to provide informed consent. Participants were also excluded if they were involved in other research. All participants in this study had a primary diagnosis of schizophrenia, or bi-polar disorder.

Procedure

Ethical approval was given by the Local Research Ethics Committee (LREC number 06/s1103/76). Participants were recruited from a high security inpatient NHS setting. Letters were sent to Responsible Medical Officer's and Clinical Psychologists in the hospital in order to identify potential participants. Prior to seeking informed consent from potentially eligible patients, the respective patient's Responsible Medical Officers were asked to provide consent for their patient to be approached. Following consent, patients were approached by a

Chartered Clinical Psychologist (HL) and following a full description of the study, patients were invited to participate.

Assessments

Assessments were administered to participants at the start, at 5 weeks (mid group) and at the end of the programme with a 6 week follow-up. All the clinical outcome measures were standardised measures, either self-report questionnaires or structured interviews with acceptable psychometric properties.

Inter-rater reliability

All psychometric assessments were carried out by the assistant psychologists who had both received in-house training in the delivery of such assessments. Both were trained to use the Positive and Negative Symptoms Scale (PANSS) using video assessment (with reliability at $r > 0.80$).

Primary outcomes

Social comparison scale (SCS) – this scale was developed by Allan and Gilbert (1995), and is an 11 item scale, which taps global comparisons to others in the domains of attractiveness, rank and group fit (feeling similar or different to others). A lower total score reflects relative inferiority compared with others, whereas a higher total score indicates relative superiority.

Other as Shamer Scale (OAS) - this scale was developed by Goss, Gilbert and Allan (1994) and Allan, Gilbert and Goss (1994) to measure external shame (how an individual thinks others see him/her). The scale consists of 18 items asking respondents to indicate the frequency of their feelings and experiences to items such as, “I feel insecure about others opinion of me” and “other people see me as small and insignificant” on a 5 point Likert scale (never, seldom, sometimes, frequently, almost always). A total score is given by adding up the items. A higher score indicates greater experience of external shame.

Self Compassion Scale (SeCS) (Neff, K, 2003). This scale is a self-report measure that explores self-compassion in individuals. It is a 26 items scale that measures self-compassion (13 items) and coldness towards the self (13 items). There are six subscales, three measure self-compassion: common humanity, self-kindness and mindfulness. There are also three subscales to measure coldness towards the self: self-judgment, over identification and isolation. Responses are given on a 5 point Likert scale ranging from 1=’almost never’ and 5=’almost always’. To compute a total self-compassion score, the mean of each subscale was taken, and then the total mean was computed. The higher the total score, the greater the self-compassion.

The Beck Depression Inventory II (Beck, Steer & Brown, 1996) was used as a self-report measure of mood (score range 0-63). Higher scores reflect increase in self-reported low mood.

Secondary outcome measures

The Positive and Negative Syndrome Scale (PANSS; Kay, Fiszbein, & Opler, 1987) measures 32 symptoms on 7 point Likert Scales, deriving three composite subscales: Positive, Negative, or General Psychopathology. Higher raw scores indicate higher symptomatology.

The Rosenberg Self-Esteem measure (RSE, Rosenberg, 1965; Rosenberg, Schooler, Schoenbach & Rosenberg, 1995) is a 10 item self-report measure of self-esteem. Higher scores (range 0-30) are indicative of higher self-esteem.

The Self-Image Profile for Adults (SIP-AD; Butler & Gasson, 2004) consists of 30 self-descriptions and is a self-report questionnaire. Participants are invited to rate themselves as they are and how they would like to be (ideal) along each self-description. A self-image score (SI) represents how the individual feels about him/ herself. A high self-image score suggests the person has a positive view of him/ herself. Self-esteem (SE) reflects an individual's evaluation of him/ herself. On the SIP-AD this is operationalised as the discrepancy between how the person sees him/herself and how they wish to be (ideal). A high score reflects a wide discrepancy and therefore lower scores are interpreted as reflecting high self-esteem.

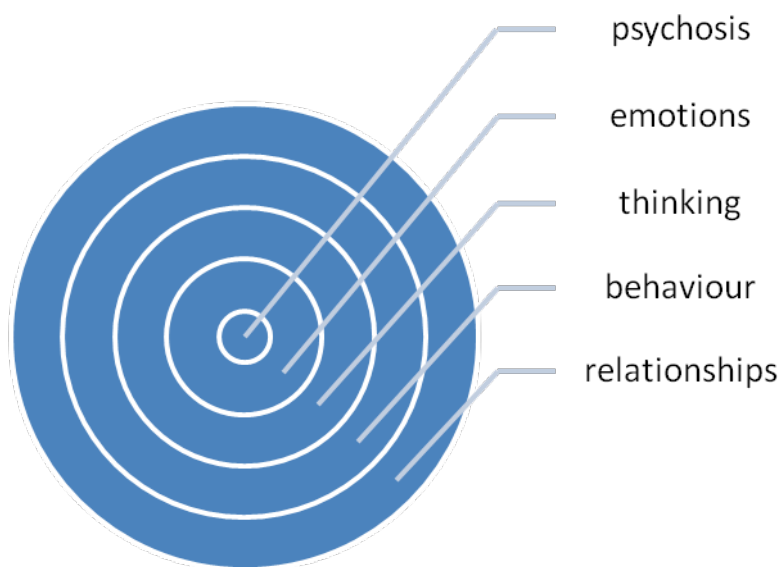
Intervention

The Recovery After Psychosis programme was delivered by a team comprising of two Chartered Clinical Psychologists (HL and PC), an Advanced Practitioner (M O'H), a trainee clinical psychologist (LA) and two assistant psychologists (SP and PD). The programme was developed by HL and AG and based on Compassionate Mind Training (Gilbert 2001).

