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AN EXPLORATION OF THE USE OF LANGUAGE WITHIN THERAPEUTIC INTERVENTIONS FOR PEOPLE EXPERIENCING PSYCHOSIS

Section A: Different Approaches to Understanding How Language is Used to Construct Experience in Psychosis and the Implications for Psychosocial Outcomes: A Literature review
Word Count: 7,260 (47)

Section B: An Exploration of How Service Users Experience and Make Use of Formulation in Therapy for Psychosis
Word Count: 7,998 (81)

Overall Word Count: 15,258 (128)

A thesis submitted in partial fulfilment of the requirements of Canterbury Christ Church University for the degree of Doctor of Clinical Psychology

May 2018

SALOMONS
CANTERBURY CHRIST CHURCH UNIVERSITY

Acknowledgments

I would like to say big thank you to my husband and son who have accepted me having to disappear to study at the weekends instead of spending time with them, and who have continually supported me throughout my doctorate. Thank you also to my wider family and friends who have been on hand with encouragement and positivity whenever I needed it.

I would also like to say how much I appreciate the time and expertise that my supervisors offered to me throughout my research project. Thank you for always being on hand and for your thorough feedback.

Finally, thank you to all those who took part in my study. It was a privilege to hear about your experiences of formulation.

Summary of Major Research Project

Section A: Research suggests language may have positive psychosocial benefits when used to construct psychotic experience. However, research is emerging from different sources which have so far not been amalgamated. A systematic review of the literature was undertaken to explore different ways of using language to construct experience in psychosis and its influence psychosocially. Altogether, 31 studies were included in the literature review. Three themes were prominent in the reviewed studies; meaning making, developing a shared understanding and quality of narrative. The implications of the findings are discussed in the context of the literature reviewed.

Section B: Formulation is a core skill of clinical psychologists. However, little is known about how service users experience and make use of formulation. Semi-structured interviews were conducted with 11 service users and two clinical psychologists with experience of formulation in therapy for psychosis. Data from the interviews were analysed using Grounded Theory methodology, and a model was constructed to depict the processes that were suggested to occur during formulation. 'Linking previous experiences with current ways of being' and 'building the therapeutic relationship' emerged as a core reciprocally influential categories. The model is discussed in the context of previous research before the implications of the findings are outlined.

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Section A: Different Approaches to Understanding How Language is Used to Construct Experience in Psychosis and the Implications for Psychosocial Outcomes: A Literature review

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Accurate Word Count: 7,260 (47)

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Abstract

Research suggests that language can be used to process emotional material, and to develop understanding and personal meaning (e.g. Auszra, Greenberg & Herrmann, 2013; Kallestad et al., 2010; Kahlon Neal & Patterson, 2014). The use of language may therefore be important in recovery from psychosis. However, the evidence for this is emerging from different sources that, so far, have not been brought together to develop understanding of the overall implications.

A systematic review of the literature was undertaken exploring different approaches to understanding how language can be used to construct experience in psychosis. Four electronic databases were searched including; MEDLINE, PsycINFO, Web of Science and Science Direct. The search generated 31 papers for inclusion in the review.

The literature obtained in the search broadly fell into three areas; meaning making, developing a shared understanding and quality of narrative. It was concluded that language can be used in diverse ways to construct psychotic experience and can have a positive impact on psychosocial outcomes. The research suggested that it can be helpful for individuals to develop a meaningful life narrative. Service users should be given the choice about whether they would prefer this to occur verbally or in a written format. The building of narratives in individual or group therapy may be acceptable for some individuals. Service users should be offered interventions involving their social network where possible. They should also be given more control and space to be heard in meetings regarding their care. More research is needed to further elaborate our understandings of how language can helpfully be used in interventions for people experiencing psychosis.

Key Words: Psychosis, Psychological Intervention, Language, Literature Review

Introduction

The current literature review summarises and critiques research exploring different ways of using language to construct experience in psychosis and its influences psychosocially. Given that this research sits within a wider field that has been lively contested, the review commences with a definition of 'psychosis' and a summary of the political debate surrounding the use of the medical model to understand mental health difficulties. The literature concerning psychological interventions to treat psychosis is then explored. The 'active ingredients' involved in effective therapy are considered, including the role of language, providing a rationale for the review.

Psychosis

Experiences thought of as 'psychosis' include; hearing, tasting, smelling or feeling things others do not, holding strong beliefs that others do not share, difficulties thinking and concentrating, and appearing withdrawn or unmotivated (British Psychological Society, Division of Clinical Psychology [BPS, DCP], 2017). Diagnosis of psychosis is grounded in a medical model understanding of a person's experiences (Frese, Knight, & Saks, 2009). Currently a diagnosis is made using the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), by the American Psychiatric Association (APA) (2013), or the International Classification of Diseases: Classification of Mental and Behavioural Disorders, Tenth Edition (ICD-10), by the World Health Organisation (WHO) (2014).

However, the use of the medical model to understand mental health difficulties, and particularly the use of psychiatric diagnosis is a contentious and active debate in the United Kingdom (UK) (Johnstone, 2017). Service users continue to campaign for their rights within the context of being diagnosed as having

a 'mental illness' and the discrimination they experience due to experiencing mental health difficulties (Johnstone, 2017). Further, the DCP (2013) has highlighted the conceptual and empirical limitations of diagnosis in their position statement. This includes, but is not limited to, the lack of reliability and validity of diagnosis and the emphasis it places on biology, minimising the psychosocial causes of an individual's distress.

The DCP (2013) argued that a multi-factorial and contextual approach to understanding mental health difficulties was needed. In response to this, a working group of senior clinical psychologists and service users worked together to produce 'The Power Threat Meaning Framework' (Johnstone et al., 2018). The framework can be used as a way of helping people to create more hopeful narratives about their lives and the difficulties they have faced instead of seeing themselves as 'mentally ill'. It explains the links between wider social factors such as poverty, discrimination and inequality, along with traumas such as abuse and violence, and the resulting emotional distress.

The DCP (2017) also published a report encouraging a more holistic view of psychosis drawing on multiple models of understanding and emphasising the importance of personal meaning making in recovery. Within the report 'collaborative formulation' is favoured over diagnosis.

Collaborative formulation is described as a process whereby an individual works with their therapist to explore the personal meaning of their relationships, social circumstances, life events and current experiences of distress (DCP, 2017). A hypothesis about the individual's difficulties, drawing on psychological theory, is then formed and used to plan a way forward (Johnstone & Dallos, 2015). Unlike a diagnosis of 'schizophrenia' or psychosis, it is argued that formulation makes sense of problems in a way that does not imply that an individual is to blame for their difficulties, or that their experiences are 'all in their mind' (DCP, 2017).

In line with documents published by the DCP, the term 'psychosis' will be used as a broad point of reference throughout this review. However, this term is used with the understanding that each person's experiences are unique to them, with personal meaning associated with them, which may or may not cause them distress. The term 'psychosis' therefore offers a description of the relevant experiences rather than referencing a particular medical aetiology. However, much of the previous research in this area uses medical terminology. When this research is described in this review quotation marks will be used around these terms.

A critical realist position will be taken in relation to how concepts such as 'psychosis' are discussed within the review. This view will also be taken when examining the research methods employed and the conclusions drawn in the papers examined. Critical realism encourages researchers to examine the social and historical positions which allow concepts to emerge, a view shared by social constructionists (Bhaskar, 1990). This is in contrast to positivism, the idea that there exists a real and invariant external world and entities that can be measured with some precision (Pilgrim & Bentall, 1999). A critical realist position sits between social constructionism and positivism. It acknowledges that theories and methods are shaped by social forces and informed by interests yet encourages investigation of reality in a critical manner (Pilgrim & Bentall, 1999).

Recommended Interventions for Psychosis

Recovery from mental health difficulties such as 'psychosis' has become a focus of increasing interest within Government policy in the UK (Department of Health [DoH], 2011). Previously 'psychosis' was seen as a severe disorder from which full recovery was unlikely (American Psychiatric Association [APA], 1994). However, this view has been challenged by service user campaigners (Johnstone,

2017; France & Uhlin, 2006). Further, research suggests that long-term recovery from 'psychosis' outcomes are more positive than previously believed (WHO, 2001; France & Uhlin, 2006).

This change of perspective has led to a realisation that medication alone is unlikely to lead to a full sense of recovery for many people experiencing 'psychosis' (Morrison et al., 2014). Further, many medications have unwanted side effects impacting negatively on an individual's wellbeing (APA, 2013). Due to growing emphasis on recovery and advances in phenomenological understandings of 'psychosis', interest in psychological interventions to improve the impact it has on the lives of individuals has increased (Bellack, 2006). Recovery from mental health difficulties is no longer understood only in terms of a reduction of 'psychotic symptoms' and maintaining employment. It is now recognised that it may involve subjective outcomes, for example, changes in how someone experiences and thinks about their life and the challenges they face (Bellack, 2006).

The National Institute for Health and Social Care Excellence (NICE) (2014) guidelines recommend Cognitive Behavioural Therapy for psychosis (CBTp) and family intervention as therapies for 'psychosis'. Research has demonstrated both are effective when undertaken alongside antipsychotic medication (NICE, 2014). Other interventions recommended by NICE include; acceptance and commitment therapy, art therapy, supported employment, and Mindfulness based CBT.

Active Ingredients of Therapy

As with the current review, research comparing the effectiveness of all therapies by determining changes in psychosocial outcomes makes the assumption that therapies have certain 'ingredients' that can be delivered and measured with some precision (Martin, Garske & Davis, 2000). However, despite much research effort in this area little is known about the active ingredients at work in effective

therapy (Martin, et al., 2000). Further, it is important to recognise that there is criticism of this model of investigating therapy processes. Stiles (2006) argues that as therapy is a reciprocally influential and responsive interaction it is not possible, in effect, to disentangle the relative effects of specific ingredients involved in therapy. Hence he argues the most robust link found is between the therapeutic relationship and outcome.

Studies have shown that the most extensively supported common feature in effective therapy of all orientations is the therapeutic relationship (Martin, et al., 2000). However, it is unclear how the therapeutic relationship interacts with other aspects of therapy, and whether the relationship is in itself a curative component of therapy, or creates the interpersonal context necessary for other therapeutic elements to have effect (Horvath, 2005). Further, research has shown that the quality of the therapeutic relationship alone is not sufficient in predicting positive outcomes in therapy (Horvath, 2005).