The programme ran for 10 weeks (20 sessions). This involved two sessions a week. The programme was divided into the following 3 modules:-

Module one: understanding psychosis and recovery – the aim of this module was to help patients conceptualise the holistic nature of psychosis and the impact of this on various aspects of their lives. Patients were encouraged to think about psychosis in relation to their emotions, their cognitions, their behaviour, relationships and environment (see Figure 1). This model was then used to understand recovery. Therefore, patients were encouraged to think

beyond recovery as symptom reduction, but also to view recovery in terms of their emotions, feelings, relationships with others and their environment. To help patients with this, the metaphor of the “pebble in water” was used, so that they could understand how recovery or progress in one area of their life can have an impact on another area. Another group exercise involved using the metaphor of “recovery as a journey” helped create a visual experience of the many difficulties that they may face in the future, and the “tools” they need to take with them on their journey to help with this.



Module two: Understanding compassion and developing the ideal friend – in this module the group explored the concept of compassion and the many features of this (strength, forgiveness, acceptance, trust, non-judgemental). The strengths and weaknesses of these characteristics were discussed in depth. This exercise progressed to the creation of the “ideal friend”. The intention of creating this ideal friend is for patients to be able to refer to “someone” who is compassionate and over time, it is anticipated that they will internalise the characteristics of this ideal friend, to develop their own compassionate responses towards themselves and others. Guided discovery techniques were used to illicit an image of this ideal friend, and patients were encouraged to focus on characteristics such as voice tone, facial expressions, body posture etc. Throughout the remainder of sessions, the programme referred to the ideal friend, and used exercises to help develop compassionate responding. Participants were asked to keep a diary of any negative emotions and self-critical thoughts they experienced during the week, and how they responded to this using their “ideal friend.”

Module three: Developing plans for Recovery after Psychosis – this part of the programme involved the development of a Recovery After Psychosis plan (focusing on triggers, early warning signs, use of safety behaviours, action plan and agreed coping strategies). This information was used to create a compassionate letter, which involved participants writing a letter to themselves (as written by their ideal friend). This letter contained encouragement and support in relation to how to respond to set-backs and how to seek help in the future.

Results

Participant characteristics

Three groups were run in the hospital. There were 19 (all male) participants in total and 18 participants completed the programme. The mean age of the participants was 36.9 (SD 9.09). The mean duration in hospital was 8 years. Five patients were diagnosed with schizophrenia; 10 with paranoid schizophrenia and 3 with bi-polar affective disorder. Eight of the patients also had a co-morbid personality disorder. One patient was considered to be in the “borderline” intellectual disability range.

Outcome measures

Analyses were carried out using SPSS for windows (version 14). Descriptive statistics were conducted and further analyses were carried out using Friedman’s ANOVA. Significant overall effects were followed up with Wilcoxon signed ranks (two-tailed).

Primary Outcomes measures

Overall significant effects were found on the Social Comparison Scale, Other As Shamer Scale and the Beck Depression Inventory II. Further analyses using Wilcoxon signed ranks test found significant effects on the Social Comparison Scale between the start and end of the group ($Z=1.96$, $n\text{-ties}=11$, $p<0.05$, $r=0.3$) and this effect was maintained at follow-up ($Z=2.148$, $n\text{-ties}=10$, $p<0.05$, $r=0.36$). A small effect was found on the Other as Shamer scale between the start of the group and 6 week follow-up ($Z=.801$, $n\text{-ties}=11$, $p>0.5$, $r=0.15$). Significant effects on the Beck Depression Scale were found at the end of treatment ($Z=2.332$, $n\text{-ties}=15$, $p<0.05$, $r=0.38$) and at 6 week follow-up ($Z=-2.825$, $n\text{-ties}=16$, $p<0.01$, $r=0.47$).

Secondary outcome measures

This was measured using the PANSS, the Rosenberg Self-Esteem measure and the Self-Image profile for Adults. Significant effects were found on the PANSS general psychopathology

score at the end of the group ($Z=2.23$, $n\text{-ties}=14$, $p<0.05$, $r=0.38$) and this was maintained at follow-up ($Z=2.75$, $n\text{-ties}=12$, $p<0.01$, $r=0.41$). An overall significant effect was found on the Rosenberg self-esteem questionnaire. Further analyses using Wilcoxon signed ranks test demonstrated a significant effect at 6 week follow-up ($Z=-2.80$, $n\text{-ties}=15$, $p<0.01$, $r=0.47$).

Discussion

This was a pilot, pre-trial study. This was the first time that a compassion focused group intervention has been run at the State Hospital and to our knowledge, the first time that it has been run with a forensic clinical population. The primary objective of this study was to evaluate whether the programme would improve depression, develop self-compassion and social comparison.

The findings of this study demonstrate large treatment effects for depression, and self-esteem as measured by the Beck Depression Inventory II, and Rosenberg Self-Esteem Inventory. A medium effect was found for the social comparison scale and general psychopathology, with a small effect for shame, as measured by the Other as Shamer Scale. These effects were maintained at 6 week follow-up. Gilbert (2005) has shown that self-critical thinking biases are influential in the development and maintenance of psychopathology, therefore a programme such as this recovery programme, that focuses on developing compassionate responses to shame, self-critical and self-attacking thoughts will likely lead to a reduction in depression, shame and an increase in self-esteem.. Much of the research on psychopathology has focused on depression, however we know that self-critical thinking, shame and low self-esteem play a role in the development and maintenance of psychotic experiences (Bentall, Kinderman & Kaney, 1994; Garety et al., 2001; Smith et al., 2006). The findings of this study has shown that an intervention that focuses on reducing shame and self-critical thinking can also have an impact on the general psychopathology of individuals who experience psychosis.

Nineteen patients commenced the intervention and eighteen completed the programme. One individual dropped out of the programme at week four due to an unsuccessful tribunal hearing and the belief that there was no point in engaging in psychological therapies as he was going to be “stuck” in the hospital. Despite efforts from the facilitators in the team to re-engage him, he was not willing to complete the programme. During the programme, some of the patients reported feeling slightly anxious, particularly when discussing past experiences (in particular their offending behaviour – although this was never covered in depth; the development of mental health problems and the concepts of responsibility and forgiveness). In order to manage any increase in distress, patients all received individual support from the team facilitators. None of the patients reported experiencing deterioration in their mental state,

which was further corroborated by analysis of individual results and reports from ward based staff.

There were several challenges to delivering this programme. The concept of compassion is one that is not usually discussed in forensic clinical settings where notions of symptom reduction and risk management prevail. Participants were able to describe the characteristics of compassion but struggled to relate these characteristics to themselves. For example, acceptance and forgiveness generated much discussion in the group, with many participants reportedly feeling uncomfortable about self-forgiveness as it may be interpreted as lack of remorse or empathy for their victims. Certainly, acceptance and forgiveness may be interpreted as contentious when working with a population who have committed serious offences. This societal attitude appeared to be internalised by participants, and work in the group was done on acceptance for past behaviours but responsibility taking for future possible outcomes. This seemed to empower many of the group participants as there was some hope of moving on from the stigma and shame of the past to being positive about the future. This change in looking at future possibilities also helped participants respond to self-attacking thoughts that seemed to be mainly past orientated.

Many of the participants initially found it challenging to generate a compassionate image. For some participants, they found the notion of creating an ideal friend “childish” and voiced concerns that this might be perceived as further evidence of their psychosis. For other participants, they did not appear to have access to early memories of a compassionate care-giver from which to draw upon. This was not just simply that participants in the group found it difficult to access early memories, as some could clearly describe memories of inconsistent and ambivalent care-giving – it was that they could not relate to personal experiences of an ideal care-giver, and therefore found it challenging to generate an internal working model of this ideal interpersonal relationship. The research on attachment theory may help to explain this. When early attachment experiences are compromised, this may result in insecure adult attachment styles. The individual has no early experiences of secure attachment and limited experience of mirroring (where needs of the infant are reflected on by their care-giver). Subsequently their ability to reflect on their own emotional mental state and memories is impaired (Bowlby, 1988; Fonagy, 2002). This may explain why some of the participants struggled to generate a compassionate image. However, Gilbert (2003) also states that individuals, whose early care-giving experiences are characterised by threat, may also experience a degree of fear and re-living of threat when generating a compassionate image. To overcome some of these challenges, group facilitators offered support and helped the

group to generate a group compassionate image, and also suggested that they could think of a place or non-human object that generated feelings of warmth and safety.

There are several limitations to this study. In particular, the study was conducted with a small sample of participants without any matched control group. Future research could incorporate a larger sample size and include a matched control group, which would improve the reliability and generalisability of findings. In addition, many of the measures used in the study do not have published norms and have not been validated with a forensic clinical population. Therefore, this might explain, for example why significant findings were not achieved on the interpersonal measures.

Facilitators involved in the delivery of the group were also involved in the completion of psychometric assessments. To reduce bias, future evaluation of the programme would be improved by using raters independent of the treatment programme.

In conclusion, this preliminary study evaluated a compassion focused group intervention for patients with psychosis residing in a high security setting. The findings demonstrate an improvement in depression, self-esteem, and rating of self compared with others, and a reduction in shame, and general psychopathology. Further replication of this study could involve a waiting list control group, a larger sample size and independent rating of change in outcome. Further research could also involve extending this protocol to non-forensic populations.

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Facilitator Guidance

It is important that facilitators involved in delivering this programme have attended compassionate mind training and / or have an understanding of the principles of CMT. It is important that facilitators running the programme have experience of working in mental health settings; delivering psychological therapies in a group format; are qualified clinical psychologists/ therapists who have gained a diploma in Cognitive Behavioural Therapy.

For the purposes of delivering this programme at the State Hospital, 3 facilitators are necessary at all times (for security reasons). This includes a Chartered Clinical Psychologist; Advanced Practitioner (RMN with Diploma in CBT) and trainee clinical psychologist. In other settings, it is necessary to have 2 facilitators to run the group and to have weekly in between group session individual therapy slots for participants.

Following each 2 sessions (one full group day), facilitators convene to discuss participant engagement, and evaluations are completed accordingly.

In addition group facilitators receive weekly supervision from the clinical psychologist, and monthly supervision by the external consultant clinical psychologist to the service.

An assistant psychologist provides 2 sessions a week to the programme. Her role is to provide in between group individual sessions to the participants. This work ranges from supporting the participants in completing homework, to supporting and feedback on any emotional issues arising from their participation in the group.

Module one
Understanding psychosis and recovery

Session one: This is how we understand psychosis

Note: All sessions break down as follows:

Part one is 45 minutes

Break: 15 minutes

Part two: 45 minutes

Facilitator Note:

Get everyone to introduce themselves and to say something about themselves. This includes the facilitators.