An active ingredient thought to be important within therapy is formulation (DCP, 2017). It has been described as crucial in the implementation of CBTp (Morrison & Barratt, 2010; Morrison, 2017). Formulation can be seen as a process which is embedded within the therapeutic relationship (Johnstone & Dallos, 2015). As the therapeutic relationship develops, clients may trust their therapists more, feel better understood and share more, leading to a collaborative formulation (Johnstone & Dallos, 2015). It is possible that formulation is another component necessary for good therapy influenced by the therapeutic relationship. However, despite the importance placed on formulation, it is under conceptualised and under researched (Johnstone & Dallos, 2015).

The use of language is necessary for therapeutic relationship building, formulation and all therapeutic activities undertaken with individuals experiencing 'psychosis'. Language can be understood as both constitutive of experience and

performative (Shotter, 1993). That is, language can be used to describe subjective experiences and to perform actions which have consequences in the real world. For example, saying "I promise" represents an action which someone is committing to undertake in the world. In therapy, language can be used to help individuals to find new ways of understanding their experiences (Shotter & Katz, 1999). Shotter and Katz (1999) suggest that therapists draw their client's attention to some of the other possibilities open to them that their previous forms of talk led them to overlook, which in turn leads to new ways of being.

Whilst all therapies rely on the use of language, one approach that prioritises this explicitly is narrative therapy. Narrative therapy focuses on the stories that people bring to therapy (White & Epston, 1990). It is based on the notion that problem saturated scripts become the 'dominant story' for individuals experiencing difficulties, and therapists must work with service users to 're-author' their lives by helping them to re-connect with their own knowledge and strengths (White & Epston, 1990). However, there is a scarcity of research exploring the effectiveness of narrative therapy, possibly because it is based on principles that are congruent with context sensitive research methodologies, such as, grounded theory, that deemphasize generalisability (Etchison & Kleist, 2000).

Rationale and Objectives

Studies have shown how language can be utilised to develop understanding and personal meaning, and to process emotional events (e.g. Kahlon, Neal & Patterson, 2014; Auszra, 2013; Kallestad et al., 2010), which in turn can have positive implications psychosocially for individuals experiencing 'psychosis' (NICE, 2014). However, the evidence for this is emerging from different sources, which, so far, have not been synthesised to develop understanding of the overall implications.

Therefore the current literature review sought to bring together these diverse sources, seeking to understand how different approaches to using language can be used to construct experience in psychosis, and its psychosocial implications.

Many therapy approaches for 'psychosis' have idiosyncratic outcomes based on goals that are personally meaningful to the client, as well as more standardised ways of measuring outcomes. Consequently the current review uses the terms 'psychosocial outcomes' in its broadest sense, to include the range of outcomes that may occur as a result of using language to construct 'psychotic' experience (e.g. improvement in subjective and objective levels of distress and 'psychotic' experiences, gaining employment, changes in medication use etc). The current review will include research papers where outcomes have been assessed by both standardised measures and qualitative feedback.

Method

The Preferred Reporting Items for Systematic reviews and Meta-Analyses (PRISMA) guidelines (Moher, Liberati, Tetzlaff & Altman, 2009) were used as a framework for reporting procedures. A systematic review of the literature was undertaken. Four electronic databases were searched; MEDLINE, PsycINFO, Web of Science and Science Direct in October 2017. The search was repeated in January 2018, however no further papers were identified. Papers were identified using the following search terms; formulat* OR narrative OR language OR meaning making OR conceptualization OR conceptualisation OR dialog* (group 1) AND psychotic OR psychosis OR schizo* (group 2) AND improve* OR outcome OR recovery (group 3). The terms were searched for in the abstracts of papers only. In addition the titles of papers were examined on the first 10 pages of Google Scholar under the search 'narrative, formulation, language, psychosis' as these terms appeared to produce the most significant results when searching the research data bases.

Overall 2,323 records were identified through database searching. There were no further records obtained in the search of Google Scholar. After duplicates were removed, 2,063 records were obtained. Titles of all 2,063 records were screened and 1,143 records were excluded where it was clear that they were not relevant to the research question. The abstracts of the remaining 920 records were examined in further detail and 845 papers were excluded as it was evident that the papers did not relate to the topic. Overall 75 full text research papers were retrieved, of which 35 were excluded because they were not exploring how language is used to construct experience in psychosis, and a further nine because they did not include any discussion of psychosocial outcomes. Consequently 31 research papers were deemed relevant for inclusion. A reference list search of the research papers did not yield any further results (Figure 1).

Fig. 1. PRISMA flow chart detailing the selection of studies.
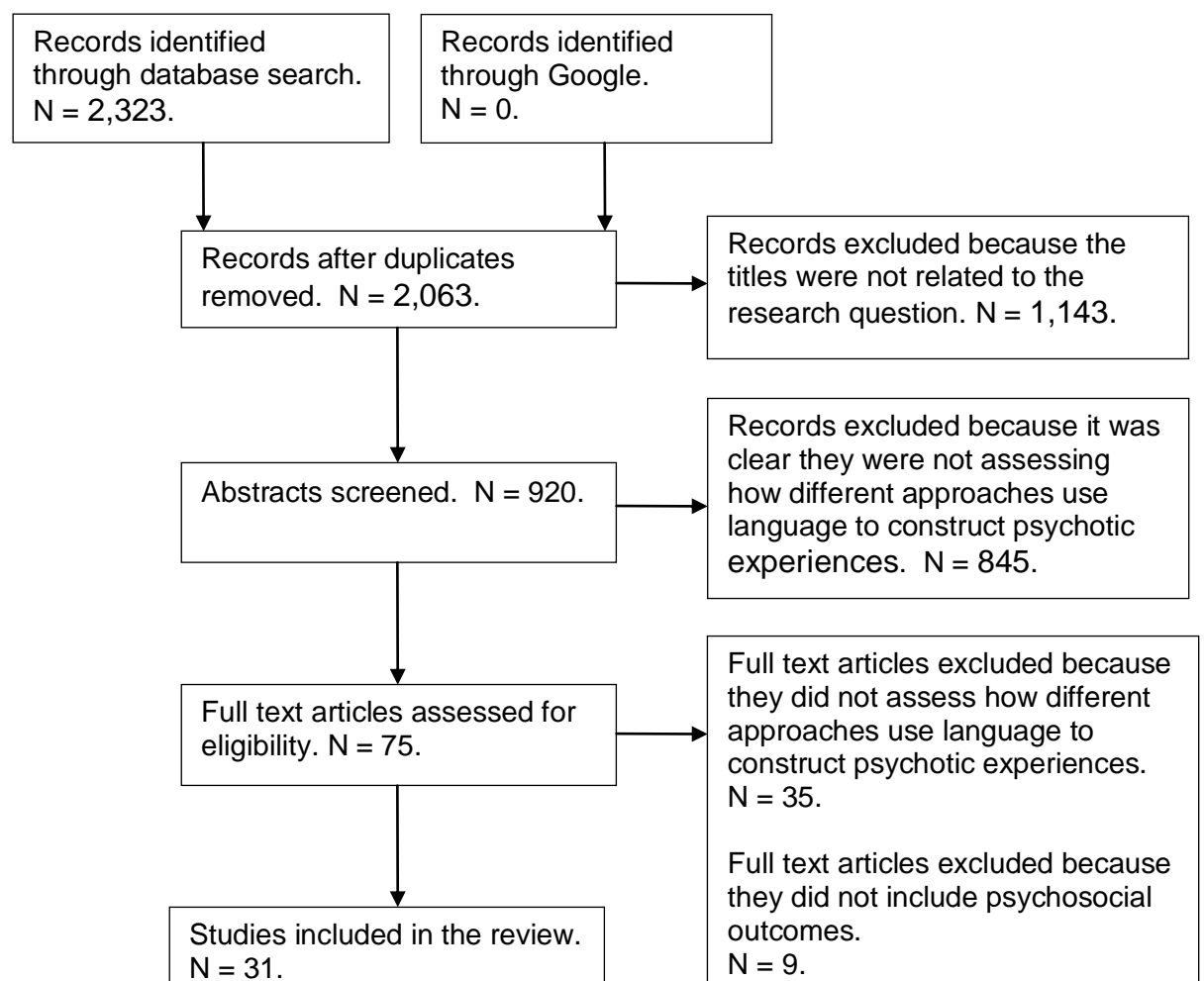
Inclusion and Exclusion Criteria

Studies were included if they were original quantitative or qualitative studies, or literature reviews with a focus on the use of language and experience in 'psychosis'. Studies that did not include psychosocial outcomes and that were not written in English were excluded.

Quality Assessment

A quality assessment of the 31 studies that emerged from the literature search was undertaken. The Mixed Methods Appraisal Tool (MMAT) was used to evaluate the quality of the design, conduct and analysis of each study (Pluye et al., 2011). The MMAT was designed to assess studies to be included in mixed method literature reviews. It is comprised of six sections of questions; screening, qualitative, randomised controlled trial, non-randomised controlled trial, descriptive and mixed method. Reviewers use the relevant sections of the tool to appraise studies.

For each study the reviewer answers 'yes', 'no' or 'can't tell' to between six to 13 questions. The MMAT does not suggest a threshold for what might be considered a 'good' study, rather, it encourages the assessor to systematically consider how a deficit in each area may bias the findings of each study. The MMAT was deemed the most suitable for this review as it enabled consistent appraisal of the studies and evaluation of how successfully the unique characteristics of different methodologies were executed. The significant limitations of the studies are highlighted throughout the literature review. Each study's MMAT appraisal is also summarised in a table (Table 1, 2 & 3).

Literature Review

The literature obtained in the literature search was thoroughly reviewed by the researcher before being amalgamated. It was felt that the literature broadly fell into

three themes; meaning making, developing a shared understanding and quality of narrative. To ensure the research was discussed in a clear and concise manner the research was therefore reported under these headings. Throughout the paper, studies explored under the headings are outlined and, as each new section of studies is introduced, they are summarised in a table. Studies explored under previous headings are revisited when relevant to enable exploration of the different elements of the studies. A detailed summary of each of the 31 studies is shown in Appendix 1. After reviewing the literature, the main conclusions that can be drawn are summarised as a whole, before the clinical and research implications are outlined.

Meaning Making

Meaning making was a theme that ran through a number of the studies. Meaning making describes the process of how a person comes to construe, understand, or make sense of their life events, relationships and themselves (Leontiev, 2014). Studies exploring the Open Dialogue (OD) approach, therapies with a focus on narrative development and formulation, are discussed in the following section (Table 1). This literature assumes that language is important in the process of meaning making. It also suggests that the process of making meaning out of 'psychotic' experiences can lead to positive psychosocial outcomes. However, it is important to note that the connection between meaning making and better functioning or psychosocial outcomes is a hypothesised connection only, regardless of how meaning making is measured or understood.

Table 1. Summary and quality assessment of each study introduced in this section

Study	Aims	Outcomes	MMAT
Seikkula, Alakare &	To describe the OD* approach	• Two years after treatment 'Siiri' did not express any	Paper met criterion in 5

Aaltonen (2001a)	using a case study.	psychotic ideas. • Five years after she had not experienced any 'psychotic symptoms' throughout the previous three years.	out of 6 areas on the MMAT*.
Gromer (2012)	To combine research studies exploring the effectiveness of the OD approach to treating 'psychosis'.	• Outcomes from the OD approach were equal or superior to standard care. • Newer versions of OD were also equal or superior to older incarnations of OD.	Paper met criterion in 6 out of 6 areas on the MMAT.
Seikkula et al. (2003)	To compare the effectiveness of OD with previous incarnations of OD and standard care in treating 'psychosis'.	• Outcomes from the OD approach were equal or superior to standard care. • Newer versions of OD were also equal or superior to older incarnations of OD.	Paper met criterion in 6 out of 6 areas on the MMAT.
Aaltonen , Seikkula & Lehtinen (2011)	To compare incidence of 'psychosis' before and after the implementation of OD.	• The mean annual incidence of 'schizophrenia' diagnoses decreased. • Brief 'psychotic' reactions increased. • The number of long-stay hospital admissions due to 'psychosis' fell to zero.	Paper met criterion in 6 out of 6 areas on the MMAT.
Seikkula et al. (2006)	To compare the effectiveness of OD with previous incarnations of OD in treating 'psychosis'.	• Individuals in the recent OD group spent fewer days in hospital. • They also experienced a shorter duration of untreated 'psychosis'. • No significant differences were identified in the five year treatment outcomes.	Paper met criterion in 6 out of 6 areas on the MMAT.
Seikkula , Alakare & Aaltonen (2011)	To compare the effectiveness of OD with previous incarnations of OD in treating 'psychosis'.	• In the recent OD group, fewer individuals were diagnosed with 'schizophrenia'. • Further, the mean age of individuals diagnosed with 'schizophrenia' significantly lowered. • Finally, the duration of untreated 'psychosis' shortened.	Paper met criterion in 6 out of 6 areas on the MMAT.
Seikkula, Alakare & Aaltonen (2001b)	To compare good and poor outcome OD cases in 'psychosis'.	• Differences in diagnosis and length of 'symptoms' were identified in both groups. • Treatment processes in the two groups differed.	Paper met criterion in 6 out of 6 areas on the MMAT.

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		• Using anxiolytics instead of neuroleptics and avoiding hospitalisation was associated with a good outcome.	
Seikkula (2002)	To explore the quality of the dialogue in the treatment meetings of good and poor outcome 'psychosis' cases.	• In good outcomes, participants had "both interactional and semantic dominance and the dialogue took place in symbolic language and in a dialogical form" (p. 263). • Further, in the first meeting the team responded to the service user using words in a dialogical way.	Paper met criterion in 6 out of 6 areas on the MMAT.
Bargenquast & Schweitzer (2014)	To explore the effectiveness of MNP*.	• After therapy, participants' scores on the RAS* and MAS-SR* significantly improved, with medium to large effect sizes.	Paper met criterion in 10 out of 13 areas on the MMAT.
Greben Schweitzer & Bargenquast (2014)	To explore whether narrative reflexivity is a mechanism of therapeutic change in MNP.	• Seven participants demonstrated an increase on the NPCS* and the RAS throughout therapy. • For six participants, an increase on the RAS was correlated with an increase on the NPCS.	Paper addressed potential bias in 9 of 13 areas on the MMAT.
Schweitzer, Greben & Barqenquast (2017)	To explore the long term outcomes of MNP.	• Seven participants demonstrated improvement on one or more of the outcome measures. • Four participant's scores on the RAS increased. • Six participants demonstrated an improvement on the MAS-SR.	Paper met criterion in 9 of 13 areas on the MMAT.
Mehl-Madrona, Jul & Mainguy (2014)	To explore the effectiveness of transpersonal, narrative psychotherapy in individuals keen to reduce or eliminate medication.	• After therapy, 38 participants managed their 'psychosis' without the use of medication. • Another nine participants managed well on low dose medications. • Three individuals required higher levels of medication.	Paper met criterion in 6 of 6 areas on the MMAT.
Hamm & Leonhardt (2016)	To describe the effective implementation of integrative	• 'Simone' continued to experience 'symptoms'. • However, after therapy her 'symptoms' interfered less in	Paper met criterion in 6 of 6 areas on the MMAT.

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	psychotherapy with a focus on personal narrative using a case study.	therapy sessions and she appeared to have made a number of psychological and behavioural changes.	
Lysaker et al. (2005)	To explore whether measures of metacognition, narrative structure and content changed during a course of integrative psychotherapy.	• The degree of improvement in narrative structure between months four to 29 was significantly more than the improvement found in narrative content on the STAND*, NCRA* or on the MAS*.	Paper met criterion in 6 of 6 areas on the checklist.
Vassallo (1998)	To describe the implementation and outcomes of a narrative therapy group.	• Participants said their lives had changed in a number of ways due to the group, for example, they had more confidence and had developed friendships.	Paper met criterion in 3 of 6 areas on the MMAT.
Pain, Chadwick & Abba (2008)	To explore the effectiveness case formulation during CBT* for 'psychosis'.	• Participants' reactions to case formulation were emotionally, behaviourally and cognitively complex. They were also subject to change over time. • Therapists reported that they found case formulation to be most helpful in increasing their understanding of clients.	Paper met criterion in 6 of 6 areas on the MMAT.
Chadwick, Williams, & MacKenzie (2003)	To explore the impact of CBT case formulation on the therapeutic relationship, strength of 'delusional' and self-evaluative beliefs, and on anxiety and depression.	• Therapists' scores on the HAQ* increased. • Scores on all other measures did not change significantly. • Qualitative feedback from the interviews suggested that case formulation was viewed both helpful and unhelpful by different participants.	Paper met criterion in 12 of 13 areas on the MMAT.

* MMAT: Mixed Methods Appraisal Tool, OD: Open Dialogue, MNP: Metacognitive Narrative

Psychotherapy, RAS: Recovery Assessment Scale, MAS: Metacognitive Assessment Scale, MAS-

SR: Metacognitive Assessment Scale- Self Reflectivity, NPCS: Narrative Processes Coding System,

STAND: Scale to Assess Narrative Development, NCRA: Narrative Coherence Rating Assessment,

CBT: Cognitive Behavioural Therapy, HAQ: Helping Alliance Questionnaire.

The Open Dialogue (OD) approach to treating 'psychosis' proposes that meaning making can be approached through the development of a shared dialogue between individuals and those in their social support systems (Seikkula, Alakare & Aaltonen, 2001a). Open Dialogue is a psychotherapeutic treatment that involves the use of mobile crisis intervention teams, service users, and their social networks generating dialogues in joint meetings (Seikkula et al., 2001a). This approach was explored in eight of the papers included in the review.

Gromer (2012) conducted a systematic review exploring the effectiveness of the OD approach in treating 'psychosis'. The review included four papers also considered in this review. Gromer (2012) concluded that compared to standard care, the OD approach appeared to be statistically equal or superior in treating people experiencing 'psychosis' for the first time (Seikkula et al., 2003; Aaltonen, Seikkula & Lehtinen, 2011). Open Dialogue was associated with less 'symptoms', better social functioning, more employment and fewer hospital stays. Studies comparing recent incarnations of the OD approach to previous less developed forms indicated outcomes were equal or superior in the former (Seikkula et al., 2003; Seikkula et al 2006; Seikkula, Alakare & Aaltonen, 2011). They found newer versions of OD appeared to be associated with fewer days spent in hospital. This suggests that OD is developing and showing increased positive outcomes as its practice is refined.

The same OD research group also published a case study describing the effective implementation of the approach with one individual and her family (Seikkula et al., 2001a), and explored predictors of good and poor outcomes in OD (Seikkula, Alakare, and Aaltonen, 2001b). In the latter paper, individuals experiencing more than mild 'symptoms' and not working, studying, or seeking employment were defined as poor outcome cases. The team found differences in treatment processes, the duration of 'symptoms' and diagnosis in the two groups. Most relevant to this

review, they found that if the opportunity for starting a dialogical process with the client and their family was minimal, the treatment was more likely to lead to poor outcomes, even when it was not predicted by premorbid psychological and social factors. The authors concluded that more research was needed into the quality of the dialogue in treatment meetings.

Following on from this, Seikkula (2002) conducted a dialogical sequence analysis of conversations in the meetings of good and poor outcome cases. Seikkula (2002) concluded that, in the good outcome case meetings, clients had more control over what was discussed, spoke more often, and introduced more content words. Further, dialogue was undertaken in a symbolic sense and took dialogical form. That is, "words were used to refer to other words rather than an existing thing or matter, and utterances answered previous utterances" (p. 268). This suggests that the way that language is used in meetings is a key ingredient in OD. However, firm conclusions cannot be drawn as the authors did not control for other factors that may have contributed to outcomes (Pluye et al., 2011). A continuation of the research exploring the role of dialogue and other mechanisms that may be at work in the OD approach is warranted.

Metacognitive Narrative Psychotherapy (MNP) is also an approach that draws upon dialogical understandings of 'psychosis' (Bargenquast & Schweitzer, 2014). Three of the studies included in the review explored the effectiveness of MNP in treating individuals diagnosed with 'schizophrenia' (Bargenquast & Schweitzer, 2014; Greben, Schweitzer & Bargenquast, 2014; Schweitzer, Greben & Barqenquast, 2017). Metacognitive Narrative Psychotherapy aims to enhance recovery by increasing metacognition and through helping individuals to enrich their life story narratives (Greben et al., 2014).

As a whole the three studies offered support for the role of MNP in facilitating recovery. The studies suggested that MNP enhances subjective recovery and

narratives, particularly in those with notable 'deficits' in narrative coherence (Bargenquast & Schweitzer's, 2014; Schweitzer et al., 2017). Greben et al's (2014) study offered support for the role of narrative reflexivity as a mechanism underlying the effectiveness of MNP. Narrative reflexivity is described as "making meaning of mental states and experience by processing them within the context of oneself" (Adler, Skalina & McAdams, 2008, p. 3). However, the generalisability of the findings of the three studies was limited by the small sample sizes, predominately made up of men, and attrition in the latter two studies (Pluye et al., 2011). The lack of a control group also meant the researchers were unable to attribute changes to the intervention (Pluye et al., 2011).

The role of narrative development in recovery was also emphasised in four case studies included in this review. Three of the case studies described the successful implementation of integrative therapies with a narrative focus (Mehl-Madrona, Jul & Mainguy, 2014; Hamm & Leonhardt, 2016; Lysaker et al, 2005). One case study described a narrative therapy group which led to positive psychological and behavioural changes within its participants (Vassallo, 1998).