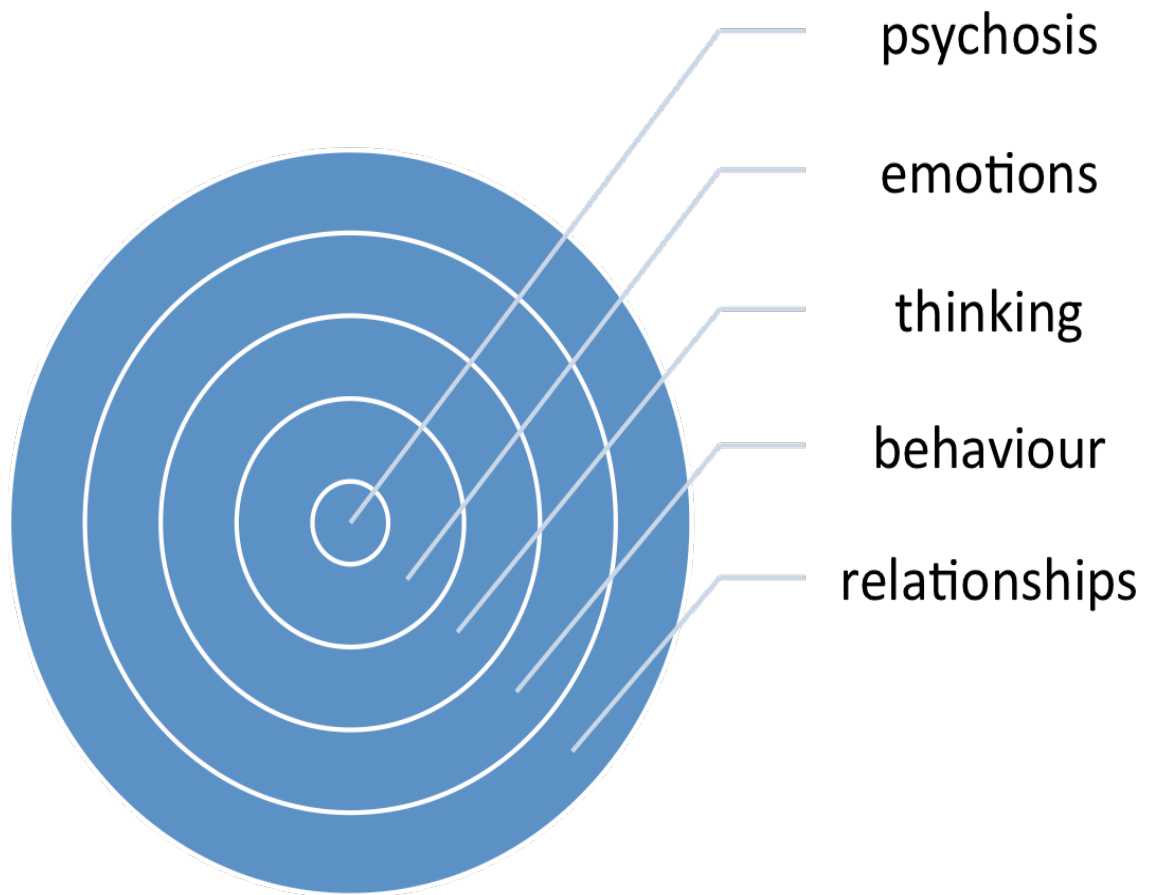
As an icebreaker ask everyone what it is they are hoping to get out of the group programme – what are their personal goals?

Set up the group rules – make this shared group rules and they can be typed up on a large piece of paper and put up on the wall for every group session.

Exercise one: How psychosis impacts on me and my life

As a large group let us think about psychosis. Let us talk about the impact of psychosis on the following (this will be demonstrated diagrammatically below). Facilitators should have this on a big piece of paper to fill in. The areas to discuss are:

Impact of psychosis on	Emotions
	Thinking
	Behaviour
	Relationships
	Environment



Facilitator note: When doing this as a large group, it is important to draw up the dynamic aspect of this i.e. psychosis will impact on each of these areas, but these areas will also impact upon each other.

15 minute Break for coffee and tea.

Exercise two: the group should split off into pairs and complete the exercise above (blank templates will be given out) and encouraged to fill this in, reflecting their own personal experience of psychosis.

Facilitator note: participants should be encouraged to complete as much as this on their own, or with the support of others in their group. However, facilitators can sit in some of the discussions to help prompt ideas, and to encourage dynamic thinking. The purpose of this exercise is to encourage participants to think of their psychosis beyond that of symptoms and to see how it has impacted on other aspects of their life. This exercise can be completed with reference to past and current experiences.

At the end of this exercise allow participants to provide feedback to the group on how they felt about the exercise. Was it beneficial, what did it make them think about, how did it make them feel? Did anyone struggle to complete it? Why was that? Check that everyone is feeling fit and fine to go back to the ward.

Session two: How can we understand recovery?

Introduction

Facilitator note: Check that everyone is fine from this morning's session. Ask if anyone has any questions.

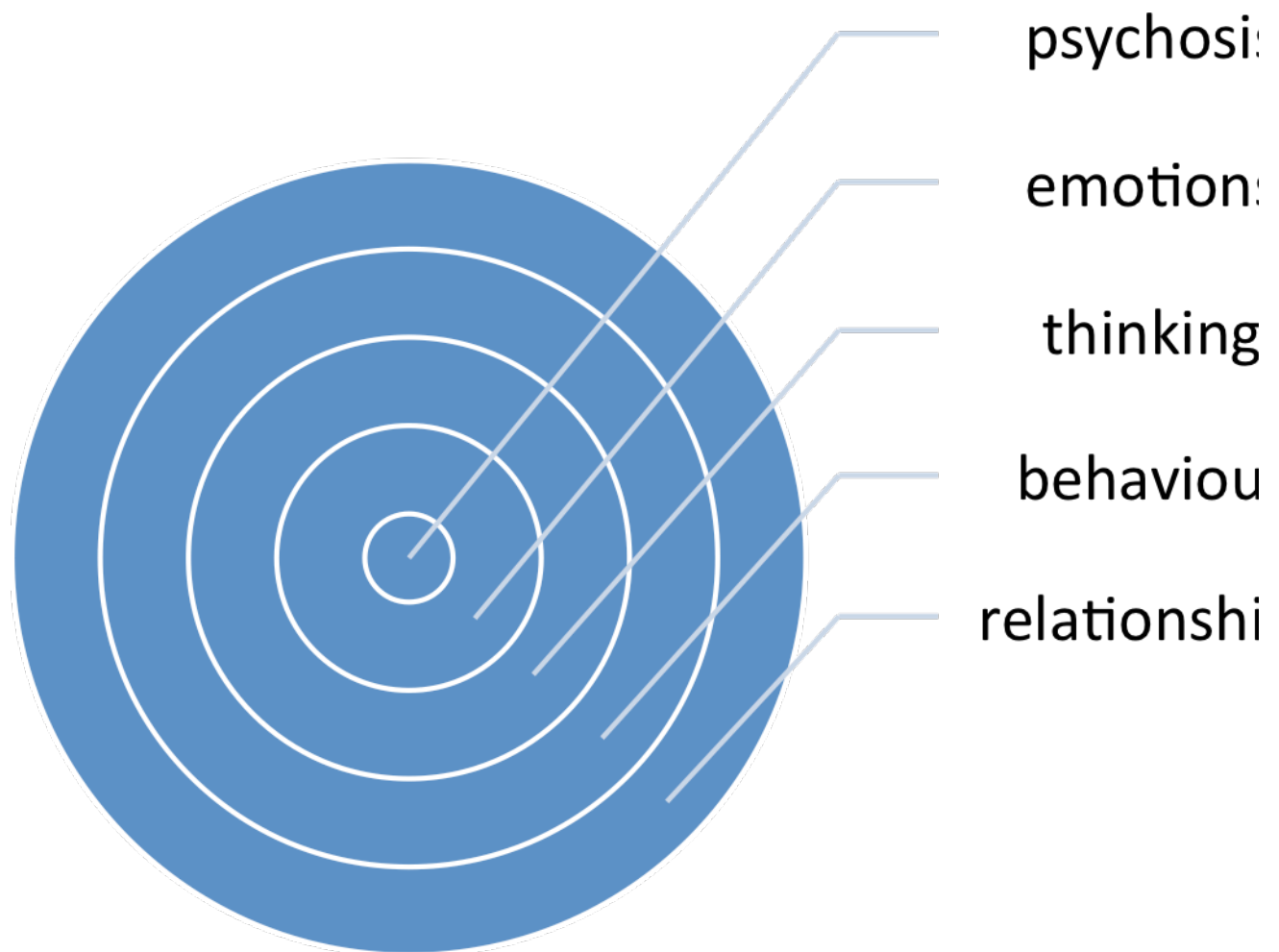
Exercise three:

Start with the metaphor of the pebble (show picture below). Ask the following questions:

- What does this make you think of?
- What does it remind you of?
- How does this make you feel?



Explain that this picture may help us find a way of understanding recovery. Then bring in the diagram shown earlier this morning, but now with reference to recovery.



Exercise three: understanding recovery

Facilitator note: As in exercise one, it is important to encourage participants to think about the dynamic aspect of recovery. Many will think of it in terms of getting rid of symptoms, however it is more than that. It is also important to show the links between the different parts of this diagram and how impact on one area impacts on others parts – like the pebble dropping into the water and the ripples coming from this. This can be seen as a metaphor for recovery.

Break for tea and coffee

Part Two – what recovery means for me? Ask participants to split into groups of two or three and to use the worksheet titled “What recovery means for me”. This builds on part one of the session, but with an emphasis on individual personal accounts of what recovery means. Facilitators will go round and offer support on this task.

At end of the session reconvene as a large group and ask participants to give some feedback on their individual accounts of recovery. Ask how they felt about the session and was it helpful? What are the main things that participants are taking away from the session today?

- Homework – to complete the individual accounts of recovery – or to add to it.

Session three: Recovery as a journey

Facilitator Note: Re-cap on last weeks sessions. Ask participants if they can summarise the main points from last week. Introduce today's session as a discussion of recovery as a journey. We will spend the morning session talking about this journey

(Spend between 30-45 minutes on this)

1. If recovery is a journey, what is it like?
2. What kind of journey is recovery? Facilitator note: Encourage participants to think about a journey that has many aspects to it. There are times that you will be walking on the flat and it seems quite easy. There will be other times when you are climbing up hills and you feel tired. Sometimes the weather isn't good and that makes your journey miserable. There are times when you feel like stopping and going home.
Facilitator note: the pace of this discussion is important. It should be slow and measured. It is important to focus on the words used by participants to describe their journey. For example, if they use words such as "feeling weary" then that should be discussed – what is meant by this?

Facilitator Note: if participants are struggling to generate examples of a journey, a good example is that of hill walking. In this, you can talk about going up the hill; climbing over rocks; feeling that you have reached the top only to find that you have further to climb; coming down hill (which although it should be easier, sometimes has its own risk and can be just as difficult). Put this onto a large piece of flip chart paper (the mountain metaphor) and work on this as a large group.

Break for tea/ coffee

Part two

3. Can we think about this journey in relation to recovery from psychosis? What are the parallels?

4. In small groups encourage participants to think about their own journeys of recovery – can they identify the difficult points, the times they felt like giving up, the times that seemed to be a bit easier. *When discussing this, it is important to draw out the following: behaviour, emotions, thinking. Continue to use the mountain metaphor, and get participants to draw a mountain on a large piece of flipchart paper and to think about their own journey of recovery. The ascent reflects their journey in the Hospital and the descent reflects their recovery in a local hospital/ the community.*
- At this point in the discussion, bring back the RAP diagram (The circular model) and try and relate all of this to their recovery as a journey metaphor.

Session four: What do you need to take with you on this journey of recovery?

Facilitator note: Following on from the session this morning, the afternoon session will now focus on the kind of person participants would want with them on their journey. This is developing the “Perfect nurturer” model (Lee, 2005). The idea behind this is that a way to help participants develop feelings of warmth and acceptance is by generating an image of a perfect nurturer/ friend. This image is then used to generate and direct warmth, acceptance and new meanings for the self.

Introduction and setting the scene

Facilitator note: Recovery is a journey (as discussed this morning). This journey can be very difficult at times and sometimes it is good to have someone with us, to help us when times are hard. We are now going to spend this session thinking about this person, and what it is about them that makes them somebody we want to have with us on our journey.