Lysaker et al. (2005) undertook blind assessments of one individual's psychotherapy transcripts. They found significant changes in metacognition, narrative structure and content. The improvement in narrative structure from months four to 29 was significantly greater than the observed improvement in narrative content or metacognition. Lysaker et al. (2005) hypothesised that narratives may gain greater complexity and structure prior to capacity for self-reflection or the changing of a story. Taken together the studies offer support for the role of narrative development in both an individual and group format. However, the authors of three of the papers (Mehl-Madrona et al., 2014; Hamm & Leonhardt, 2016; Vassallo, 1998) were also the therapists, leading to potential researcher bias (Pluye et al., 2011).

Open Dialogue, MNP and the narrative case studies suggest that meaning making is an ongoing process that can be approached through verbal dialogue. This understanding of meaning making has research implications, for example, how to identify, measure and evaluate the meaning making process and its components. The view that meaning making is an ongoing process, is also in contrast to that taken in two of the other papers included in the current review. In both studies, CBT based written formulations were shared with clients during therapy for 'psychosis' and they were then asked to complete measures or interviewed regarding their experiences of this formulation as an event (Chadwick, Williams, & MacKenzie, 2003; Pain, Chadwick & Abba, 2008). Meaning making is therefore understood as taking place within this one off event, rather than as part of an ongoing process.

Chadwick et al. (2003) assessed the impact of case formulation on participants' and therapists' perspectives of the therapeutic relationship, anxiety, depression, strength of 'delusions' and negative self-evaluations (Chadwick et al., 2003). They did not find any changes on the outcome measures from the client's perspective. Similarly, Pain et al. (2008) interviewed clients and therapists after the sharing of a case formulation. Overall, participants' reactions to case formulation were emotionally, behaviourally and cognitively complex, and subject to change over time.

Interestingly, both studies suggested that therapists found formulation helpful in some way, for example, by improving the therapeutic relationship (Chadwick et al., 2003) or increasing understanding of their clients (Pain et al., 2008). This suggests that the sharing of a written formulation was more useful for therapists. It casts doubts on whether the sharing of a document is a necessary part of the formulation process, equally, the sharing of written formulations may have other benefits not examined in the current studies (Pluye et al., 2011). More research is therefore

needed to explore the impact of sharing written formulations with clients in therapy for 'psychosis'.

Developing a Shared Understanding

The importance of developing a shared understanding of 'psychotic' experience was considered in a number of the papers explored in this review. The ways that different approaches suggest language can be used to contribute to developing a shared understanding are discussed in the following section. Literature exploring therapy processes and the use of communication aids are discussed (Table 2). The OD and formulation literature is also revisited to enable the consideration of contrasting views regarding the importance of developing a shared understanding.

Table 2. Summary and quality assessment of each study introduced in this section

Study	Aims	Outcomes	MMAT
Dilks, Tasker & Wren (2008)	To explore therapy processes in 'psychosis'.	• A Grounded Theory* was developed conceptualising the processes involved in psychological therapy for 'psychosis'.	Paper met criterion in 6 of 6 areas on the MMAT*.
Dilks, Tasker & Wren (2010)	To explore the links between therapy and recovery in 'psychosis'.	• A GT theorising the key activities involved in managing the impact of 'psychosis' was developed.	Paper met criterion in 6 of 6 areas on the MMAT.
Dilks, Tasker & Wren (2013)	To explore therapist activities during therapy for 'psychosis'.	• A GT theorising therapist actions and activities during therapy for 'psychosis' was generated.	Paper met criterion in 6 of 6 areas on the MMAT.
Van Os et al. (2004)	To explore the use of 2-COM*	• After using 2-COM, there was an	Paper met criterion in 6 of 6 areas on the

		improvement on participants' reported quality of 'patient doctor' communication. • Changes in management occurred immediately after the use of 2-COM.	MMAT.
Priebe et al. (2007)	To explore the effectiveness of a computer mediated intervention structuring patient and clinician dialogue (DIALOG).	• 12 months after DIALOG participants' scores on the MANSA* and the CSQ* increased. • Participants also reported fewer unmet needs on the CANSAS*.	Paper met criterion in 5 of 6 areas on the MMAT.
Priebe et al. (2015)	To explore the effectiveness of a computer mediated intervention structuring patient and clinician dialogue (DIALOG+).	• Three, six and 12 months after DIALOG+ participants' scores on the MANSA had increased. • Participants reported less unmet needs on the CANSAS at three and six months. • Finally, they experienced fewer 'symptoms' on the PANSS* at all three time points.	Paper met criterion bias in 5 of 6 areas on the MMAT.
Sousa, Corriveau, Lee, Bianco & Sousa (2013)	To explore the effectiveness of the LED* in reducing the discrepancy between clinicians' and 'patients' ratings of the severity of 'symptoms'.	• Participants in the LED intervention experienced less 'symptoms' on the PANSS. • An improvement in functioning was also noted, along with a decrease in discrepancy scores.	Paper met criterion in 5 of 6 areas on the MMAT.

* MMAT: Mixed Method Appraisal Tool, GT: Grounded Theory, 2-Com: Two-Way Communication

Checklist, MANSA: Manchester Short Assessment of Quality of Life, CSQ: Client Satisfaction

Questionnaire, CANSAS: Camberwell Assessment of Need Short Appraisal Schedule, PANSS: Positive and Negative Symptoms Scale, LED: LORS-Enabled Dialogue.

CBTp emphasises the importance of developing a shared understanding of 'psychotic' experience between client and therapist (Pain et al., 2008). This is supported by Dilks, Tasker and Wren (2008; 2010; 2013) who developed a grounded theory conceptualising the processes and activities at work in therapy for 'psychosis'. The grounded theory was based on recordings of sessions and interviews with therapists and their clients. 'Building bridges to observational perspectives' emerged as a core process in psychological therapy for 'psychosis'. 'Negotiating shared understandings' was one of the four main activities found to be part of this core process. 'Negotiating shared understandings' was defined as a constantly negotiated sharing of views between therapist and client during the course of conversation to enable them both to move towards shared alternative perspectives on the client's distress.

The CBTp literature specifies that a co-constructed, shared understanding of 'psychotic' experience should be reached between a client and therapist (Pain et al., 2008). It has been found to be one of the principal change agents in CBT, termed 'collaborative empiricism' (Dattilio & Hanna, 2012). However, to what extent this is achievable given the power and 'knowledge' inequalities within a therapeutic relationship is questionable. For example, Dilks et al. (2008) observed in the therapy tapes that psychologists would emphasise some understandings over others as they "focused on some lines of discussion, ignored others, and offered their own understandings" within therapy for psychosis (p. 220). This suggests that the shared understanding developed within therapy may at times be 'therapist led', rather than co-constructed. However, little is known about how important a co-constructed, shared understanding is within interventions for 'psychosis'.

Four of the papers included in the current review explored the effectiveness of communication aids for use in meetings between clients and their doctors or care co-ordinators, for example, Van Os et al. (2004) explored the impact of using the Two-Way Communication Checklist (2-COM) in routine meetings. As within the CBTp approach, the literature exploring the use of communication aids emphasises the need to build a shared understanding between a client and their clinician. It is suggested that it is the development of a shared understanding of 'psychotic' experience that impacts on the interventions implemented after meetings, and in turn on psychosocial outcomes.

Using a randomised controlled trial, Van Os et al. (2004) evaluated the use of the 2-COM in meetings between clients diagnosed with 'schizophrenia' and their doctors. They found that its use improved client reported quality of 'patient-doctor communication' and resulted in changes in management directly after the intervention.

Similarly, Priebe et al. (2007; 2015) evaluated the use of a computer mediated intervention, 'DIALOG', to focus 'patient-clinician' dialogue on 'patients' quality of life and needs for care. They tested the effectiveness using two cluster randomised controlled trials and found that using the intervention led to increases on subjective outcomes measuring 'patient' care and treatment satisfaction (Priebe et al., 2007), quality of life and objective social outcomes (Priebe et al., 2007; 2015). It also led to decreases in 'psychopathological symptoms' (Priebe et al., 2015). However, there were problems with blinding in three of the 'communication aids' studies (Pluye et al., 2011). In one study, outcome assessors and clinicians were not blind to allocation (Van Os et al., 2004). In the two Priebe et al. (2007; 2015) studies, participants' allocation was not successfully concealed to the outcome assessor for three participants (Priebe et al., 2007), or not concealed for the majority of cases (Priebe et al., 2015), potentially leading to bias (Pluye et al., 2011).

Finally, Sousa, Corriveau, Lee, Bianco and Sousa (2013) examined the effectiveness of the Levels Of Recovery from 'psychotic disorders' Scale (LORS-Enabled Dialogue). With this aid, both the client and clinician complete their respective scales before a discrepancy rating is calculated. The discrepancy is conceptualised as a 'patient's' lack of awareness of their 'symptoms'. The score is then used as a tool by the clinician for brief motivational interviewing. In this study, the discrepancy score is used to focus the way language is used in the subsequent client and clinician meeting. Sousa et al. (2013) concluded that the LORS-Enabled Dialogue led to a decrease in 'psychopathology', improvement in functioning and a decrease in discrepancy of 'symptom' severity between 'patients' and clinicians. However, participants received different amounts of the treatment which may have biased findings (Pluye et al., 2011).

Each of the four papers describe communication aids that are a way of structuring conversations with people experiencing 'psychosis'. However, the use of a 'psychosis' specific communication tools suggests that a problem needs to be 'fixed', a problem which has arguably been located 'in' the client, rather than the clinician-client pair. This body of work suggests that the client has a 'deficit' that the aid must compensate for. The idea that there is a 'deficit' that must be compensated for, or even that there is one shared way of understanding 'psychotic' experience is in contrast to the philosophical underpinnings of the OD position (Seikkula, 2002). In the OD approach there is no 'true' or 'real' way of understanding 'psychotic' experience (Seikkula, 2002). The primary intervention of the approach is the network meeting which is used to share *multiple* perspectives and understandings (Seikkula, 2002). This is a significant conceptual difference and relates to the question of whether there is a 'helpful' way to develop meaning, or if there are processes of meaning making that have different impacts, functions and outcomes for the self, relationships, social integration, stigma etc.

As well as describing contrasting ideas about shared understandings, the papers included in the review differed in terms of who they emphasise these understandings should be shared or developed with. The OD literature suggests that the understandings should be shared with all the individuals within a support system (Seikkula et al., 2001a). This is in line with research suggesting that family therapy is an effective intervention for 'psychosis', and the NICE (2014) recommendation that Family Intervention be utilised as a first line treatment. The use of the whole network in OD is in contrast to individual therapy and the communication aids literature where a shared understanding of 'psychotic' experience is developed between only the client and their clinician or therapist. Further research is necessary to elucidate the importance of developing a shared understanding and who should be involved in this process.

Quality of Narrative

The quality of the life narratives of individuals diagnosed with 'schizophrenia' was explored in a number of studies. This section of the review will include the exploration of this literature, which asks individuals to recall their life narratives and correlates it with psychosocial outcomes. For brevity this literature will be referred to collectively as the 'deficit literature', a term coined by the researcher to summarize the focus of these papers (Table 3). The OD studies are also reconsidered in this section to enable the exploration of alternative views regarding the quality of life story narratives.

Table 3. Summary and quality assessment of each study introduced in this section

Study	Aims	Outcomes	MMAT
Lysaker, Ringer, Maxwell, McGuire &	To explore whether more detailed life narratives are	• Higher scores on the STAND* were associated with more frequent social	Paper met criterion in 6 out of 6 areas on the MMAT*.

Lecomte (2010)	associated with wellness independent of other factors.	contacts and increased capacity for such experiences.	
Moe, Breitborde, Shakeel, Gallagher & Docherty (2016)	To compare idea density in the life story narratives of people diagnosed with 'schizophrenia' and those without mental health difficulties.	• Idea density was reduced in individuals diagnosed with 'schizophrenia'. • Idea density was correlated positively with the overall STAND score, and on illness awareness and agency on the IPII*.	Paper met criterion in 6 out of 6 areas on the MMAT.
Raffard et al. (2010)	To compare the life narratives of people diagnosed with 'schizophrenia' and those without mental health difficulties.	• The narratives of participants diagnosed with 'schizophrenia' were less coherent. • They were also more severely 'impaired' in their ability to make connections with the self and extract meaning from their memories, which correlated significantly with 'illness' length.	Paper met criterion in 6 out of 6 areas on the MMAT.
Allé et al. (2015)	To compare life narratives and ability to integrate and bind memories of personal events into a coherent narrative in people diagnosed with 'schizophrenia' and those without mental health difficulties.	• In participants diagnosed with 'schizophrenia' temporal coherence was partially 'impaired'. • Causal-motivational and thematic coherence was significantly 'impaired'. • 'Impairment' of global causal-motivational and thematic coherence was correlated significantly with 'patients' executive dysfunction.	Paper met criterion in 6 out of 6 areas on the MMAT.

Allé et al. (2016a)	To compare self-continuity in the life narratives of individuals diagnosed with 'schizophrenia' and those without mental health difficulties.	• Participants diagnosed with 'schizophrenia' experienced less detailed representations of personally significant events. • Their ability to make connections between personal events and self-attributes in their life narratives was also 'impaired', but only in that of their past narrative.	Paper met criterion in 6 out of 6 areas on the MMAT.
Allé et al. (2016b)	To compare the temporal structure of life narratives in individuals diagnosed with 'schizophrenia' and those without mental health difficulties.	• Global temporal coherence was reduced significantly in participants diagnosed with 'schizophrenia'.	Paper met criterion in 6 out of 6 areas on the MMAT.
Holm, Kirkegaard Thomsen & Bliksted (2016)	To compare self-continuity in the life narratives of individuals diagnosed with 'schizophrenia' and those without mental health difficulties.	• Participants diagnosed with 'schizophrenia' rated their life story chapters more negatively. • They experienced problems with neurocognitive function. • A higher degree of 'negative symptoms' were related to lower self-continuity and less causal coherence in the life chapters of individuals diagnosed with 'schizophrenia'. .	Paper met criterion in 6 out of 6 areas on the MMAT.

* MMAT: Mixed Methods Appraisal Tool, STAND: Scale to Assess Narrative Development. IPII:

Indiana Psychiatric Illness Interview.

Seven studies examined aspects of personal narratives and correlated them with psychosocial outcomes. The papers take the position that through asking individuals diagnosed with 'schizophrenia' to narrate their lives, 'deficits' can be gauged. In this body of literature, language is used to understand how individuals experiencing 'psychosis' comprehend their experiences, and to search for 'deficits' in their narratives. However, how an individual's story is judged to be 'impaired' and by whom should be considered critically.

Lysaker, Ringer Maxwell, McGuire & Lecomte (2010) found that a more detailed narrative was correlated with more frequent social contacts and greater capacity for such contacts in individuals diagnosed with 'schizophrenia'. The authors hypothesised that narrative development may be a distinctive domain of recovery and that a detailed personal narrative may allow a person diagnosed with 'schizophrenia' to make meaning of - and share - their experiences with others. However, the correlational nature of the study prevents any causation conclusions to be drawn (Pluye et al., 2011). It seems equally possible that this relationship could be reversed, for example, if individuals are more socially active, they may have more to discuss. The generalisability of this study was also limited by the sample composition as most participants were men in their 40's (Pluye et al., 2011).

Moe, Breitbprde, Shakeel, Gallagher & Dovherty (2016) compared idea density in the life story narratives of participants diagnosed with 'schizophrenia' and those without mental health difficulties. Idea density was defined as the degree of information in a narrative (Farias et al., 2012). The researchers found that idea density was reduced in individuals diagnosed with 'schizophrenia' and that lower scores of idea density were associated with increased 'positive symptoms' of 'psychosis'. Further, people diagnosed with 'schizophrenia' and having richer idea density were more likely to have increased 'insight' into their 'illness', and higher levels of avolition, anxiety and depression. The authors hypothesised that individuals

that demonstrate more complexity in their language may be more aware of the negative impact of their difficulties on their lives, and that this may mean they are more vulnerable to depression, anxiety and diminished motivation.

Similarly, Raffard et al. (2010) compared narratives of participants diagnosed with 'schizophrenia' with those without mental health difficulties through the recall of self-defining memories. As in Moe et al's (2016) study, the narratives of participants diagnosed with 'schizophrenia' were found to be less elaborate and coherent. Individuals diagnosed with 'schizophrenia' were also found to be 'impaired' in their ability to organise and extract meaning from their memories, which correlated significantly with 'illness' length. Further, individuals diagnosed with 'schizophrenia' exhibited an early 'reminiscence bump', that is, their memories were mostly from an earlier period in their lives. The period of the reminiscence bump was characterised by less achievements and having experienced more life-threatening events. A negative correlation was also found between the number of self-event connections, specificity of narratives and 'negative symptoms'.

In a similar vein, Allé et al. (2015; 2016a; 2016b) compared life narratives and capacity to assimilate and bind memories of life events into a coherent narrative in individuals diagnosed with 'schizophrenia' and those not diagnosed with any mental health difficulties. They found that in participants diagnosed with 'schizophrenia' temporal coherence was partially 'impaired'. 'Temporal coherence' reflects the narrator's capacity to identify when and in what order events took place (Allé et al., 2015). Furthermore, causal-motivational and thematic coherence was reported to be significantly 'impaired'. That is, participants had problems explaining how events had moulded their identity and with assimilating different events along thematic lines. 'Impairment' of global causal-motivational and thematic coherence was correlated significantly with participants' executive dysfunction (e.g. difficulties with mental flexibility and retrieval of information in memories).

Allé et al's (2016a) study also suggested that individuals diagnosed with 'schizophrenia' experienced less detailed representations of significant life events in both the past and future. Further, their ability to make clear connections between life events and self-attributes in their life narratives was also described as 'impaired' but only in their past narratives (Allé et al., 2016a). This is in line with Raffard et al's (2010) findings that individuals diagnosed with 'schizophrenia' were more severely 'impaired' in their capacity to make connections with the self and abstract meaning from their memories.

Finally, Allé et al.'s (2016b) results suggested that chronological coherence was significantly reduced in participants diagnosed with 'schizophrenia'. This was mainly because participants diagnosed with 'schizophrenia' exhibited a stronger tendency to stray from the sequential order of events, without stipulating it within the narration of their life story. The researchers also found significant correlations in individuals diagnosed with 'schizophrenia' between chronological coherence and executive dysfunction.

The final study in this area by Holm, Kirkegaard and Bliksted (2016) compared self-defining memories and life story chapters in participants diagnosed with 'schizophrenia' and individuals without mental health difficulties. Life story chapters were defined as periods within an individual's life (e.g. school years or teenage years etc.). In contrast to the consistent findings in previous studies, Holm et al. (2016) did not find that participants diagnosed with 'schizophrenia' experienced reduced temporal (Allé et al., 2015; Allé et al., 2016b) or causal coherence (Allé et al., 2015). Holm et al. (2016) found few differences between the 'patient' and control groups. This finding is also in contrast to Raffard et al's (2010) finding that individuals diagnosed with 'schizophrenia' expressed less coherent and elaborate narratives.

However, Holm et al. (2016) did find that reduced neurocognitive function and increased 'negative symptoms' were associated with less causal coherence and

lower self-continuity in the life story chapters of individuals diagnosed with 'schizophrenia'. Self-continuity was defined as a sense that the past self was meaningfully related to the present self. Similarly, Allé et al's (2015; 2016b) studies found that 'impairment' of global causal-motivational and thematic coherence was correlated significantly with 'patients' executive dysfunction. Allé et al. (2015; 2016b) argue that the cognitive 'impairment' observed in individuals diagnosed with 'schizophrenia' may affect their ability to build a coherent narrative of their life by connecting significant events to their sense of self.

Overall, the 'deficit literature' suggests that individuals diagnosed with 'schizophrenia' exhibit 'impairments' in various elements of their life narratives (Lysaker et al., 2010; Moe et al., 2016; Raffard et al., 2010; Allé et al., 2015; 2016a; 2016b; Holm et al., 2016). 'Impaired' life narratives were associated with increased 'positive psychotic symptoms', increased 'illness' duration (Moe et al., 2016), 'negative psychotic symptoms' (Raffard et al., 2010; Holm et al., 2016) and decreased executive function (Allé et al., 2016b; Holm et al., 2016). More detailed narratives were associated with more social contacts and the greater capacity for such experiences (Lysaker et al., 2010), better 'insight', and increased depression, anxiety and a lack of motivation (Moe et al., 2016).

However, it must be noted that all seven studies were cross sectional and therefore conclusions cannot be drawn regarding the cause of 'deficits' within the life narratives of individuals diagnosed with 'schizophrenia' (Pluye et al., 2011). Further, none of the papers took account of the impact of adversity on life narratives, for example; the impact of early trauma; despite trauma being common in the histories of people experiencing 'psychosis' (Morrison, Frame & Larkin, 2003). The relevance of considering possible connections between life experiences and narrative structure is also supported by research that suggests that trauma is associated with disorganised narratives in the Adult Attachment Interview (Berry, Barrowclough &

Wearden, 2007). Instead the research discussed in this section takes a reductionist approach by relating impoverished life narratives, memories and chapters with the 'presence' of 'schizophrenia' or specific 'deficits' only.