Part one:

What do you think are the most important characteristics of this ideal friend? *Facilitator note: try to draw out the meaning of the adjectives used by participants. For example, if they say “strong” ask what they mean by that – do they have examples of that? Again, if they use the word trusting, what do they mean by that? It is important in this session to try and foster feelings of warmth, compassion and acceptance.*

- What characteristics do they value the most in this individual? (put a list of those characteristics up on the flip chart). In this section, focus on physical characteristics, sensory features (facial expression, voice tone, smell).
- What feelings does generating this image evoke in participants?
- How do they prioritise those characteristics? (why do they consider some characteristics to be more important than others?)
- With the characteristics that they list ask the following questions?

1. Can you think about how forgiveness might be a useful tool for this person to have?

Break for tea/ coffee

Part two

- Let us image the traits highlighted above, in this person who is going to accompany you in your journey. Can you imagine them being forgiving? (or use any of the other characteristics they listed – try to go through most of the words on the list)
- What kind of things might they say to you?
- In what situation might they says things to you?
- How might they say those things (e.g. tone of voice, expressions, body posture)?
- How might they make you feel?
- What might this person say to you if things are not going so well for you?
- How might they say it?
- How will they support you when you need? What will they say?
- What will they say to you when you are feeling frustrated?

Homework – for participants to create their own ideal friend (see below).

Compassionate image: Ideal friend. Description of what they look like, what their personality is like, and their qualities.

“I imagine my ideal friend to look like....

Description of emotional responses associated with image

When I imagine my ideal friend, I feel.....

Module Two

Understanding compassion and developing the ideal friend

Session Five : Ideal Friend

Facilitator note:

*The main aim of this session is to focus on the creation of a '**unique ideal friend**' – i.e. an imaginary creation (unique), of someone/something (a friend), who/which embodies the notion of compassion as developed over previous sessions, and as an ongoing/emerging concept (i.e. the 'ideal').*

*The rationale behind this is that the creation of an **accessible internal image** of an ideal caring other will help the person experience **compassion coming into the self**, particularly feelings of warmth, support and understanding (later leading on to, forgiveness and/or responsibility-taking).*

It is very important for facilitators to be alert to the potential for the imagery component of this exercise to lead the individual into possibly settling for a less-than-ideal construct in the first instance. In the event of that happening, facilitators should continue to guide the individual further through this process, until the absolute 'ideal' is achieved.

Introduction:

Feedback on last week's session. How did participants manage with their ideal friend homework?

[Ideal Friend](#)

Large Group Exercise:

- Introduce exercise, '*Building a Compassionate Image*', as per worksheet (attached). Instruct participants to work through questions on an individual basis. Facilitators & co-facilitators will circulate, prompt, guide & support throughout this process.
- After 15 – 20 minutes or so, the larger group will then reconvene & discuss individual responses. General discussion of points noted & raised will then ensue.
- Introduce 'Mindfulness' exercise (utilising rhythm breathing) to encourage participants to reflect & build on their image of an ideal unique friend – i.e. the emerging image prompted by the initial reflection when working through worksheet.
- After several minutes return to large group discussion. Compare *actual image achieved with ideal image sought* as per worksheet. Are there any deficits? Any areas they would want to change/refine? Where/how can this image be improved? Remember it's an *ideal* we are seeking so we can let our imaginations 'go to town'.

Part two:

- After Coffee Break, return to larger group and report on individual progress. Has an ideal image been attained in all instances? If not, can Group assist those individuals who may be experiencing some difficulty? – E.g. can some images be borrowed or shared?
- Would the compassionate reframes of this unique ideal friend have differed very much from those completed for homework last week? If so, how? & why?

Homework

Close this session by suggesting that for homework they spend a quiet period of reflection – say a period of some 10 minutes or so (or whatever they can manage) each day over the next week - intentionally conjuring up this image. Individual sheets will be distributed to record this activity (attached).

Summary of session

As a large group, encourage participant feedback on their thoughts and feelings to do with the group exercises. Make sure that everyone feels "safe" and feels okay to go back to the ward for lunch.

Building a Compassionate Image (taken from P.Gilbert training manual , Glasgow 2007)



This exercise is to help you *build* a compassionate image of a **unique ideal friend** for you to work with and develop. Whatever image comes to mind or that you chose to work with, note that it *is your* creation and therefore your own personal ideal – what you would really like from feeling cared for and cared about. However, in this exercise it is important that you try to give your image certain qualities. These will include:

Wisdom, Strength, Warmth and Non-judgement

So in each box below think of these qualities (wisdom, strength, warmth, and non-judgement) and imagine what they would look, sound or feel like.

If possible we begin by focusing on our breathing, finding our calming rhythm and making a half smile. Then we can let images emerge in the mind – as best you can – do not try too hard. If nothing comes to mind, or the mind wanders, just gently bring it back to the breathing and practice compassionately accepting.

Here are some questions that might help you build an image: would you want your caring/nurturing image to feel/look/seem old or young; male or female (or non-human looking – e.g. an animal, sea or light)? What colours and sounds are associated with the qualities of wisdom, strength, warmth and non-judgement? Remember your image brings compassion to you and for you.

How would you like your ideal caring-compassionate image to look/appear – visual qualities?	
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How would you like your ideal caring-compassionate image to sound (e.g. voice tone)?	
What other sensory qualities can you give to it?	
How would you like your ideal caring-compassionate image to relate to you?	
How would you like to relate to your ideal caring-compassionate image?	

Daily Log

Day/Date	Time reflecting on <i>UIF</i>	Comments

Session Six : What is Compassion?

Facilitator note: The main aim of this session is to focus on compassion, the key components of this and how the ideal friend demonstrates compassion. The rationale behind this is that a key part of recovery is developing self and other compassion. It is very important for facilitators to be aware of body posture and voice tone. The pace of these sessions should be quite slow and measured.

Introduction

Feedback on last week's session. How did participants manage with their ideal friend homework?

Large group Exercise

- On a large flip chart, brain storm what participants understand by the word *compassion*. In this discussion, it is important to draw out the different elements of compassion such as *strength, forgiveness, acceptance, trust, non-judgemental*. Elicit participants' understanding of each of these elements.
- What are the strengths and weaknesses of each of these characteristics?

Part two

- Ask the group the following questions:
- How would this perfect friend demonstrate acceptance? (what would their voice tone be like; their body posture; their facial expressions. Use guided discovery and images to draw out this information.
- Repeat the above for other characteristics of compassion such as forgiveness, non-judgemental, trusting, empathy

Summary of session

As a large group, encourage participant feedback on their thoughts and feelings to do with the group exercises. Make sure that everyone feels “safe” and feels okay to go back to the ward for lunch.

Session seven: Compassionate responding

Large Group Exercise

Discussion points:

- Think over the last few weeks to a time where you felt angry, paranoid, suspicious, distressed. What was it you felt at the time, what were you thinking at the time?
Facilitator note: Encourage participants to think of feelings and get feedback on it.
- To help with the above exercise, use the key prompts:-
 - *What actually happened?*
 - *What was the trigger?*
 - *Beliefs and thoughts – what went through your mind? What were you thinking about others, and their thoughts about you? What were you thinking about yourself and your future?*
 - *What were your main feelings and emotions?*

Then help participants to draw out compassion-focused alternatives to negative thoughts. Use the following prompts:-

- What would this ideal friend say to you?
- How would they react?
- What would their tone of voice be like, their facial expressions?
- How would this make you feel?
- What would be the main emotions you would feel?
- Compare emotions generated by ideal friend (compassionate response) to that generated by their own reaction to distress?

Homework:

Ask participants to keep diaries of compassionate responding

Session eight: Compassionate Responding contd

Review homework from last session

Facilitator Notes: Ask participants the following:-

As a large group, work through the compassionate mind training exercises (previous session) of creating the image of the ideal friend.

After this exercise, work through the following:-

Think of a time recently when you have been feeling upset or frustrated. Spend the rest of the time thinking about how this ideal friend can help you to develop feelings of warmth and safeness. Think of a time when you felt distressed.

Facilitator note: In a large group, ask for participants to discuss their examples, and put scenarios and responses onto a large flip chart. Encourage each participant to give feedback.

To help with this, go back to the metaphor of climbing the hill, and getting them to recall a situation (could be before the TSH – but do not discuss the index offence – make this clear from the start). Think of everyday situations such as falling out with a friend, relapse, getting frustrated by being stuck in hospital. In this section, focus on thoughts and feelings. Try to reconstruct the scenario. Then bring in the ideal friend, what would they say and how would they say it. Encourage them to see themselves through the eyes of the perfect friend. Again, what does the perfect friend say, what do they feel towards you – how does this feel?

If they can not think of personal examples, get them to think of someone else's distress and to use the perfect friend scenario.

Homework: To continue filling in diaries recording episodes of distress, anger, anxiety and considering compassionate responses to this.

Session 9 - Developing Flashcards of Ideal Friend

Large Group Exercise:

Flash cards. Encourage participants to create flashcards of their ideal friend. These cards can be carried around with them and used when required. To create this flashcard, the following questions can be used:

- What does my ideal friend look like (physical qualities);
- what is their voice tone?
- what other sensory qualities does this person have?
- how does my ideal friend relate to me?
- How does my ideal friend make me feel?

On the back of the flash card, prompt questions can be used to encourage participants when to use the cards. For example:-

- when I feel I am being critical of myself, what would my ideal friend say to me?
- When I am feeling depressed/ anxious/ hopeless, what would my ideal friend say?

This section can be personalised, so that the situations are relevant to each participant.

This can be discussed in the large group and relevant situations for using the cards can be discussed.

Break

After the break hand out small postcards to each participant. As a large group recreate the image of the ideal friend using the visual task and then ask participants to find a quiet part of the room and to fill out their flashcards. Upon completion of this, ask participants to give feedback to the group on their flashcards.

Session Ten: Compassion and Forgiveness

Forgiveness

Large Group Exercise:

Discussion points:

- On a large flip chart, brain storm what participants understand by the word *forgiveness*. In this discussion, it is important to draw out beliefs about *forgiveness*, such as whether it is thought of as an *all or nothing concept* (?), can there be *degrees* of it (?), what is *difficult* about it (?), *what conditions have to be in place before it can be exercised* (?), *are there occasions when it can never be exercised* (?) – *If so, how do/can we otherwise heal/reconcile on such occasions? How do we know we are forgiving/ or forgiven?*
- Exercise. Re-introduce ‘Mindfulness’ exercise (utilising rhythm breathing) to encourage participants to once again reflect on image of unique ideal friend. This time stay with imagery a little longer & reflect on what the ideal friend’s ‘take’ on *forgiveness* might be.
- Reconvene in large group. Share perspective of *forgiveness* as identified by unique ideal friend.

Summary of session

As a large group, encourage participant feedback on their thoughts and feelings to do with the group exercises. Make sure that everyone feels “safe” and feels okay to go back to the ward.

Session eleven: Compassion and Trust

Large Group Exercise:

Discussion points:

- On a large flip chart, brain storm what participants understand by the word *trust*. In this discussion, it is important to draw out beliefs about *trust*, such as whether it is thought of as an *all or nothing concept* (?), can there be *degrees* of it (?), what is *difficult* about it (?), *what conditions have to be in place before it can be exercised* (?), *are there occasions when it can never be exercised* (?) – *If so, how do/can we otherwise heal/reconcile on such occasions? How do we know we are being trusting/ or trusted?*
- Exercise. Re-introduce ‘Mindfulness’ exercise (utilising rhythm breathing) to encourage participants to once again reflect on image of unique ideal friend. This time stay with imagery a little longer & reflect on what the ideal friend’s ‘take’ on *trust* might be.
- Reconvene in large group. Share perspective of *trust* as identified by unique ideal friend.