The 'deficit' literature also implies that recovery may not be possible for individuals diagnosed with 'schizophrenia'; for example, if these individuals have a cognitive 'deficit' that cannot be 'fixed' it has negative implications for recovery. This is not supported by the effective application of the therapeutic approaches discussed earlier in the review that suggest that psychotherapeutic intervention can be used to help individuals, which in turn can have positive implications psychosocially for individuals experiencing psychosis (NICE, 2014). It is also in contrast to research that suggests that recovery from difficulties such as 'schizophrenia' or 'psychosis' is more promising than previously thought (WHO, 2001; France & Uhlin, 2006).

Reflections on MMAT

The MMAT was used to appraise the quality of the 31 studies considered in the review. This was felt to be well suited to the current review enabling the researcher to consistently appraise a large number of diverse studies utilising mixed methods. However, for studies that were solely qualitative or quantitative the researcher was required to answer six questions to assess the quality of the studies only. This is fewer questions than on other quality assessment tools available and may have meant the studies were not scrutinised as in-depth as other tools may have allowed. The conclusions drawn in the current review should be considered in line with the various biases highlighted in each of the studies.

Summary

A systematic review of the literature exploring different approaches to using language to construct experience in 'psychosis' was undertaken. It was concluded

that using language can have a positive impact psychosocially. Specifically, the studies suggested that it can be helpful for individuals experiencing 'psychosis' to develop a meaningful life narrative. However, different approaches diverged in terms of whether they felt this process should be undertaken verbally or through the development of a written formulation. It was concluded that the benefits and processes involved in sharing written formulations were so far unclear. The OD studies suggested that involving an individual's support network and also the way language is used in network meetings may be important ingredients in the approach. The OD approach also emphasised that network meetings be used as a place where *multiple* understandings of 'psychosis' are voiced. This was in contrast to other approaches to using language that emphasise interventions should be aimed at developing shared understandings with individuals experiencing 'psychosis'. The 'deficit' literature was then discussed. In these studies, language was used to understand how individuals experiencing psychosis comprehend their experiences, and to search for 'deficits' in their narratives. This was understood to take a very different, somewhat reductionist approach to language, and it was acknowledged that it did not take account of the possible impact of traumatic life events.

Research Implications

Further research is needed to explore how language can be used to construct experience in 'psychosis' and how helpful this is for service users. This includes the continuation of research exploring the role language plays in therapeutic approaches such as OD and MNP. The value for service users and individuals in their social network, being able to share *multiple* understandings of 'psychotic' experiences - or the development of a *shared* understanding with one other person - requires further elaboration. Further exploration of the importance of coming to a co-constructed, shared understanding with service users is necessary, and if this is found to be

important, research exploring how therapists can increase collaboration with service users in the midst of power and 'knowledge' discrepancies could be important. Additionally, to what extent the sharing of written understandings as well as verbal understandings of psychotic experience is helpful remains unclear. Given the importance placed on formulation, future research might use qualitative methods suited to examining processes to explore how service users experience and make use of written formulations.

Clinical Implications

The results of the review have implications for clinical practice. The research suggests that it may be helpful for persons diagnosed with 'psychosis' to develop a meaningful sense of their own life story. The building of narratives in individual and group settings may be acceptable for some individuals. Service users should be given a choice as to whether they would prefer the development of their story to take the form of ongoing verbal discussions or presented in a written format since the research remains unclear as to how important the latter is. Consideration should be given to whether service users may prefer to develop a shared understanding or may benefit from a space where multiple understandings of 'psychotic' experience are voiced. The OD literature suggests that interventions involving an individual's network are helpful, this intervention should therefore be made available where possible. The studies reviewed suggested that the way language is used in treatment meetings can be helpful and hindering. Service users should be encouraged to take control over their care, for example, they should be able to decide what is discussed and have adequate chance to be heard in routine meetings.

Conclusion

The research outlined in the current review suggests that language can be used in diverse ways to construct 'psychotic' experience and can have a positive impact on various objective and subjective psychosocial measures. The studies were diverse and arguably contradictory, in some areas, regarding the most helpful ways to use language. However, much of the research appeared to suggest that it can be helpful for individuals to develop a meaningful life narrative with key people in their lives. More research is needed to further elaborate our understandings of how language can helpfully be used in interventions for people experiencing 'psychosis'.

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Section B: An Exploration of How Service Users Experience and Make Use of Formulation in Therapy for Psychosis

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Accurate Word Count: 7,998 (128)

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Abstract

Formulation is a fundamental component in many of the psychological therapies practised within the National Health Service (e.g. cognitive behavioural therapy and psychodynamic therapy) (British Psychology Society, Division of Clinical Psychology, [BPS, DCP], 2011). It is seen as a starting point for the process of intervention (DCP, 2011). However, despite the importance placed on formulation, it is under conceptualised and under researched (Johnstone & Dallos, 2015). More specifically, little is known about how service users experience and make use of formulation in therapy for psychosis.

Semi structured interviews were undertaken with 11 service users and two clinical psychologists with experience of formulation in therapy for psychosis. Data from the interviews were analysed from a critical realist perspective using grounded theory methodology.

An emerging model was constructed to depict the processes that occur during the sharing of a formulation. 'Linking previous experiences with current ways of being' and 'building the therapeutic relationship' emerged as core reciprocally influential processes. 'Making use of new understandings' was also identified as an important process. The findings suggest that formulations should be developed collaboratively and progressively with service users, and that care should be given to the emotions that arise as a result. Further research is necessary to elaborate our understanding of formulation given the importance placed on it in UK clinical psychology.

Key Words: Psychosis, Psychological Intervention, Formulation, Therapeutic Processes

Introduction

The current paper describes a qualitative research study exploring how service users with experience of psychosis feel about and make use of formulation in therapy. The paper commences with a review of the relevant literature on psychosis and psychological interventions that have been recommended to ameliorate the negative impact on individual's lives. Previous emphasis on the use of medication to treat psychosis is critiqued. Further, it is acknowledged that research and increased understanding of psychosis has led to an interest in how psychological therapies can be used to help people experiencing psychosis. As a key component of many psychological therapies, the roots of formulation are reviewed along with current research exploring service user experiences of it. It is concluded that the processes involved in formulation are under researched, setting the context for the current research paper.

Psychosis

Experiences thought of as 'psychosis' include; hearing, tasting, smelling or feeling things others do not, holding strong beliefs that others do not share, difficulties thinking and concentrating, and appearing withdrawn or unmotivated (British Psychological Society, Division of Clinical Psychology [BPS, DCP], 2017). An estimated 500,000 people in the United Kingdom (UK) have been given a diagnosis of psychosis (DCP, 2017).

Diagnosis of psychosis is made in the context of the medical model, where mental health difficulties are seen as arising due to something going wrong with the functioning of the brain or body (Johnstone, 2017). However, psychiatric diagnosis

has been criticised due to its lack of reliability and validity, its exclusion of social contexts and contribution towards stigma (Johnstone, 2017).

Some individuals report feelings of shame, stigma, hopelessness and worthlessness as a result of being given a diagnosis (Johnstone, 2017). Members of the 'survivor movement', individuals who do not feel that the medical model is a helpful way to understand their difficulties, continue to campaign for change (DCP, 2017).

The DCP (2017) published a report encouraging a more holistic understanding of psychosis, drawing on multiple models of understanding and emphasising the importance of personal meaning making in recovery from psychosis. The report emphasises the use of 'collaborative formulation'. Formulations can be used to explore the personal meaning of relationships, events and social circumstances of an individual's life, and of their experiences of distress (DCP, 2017). The issue of whether formulation should be used in addition to, or as an alternative to diagnosis is a contentious and active debate in the UK (Johnstone, 2017).

Throughout the current paper 'psychosis' will be used as a broad point of reference, whilst recognising the contested nature of the term. The term psychosis is used to offer a description of the relevant experiences rather than referencing a particular medical aetiology.

Psychological Interventions for Psychosis

Historically, psychosis was seen as a disorder from which full recovery was unlikely (American Psychiatric Association [APA], 1994). Treatment of psychosis focused on the use of medication (Morrison et al., 2014). However, medications can have unwanted side effects impacting negatively on an individual's wellbeing (APA, 2013). Recently, the long-term recovery outcomes on psychosis have been found to be more positive than previously thought (World Health Organisation [WHO], 2001; France & Uhlin, 2006). Due to this, and advances in phenomenological understandings of psychosis (Bellack, 2006), there has been increasing interest in recovery from psychosis (Department of Health [DoH], 2011). Recovery is no longer understood only in terms of symptom cessation. It is now recognised that it may involve subjective outcomes, for example, changes in how an individual experiences and thinks about their life (Bellack, 2006).

The National Institute for Health and Social Care Excellence (NICE, 2014) guidelines recommend that all individuals experiencing distressing psychosis should have access to talking based psychological therapies, specially Cognitive Behavioural Therapy for psychosis (CBTp) and family intervention. Research has demonstrated both are effective when undertaken alongside antipsychotic medication (NICE, 2014). NICE also recommend other interventions including; supported employment, art therapy, mindfulness based CBT and acceptance and commitment therapy.

A range of interventions can be helpful for individuals experiencing psychosis as not all individuals find it helpful to focus directly on their psychotic experiences (DCP, 2017). Some individuals prefer to focus on other parts of their lives, for

example finding work or improving their mood. Collaborative formulation can help therapists and clients to decide which areas of an individual's life they wish to focus on in the first instance (DCP, 2017).

Formulation

Formulation is an essential component of many of the psychological therapies practised within NHS (e.g. CBT and psychodynamic therapy) (DCP, 2011). It is seen as a starting point for the process of intervention (DCP, 2011). Formulations from different therapeutic modalities vary in a number of ways, including the way a formulation is developed, shared and used within therapy (Johnstone & Dallos, 2015). Due to this there is no commonly agreed definition of formulation (DCP, 2011). However, in all therapeutic modalities formulation is understood to provide a hypothesis about an individual's difficulties that draws on psychological theory (Johnstone & Dallos, 2015).

The roots of formulation date back to the 1950s and the development of the scientist-practitioner model in clinical psychology; since then it has become a core skill of the profession (DCP, 2011). However, despite the importance placed on formulation, it is under conceptualised and under researched (Johnstone & Dallos, 2015). For example, its key components, impact on therapy processes and outcomes are unclear (DCP, 2011). Nevertheless it is important to note that there is empirical evidence to support many of the theories and psychological principles that formulations draw upon, for example: developmental psychology, the therapeutic relationship and attachment theory (Johnstone & Dallos, 2015).