Homework

Continue using diaries for self-critical thoughts and **use new unique ideal friend to compassionate reframe.**

Session Twelve: Compassion and Acceptance

Acceptance

Large Group Exercise:

Discussion points:

- On a large flip chart, brain storm what participants understand by the word *acceptance*. In this discussion, it is important to draw out beliefs about *acceptance*, such as whether it is thought of as an *all or nothing concept* (?), can there be *degrees* of it (?), what is *difficult* about it (?), *what conditions have to be in place before it can be exercised* (?), *are there occasions when it can never be exercised* (?) – *If so, how do/can we otherwise heal/reconcile on such occasions? How do we know we are being accepting/ or accepted?*
- Exercise. Re-introduce ‘Mindfulness’ exercise (utilising rhythm breathing) to encourage participants to once again reflect on image of unique ideal friend. This time stay with imagery a little longer & reflect on what the ideal friend’s ‘take’ on acceptance might be.
- Reconvene in large group. Share perspective of *acceptance* as identified by unique ideal friend.

Module three:

*Developing plans for Recovery after
Psychosis*

Session Thirteen– Recovery After Psychosis

Facilitator Note: The focus of this session is on the development of self-formulation, and developing a compassionate re-frame of this. Each participant will be given a worksheet (see attached) and following completion of this will be asked to consider a compassionate way of understanding their psychosis and offending behaviour.

To help participants with this, bring in their Recovery “Pebble Image” completed in session two.

Homework – to continue working on Recovery After Psychosis Plans

Session Fourteen: Recovery After Psychosis Plans

The aim of this session is to complete the Recovery After Psychosis Plans the group started last week.

Facilitator Note: First of all ask for feedback on the first two pages of the plan. We will aim to work through everyone by the break in the morning. It is important that all the feedback with participant names is recorded on the flipchart. This means that we can add information to their SWAP plans and get them typed up and sent out to them.

Facilitator note: When getting this feedback it is important to draw out themes and to help participants see links between their presenting problems (try to draw out functional analysis of this i.e. what made it worse, what made it better) and the association between presenting problems and safety behaviours. It is also important to tease out beliefs about illness, and whether these beliefs remain. This can be done when participants are talking about their presenting problems. Asking questions such as:-

- *“what did you think was happening to you at the time?”*
- *“What sense did you try to make of these experiences?”*
- *“At the time you had these experiences, what did you think it said about you that you had these problems?”*
- *“What do you think others thought of you”? (this is tapping into external shame – in the minds of others)*
- *“When you look back on that time in your life, what do you now think it says about you that you had those experiences”?*

With these questions you are trying to see if there are self-critical thoughts/ internal/external shame

Break for tea and coffee

After the break, we will ask the participants to complete the plan (but not the compassionate reframe bit). Before breaking for lunch, we will start asking participants to provide feedback on the rest of their plans.

Session Fifteen: Recovery After Psychosis Plans

We will get feedback on the remainder of the plans before the afternoon break.

Facilitator note: when doing this, again it is important to try and draw out themes. Help participants to see what were unhelpful coping strategies; dysfunctional thinking; over-developed and under-developed strategies.

After the break, we will ask participants to think about compassionately reframing their experiences and they can give feedback on this after the break. This will lead into the final sessions of compassionate letter writing and feedback.

Role Plays to demonstrate critical thoughts and compassionate thoughts.

Discussion around Responsibility

- The importance of future directed responsibility
- Defining responsibility – getting a shared definition of this.
- Look at different systems and responsibility – what are the hospital messages around responsibility, what are the nurses messages, society messages – contradictory messages? Looking at choices along the way.
- Card sorting around early signs of relapse. Develop scenarios for each of those relapse signs – e.g. I have thoughts of harming myself – what are their responses to this – what is taking responsibility in this situation
- Having thoughts of worthlessness –
- I need drugs, medication sucks.....what are their responses to this and what is responsibility taking here?

Session sixteen : Compassionate letter writing

Facilitator note: The aim of these sessions is to facilitate participants in writing their compassionate letter. We will encourage participants to write the letter as though their ideal friend is talking to them. We want this work to be a continuation of what participants started writing about last week at the end of their Recovery After Psychosis Plans.

Prior to starting letter writing, we will practice in the group, creating the image of the ideal friend (as has been done over the past sessions).

After this, we will, as a group, create a “generic” compassionate letter. In this, the group will collectively generate a letter, which will follow the following themes:

- A compassionate understanding of the circumstances that led participants to be admitted to the State Hospital. The process of doing this will allow participants to stand back and take a different, and hopefully more compassionate perspective on their past difficulties. In this section it is important to draw out features of compassion such as acceptance, forgiveness etc.
- Encourage participants to think about the self-critical thoughts they have held in the past, and may still hold (these may be potential barriers to engagement and to seeking help in the future). Think of generating a compassionate perspective on these self-critical and possibly shame based thoughts.
- In this section, encourage participants to think about the possibility that they might become unwell in the future (or go down the path that could lead them to relapse and offending, such as drug taking). What might be the early signs of this, and how might their ideal friend help them respond to this and to seek help.
- In this section, encourage participants to think how their ideal friend can continue to help them along their journey of recovery.

With the letter, it is important that *warmth* comes across, and that when participants read it, it makes them feel warm and safe.

After the letter has been written, ask someone in the group to read it out and discuss whether the group find the letter helpful – is it as warm as it can be?

Session seventeen and Eighteen: Personalised Compassionate Letters

In this session, participants will write their own compassionate letters. They can follow the structure outlined above if they wish. It is important to note that once the letter is written, it is not set in stone. It can be re-written/ re-worked. The purpose of this letter is to help participants to develop an inwardly gentle, compassionate and self-supportive style.

***Session seventeen* – participants will start to write their letter and will complete this for their homework.**

***Session eighteen* – participants will be asked to read out their letters to the rest of the group and to get feedback on them. A group discussion of the letters will follow this.**

Session nineteen : Final review of compassionate letters

In this session, there will be a final discussion of compassionate letters and then a review of the programme will commence.

Session twenty: Feedback

This is the final session and the programme will be reviewed by the participants and feedback received.