Studies have shown the most extensively supported common feature in effective therapy of all orientations is the therapeutic relationship (Martin, Garske

& Davis, 2000). Little is known about how the therapeutic relationship interacts with other aspects of therapy and whether the relationship is in itself a curative element of therapy, or creates the interpersonal context necessary for other therapeutic components to have effect (Horvath, 2005). Research has shown that the therapeutic relationship alone is not sufficient in predicting positive outcomes in therapy (Horvath, 2005). This suggests that other processes are necessary in therapy to achieve positive outcomes.

Formulation can be seen as a process which is embedded within the therapeutic relationship (Johnstone & Dallos, 2015). As the therapeutic relationship develops, clients may trust their therapists more, feel better understood and share more, leading to a collaborative formulation (Needleman, 1999; Johnstone & Dallos, 2015). It is therefore possible that formulation is another component necessary for good therapy influenced by the therapeutic relationship.

Unlike a diagnosis of 'schizophrenia' or psychosis, formulation is grounded on the belief that, "however unusual or overwhelming the nature of that distress, at some level it all makes sense" (DCP, 2017, p. 28). Using Grounded Theory (GT) analysis, Dilks, Tasker and Wren (2010) found that 'making sense' of psychotic experiences was an important process in recovery from psychosis. For some, formulation may be a less stigmatising way of making sense of their difficulties than diagnosis (DCP, 2017).

Studies have explored the use of formulation with service users experiencing a range of mental health difficulties including anxiety and depression (Kahlon, Neal & Patterson, 2014; Redhead, Johnstone & Nightingale, 2015), 'difficult to help clients' (Evans & Parry, 1996) and psychosis (Chadwick, Williams & Mackenzie, 2003; Pain,

Chadwick & Abba, 2008). The findings from qualitative studies suggest that service users experienced both positive and negative emotions as a result of formulation (Kahlon et al., 2014; Redhead et al., 2015; Chadwick et al., 2003). Some service users reported that formulation had a considerable impact on their lives (Kahlon et al., 2014; Redhead et al., 2015), including supporting them to move forward from their difficulties (Redhead et al., 2015).

Research exploring the use of formulation in therapy for psychosis is in its early stages and has so far focused on service user reactions to the sharing of CBT based formulations (Chadwick et al., 2003; Pain et al., 2008). Initial research exploring the use of formulation in psychosis has suggested that service users feel ambivalent about formulation (Pain et al., 2008). As well as finding formulations reassuring, encouraging and helpful, service users have also experienced them as upsetting, frightening, saddening, worrying and overwhelming (Chadwick et al., 2003). Further, a content analysis of 13 service users' experience of formulation in therapy for psychosis suggested that individuals' reactions to receiving a formulation were complex and involved contrasting cognitive and emotional reactions which changed over time (Pain et al., 2008).

More research is needed to explore service users' reactions to formulation, the psychological processes that may occur as a result, and its connections with the therapeutic relationship. Research using qualitative methods suited to investigating psychosocial processes such as GT would be most suited to this area (Pain et al., 2008). Grounded Theory can be used to generate theory on under conceptualised social-psychological processes and activities (Willig, 2001), such as the current topic.

Rationale and Objectives

Research focusing on the use of formulations in therapy for psychosis is limited (Pain et al., 2008; Chadwick et al., 2003). Little is known about the psychological and behavioural processes that occur in response to the sharing of a formulation. It is for this reason the current study aimed to explore how service users experience and make use of formulations during therapy for psychosis. A GT model will be developed to describe the resulting processes to inform research and clinical practice. The following research questions were developed to guide the study:

- In what ways does the sharing of a written formulation help service users make sense of their experiences?

- How does the sharing of a formulation influence behaviour inside and outside of the therapy room?

- How does the sharing of a formulation influence the therapeutic relationship?

- In what way does the therapeutic relationship influence how a formulation is viewed and acted upon?

Method

Design

A qualitative design was utilised in which service users and psychologists took part in semi-structured interviews. Interviews were conducted, transcribed and analysed by the author. Grounded Theory methodology from a critical realist position was used to analyse the data. Data from 10 service users and two psychologists with experience of using formulation during individual therapy was triangulated (Creswell, 2007) with the data provided by service users with experiences of verbal

formulations within a group setting. Triangulation is a procedure used to "accurately increase fidelity of interpretation of data by using multiple methods of data collection" (Creswell, 2007).

Participants

Two psychologists and 11 service users were interviewed (Table 1). Service users were eligible to take part in the study if they were aged 18 or over, able to provide informed consent, fluent in English, and currently in or had completed individual therapy within the previous year.

Due to difficulties with recruitment, but also with the intention to triangulate experiences of formulation, participation was opened up to individuals who had experience of group or family therapy for psychosis. As part of individual therapy, psychologists must have shared a written or diagrammatic formulation with service users. Alternatively, where service users with experience of group or family therapy were eligible to take part, the service user must have been part of discussions exploring different psychological understandings of their psychotic experiences as part of these interventions. A written formulation may or may not have been shared in these circumstances.

Service users were excluded from taking part if they were experiencing a serious deterioration in their mental health, including experiencing suicidal ideation or thoughts of harm to themselves or others. In the second phase of the study, therapists with experience of formulating with clients during therapy for psychosis were invited to take part in the study as, based on the analysis of the data to this point, it was felt this would enrich the emerging GT.

Overall 13 interviews were undertaken, ten service users were interviewed regarding their experience of formulation during individual therapy, of which two also reflected on their previous experience of group therapy. One participant was interviewed regarding their experience of group therapy only, though he also reflected on his previous individual therapy (Table 1). Finally, two psychologists were interviewed regarding their experiences of formulation during individual therapy (Table 2). Further information on service user participants is given in Appendix 2.

Table 1. Service user participant clinical and demographic characteristics.

Service User (Pseudonyms)	Gender	Age (Range)	Ethnic Group (extracted from notes)	Therapy Mode	Therapy Length (months)	Therapy Status
Louisa	F	56-60	White/ Black (African)	Individual	3	Ongoing
April	F	61-65	White (British)	Individual	11	Ongoing
Mark	M	56-60	White (English)	Individual	10 and 9	Complete
Matthew	M	46-50	White/ Black (Caribbean)	Individual	7	Complete
Sophia	F	56-60	Black (British)	Individual	8 (most recent set of sessions)	Ongoing during "risky periods"
Edward	M	61-65	Black (Caribbean)	Group	3	Complete

*Thomas	M	51-55	White (British)	Individual	8	Complete
*Luke	M	21-25	White (British)	Individual	2	Ongoing
John	M	46-50	Black (African)	Individual	8	Ongoing
Adam	M	61-65	White/ Mixed (European)	Individual	6	Complete
Simon	M	36-40	White/ Black (African)	Individual	11	Ongoing

* Service users who also reflected on their experiences of group therapy.

Table 2. Therapist participant clinical and demographic characteristics.

Psychologist (Pseudonyms)	Gender	Age (Range)	Ethnic Group (self categorised)	Years Qualified	Psychological Approach (self categorised)
Ruth	F	36-40	White (British)	7	Integrative
Heather	F	56-60	White (British)	23	Integrative

Interview schedule

Two semi-structured interview schedules were utilised, one for service users (Appendix 3) and another for therapists (Appendix 4). Open ended questions were used to elicit rich data by allowing participants the freedom to express their views in their own terms. Service users were consulted in the development of the service user interview schedule in terms of the language used and appropriateness of the

questions. The author adapted her style and use of language with each participant to evoke further elaboration where necessary.

Procedure

Participants were recruited from London based community mental health teams from one NHS Trust. With permission from psychology leads, psychologists' were sent the service user information sheet (Appendix 5) and therapist information sheet (Appendix 6) by email. Psychologists' introduced the study to service users, gave interested service users the relevant information sheet, and also sought consent for the researcher to make contact. Psychologists' passed on the details of interested service users to the researcher by telephone.

The researcher made contact with interested service users by telephone. If service users were happy to participate, a date was arranged to obtain their written consent and conduct the interview. Service users were able to choose whether to undertake their interview in person or over the phone. If service users chose to be interviewed over the phone, two consent forms (Appendix 7) and a copy of the participant information sheet were sent in the post to them. They were required to sign both consent forms and return one to the researcher before the interview took place.

At least a week was left between the phone call and the date of the interview, to give service users time to consider their participation. The face-to-face interviews took place at the location where service users usually met with their psychologist. After each service user interview, the recruiting psychologist was asked to extract service user clinical information from electronic notes, and give consent (Appendix 8) to providing details about themselves (Appendix 9).

In the next stage of the project, psychologists who had helped to recruit service users into the study were invited to take part. Before being interviewed psychologist were provided with a therapist participant information sheet (Appendix 10) and asked to provide informed consent (Appendix 11).

Data Analysis

Data was analysed using GT from a critical realist perspective. When undertaking research from a critical realist position, researchers scrutinise the historical and social context that allow concepts such as 'psychosis' to emerge, a position shared by social constructionists (Bhaskar, 1990). A positivist perspective is in contrast to this, they argue that there exists a real and invariant external world and entities that can be measured (Pilgrim & Bentall, 1999). A critical realist position sits between social constructionism and positivism. It acknowledges that theories and methods are shaped by social forces and informed by interests yet encourages exploration of reality in a critical way (Pilgrim & Bentall, 1999).

Grounded Theory is suitable for exploring under-researched phenomena, behaviours, experiences and attitudes (Strauss & Corbin 1998). The theory is 'grounded' in the raw data, as opposed to fitting data into an existing conceptual framework, achieved through the method of 'constant comparison' (Glaser & Strauss, 1967). This includes simultaneous data collection and analysis, with the researcher moving back and forth between the data codes and categories at all coding stages. This ensures the emerging theory reflects all the data collected. The researcher followed the GT analysis stages outlined by Charmaz (2006):

- *Initial coding:* Line-by-line coding was undertaken on the first six interview transcripts (Appendix 12). Active codes, 'gerunds', were used to identify processes. The use of gerunds and "in vivo" codes (participant quotes) allowed the researcher to stay close to the data. In vivo codes can also help to preserve the subjective meaning of an individual's views and actions.

- *Focused coding:* The researcher undertook focused coding on the remaining seven interview transcripts. Initial codes that occurred more frequently or appeared to be more significant were used to explain greater sections of data. The constant comparison of the codes developed throughout all interviews ensured that the emerging codes were applicable to all participants.

- *Theoretical coding:* Focused codes were then used to develop categories and sub categories (Appendix 13 and 14). Memo writing (Appendix 15) and diagramming throughout analysis helped to explore potential relationships between codes.

Quality Assurance

To maintain the quality of the research, the author kept a reflective diary (Appendix 16), regularly communicated with two supervisors and attended a GT interest group. This aided the author's reflexivity in terms of identifying the influence of pre-existing assumptions on data analysis and interpretation. Further, the researcher used the constant comparison method and used direct quotes from participant transcripts as codes and categories, to ensure they were representative of the data (Charmaz, 2006).

Ethical Considerations

A protocol for the study and associated documentation was reviewed by two staff members at Canterbury Christ Church University, after some minor changes approval was given. Ethical and R&D approvals were also obtained from the NHS Trust involved (Appendix 17 and 18). When applying for ethical approval consideration was given to the risk of service users becoming upset during an interview and participation interfering in therapy in some way, amongst other issues. A plan was made for what the researcher would do in such circumstances. For example, it was decided that the researcher would liaise with the duty worker if participants became distressed during the interview.

Two substantial amendments were submitted throughout the study; the first was to enable the researcher to interview participants with experience of formulation during group or family therapy, and to conduct interviews via phone (Appendix 19), and the second was to enable the recruitment of therapist participants (Appendix 20). The two psychologists interviewed were also the therapists of two of the service user participants. The psychologists were not asked specifically about participants already interviewed for the study as consent for this was not sought from service user participants at the time of their interview. A summary of the completed study was sent to the Ethics and R&D departments, and all participants (Appendix 21).

Results

The transcripts of the 13 interviews were analysed to explore the psychological and behavioural processes that occur during the sharing of a formulation in the course of therapy for psychosis. Three categories and ten subcategories emerged from the data. 'Linking previous experiences with current

ways of being' and 'building the therapeutic relationship' emerged as reciprocally influential core processes underpinning formulation (Table 3).

Table 3. Categories and subcategories.

Categories	Subcategories
Linking previous experiences with current ways of being	Discussing significant life events
	Noticing patterns
	Formalising therapeutic discussions
Building the therapeutic relationship	Influencing therapist characteristics
	Influencing service user characteristics
	Working together
Making use of new understandings	Thinking differently
	Doing things differently
	Reflecting back
	Managing emotion

An emerging theoretical model was developed to detail the interactions between the categories and subcategories (Figure 1).
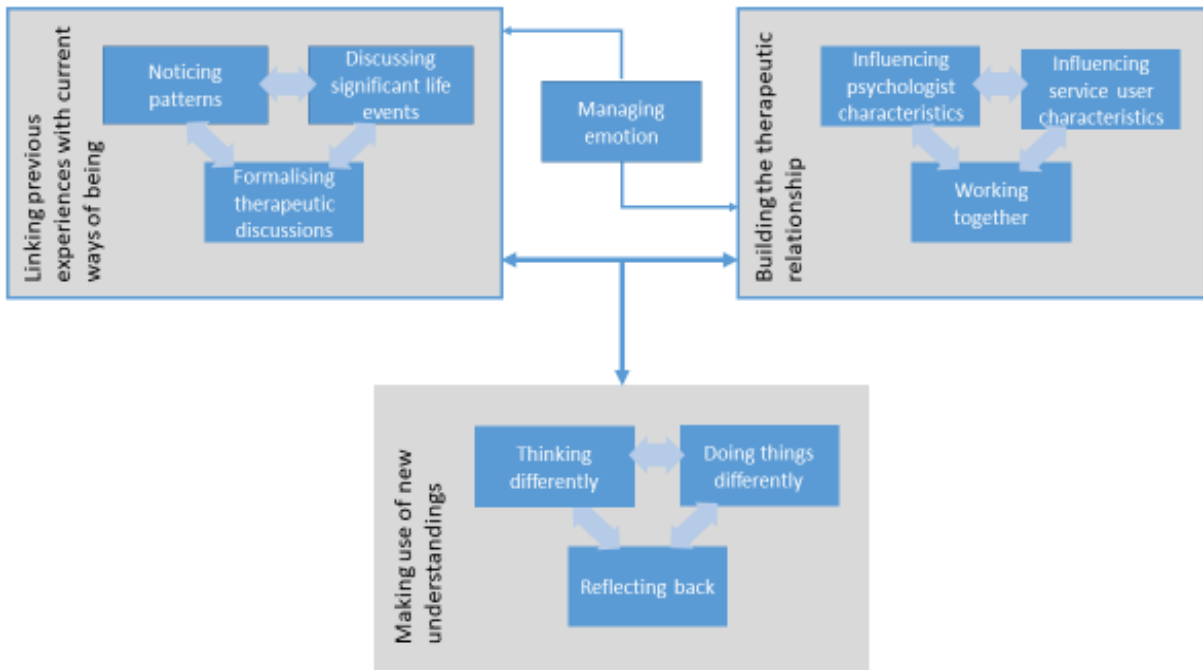
Figure 1. Emerging theoretical model of how service users experience and make use of formulations in individual therapy for psychosis.

The three categories and ten sub categories of the emerging theoretical model are now described. Throughout this section quotations are used to illustrate categorisation, **Categories** are indicated by use of bold font, and <u>subcategories</u> by underlining.

Linking Previous Experiences with Current Ways of Being

In the final model, **linking previous experiences with current ways of being** and **building the therapeutic relationship** and were defined as core processes underpinning key experiences in the sharing of a formulation. These two reciprocally influential processes appeared to be key to formulation as they enabled service users to develop new understandings, which they were able to put into

practice. This was conceptualised in the model as **making use of new understandings**.

Linking previous experiences with current ways of being involved service users discussing significant life events that may have left them more vulnerable to experiencing mental health difficulties. Service users also began to notice patterns in their current behaviour, possibly relating to their earlier experiences.

"You know with the paranoia, the psychosis, you can see that, you can see from childhood a pattern of, you know, of different psychological explanations why it probably came about" (Mark, service user).

Service users also contributed to the development of a formal document detailing their new understandings, defined in the current model as formalising therapeutic discussions. Formalising the links between these experiences by putting them into a diagram or a letter was powerful for some.

"Seeing it in black and white, people, he and others, when things are in black and white, it's much more powerful in a way, much more impactful, it stays with you, you can read it" (Ruth, psychologist).

Some service users spoke of being able to make use of the new understandings they gained through discussing significant life events and noticing patterns. For example, *Sophia (service user)* spoke about how, after noticing the vulnerable periods she experienced during the anniversaries of her past traumas, she ensured she looked after herself during these times, as did members of her

family, *"Yeah and even my grandkids say "it's your vulnerable period now nanny, so you've got to keep well".*

Discussing Significant Life Events

The process of **linking previous experiences with current ways of being** often involved discussing previous sad or traumatic life events.

"We started right at the front, from an early age, from day one sort of thing, well not from day one, up to the present day really, we went through the lot" (Adam, service user).

Service users noted a number of <u>influencing therapist characteristics</u> that enabled them to open up and speak to their therapist about difficult past experiences.

"She seemed fairly open and honest herself, she was quite clear about why she was doing things, there wasn't much mystery about it, I found myself talking to her about things I wouldn't normally talk about to anyone else" (Thomas, service user).

Noticing Patterns

<u>Noticing patterns</u> within the lives of service users happened in different ways for service users and psychologists. One service user spoke about how her daughter had helped her to notice times she was more vulnerable to experiencing a decline in her mental health.

"My daughter noticed it, she noticed I got down in May, that's when my dad died, and in October, that's when my mum died" (Sophia, service user).

Often the process of <u>noticing patterns</u> occurred in therapeutic discussions whilst <u>discussing significant life events.</u> This contributed to the ongoing development of the formulation.

"It was quite positive spotting the patterns of the way things happened throughout my life" (Thomas, service user).

For psychologists, noticing the patterns in their client's lives started early, for example, from a referral or whilst reading their client's electronic notes before meeting them.

"Before I see a client, I read all their notes to begin formulating, I see what their patterns are and that helps with formulating" (Ruth, psychologist).

<u>Formalising Therapeutic Discussions</u>

The development of a written formulation appeared to formalise what had been discussed in therapeutic sessions. In most cases this process appeared to make explicit what was implicitly known by service users, *"I think of it just as summary about what we had been talking about" (April, service user).* For some, the existence of and potential public nature of a product representing aspects of their personal experience appeared significant. For example, the service user described in the quote below experienced child sexual abuse but his life account had

previously not been believed by others, the process of having his account on paper was therefore significant and possibly felt validating.

"He said that he didn't want to make any changes to it [written formulation], he wanted it there as a kind of witness testimony to what he'd been through" (Ruth, psychologist).

For others, it appeared to be the capturing of private subjective experience in a product permanently reviewable by the self that felt powerful.

"It was quite emotional to erm, because it's basically your relationship you have with yourself, you know? To, erm yeah so it was, it threw up a lot of feelings" (Mark, service user)

A number of individuals preferred letters because they were typed and therefore seemed more important.

"It [formulation letter] seemed you know more important like, when you see illustrations [diagrams], they are just drawings" (Simon, service user).

Service users expressed a preference for either letters or diagrams for a number of other reasons. One service user said he preferred his letter because it contained *"more information" (Matthew, service user).* Another service user favoured her diagram formulation as she preferred to *"take information in visually" (Louisa, service user).*

A small number of individuals found their formulations difficult to understand, for example, *Luke (service user)* said his formulation *"went over his head". John (service user)* found his formulation difficult to comprehend as his first language was not English.

"No the only thing is, when he put it in the diagram, I told him it was quite complex to read, you know?" (John, service user).

In all the interviews it was the therapist who wrote out or typed up the diagrams and letters. Diagrams were usually drafted whilst a psychologist and service user spoke. Therapeutic letters appeared to be shared later on in therapy and were often read to clients in sessions.

"Lucy [psychologist] usually makes up a diagram while we're talking and we relate to it (Louisa, service user).

Psychologists and service users worked together to adjust the letters and diagrams until service users were happy that it reflected their experience. A number of service users felt their written formulation formally marked an *"accomplishment" (Sophia, service user)* or a *"new start" (Adam, service user)* in their lives*.

Building the Therapeutic Relationship

Building the therapeutic relationship involved therapists and their clients coming together to develop a relationship where service users felt comfortable sharing their personal experiences as part of **linking previous experiences with current ways of being.**

"We spoke about things I'd never spoke about with anyone else" (Adam, service user).

Some service users felt the therapeutic relationship *"deepen"* (Thomas, *service user)* as a result of engaging with the process of **linking previous experiences with current ways of being** with their therapist.

Researcher: "How did it make you feel towards her?" Service user: "That I could trust her, I felt I could open up more" (Sophia, service user).

However, a good therapeutic relationship in itself did not always mean that participants were able to connect their experiences. *Edward (service user),* who was interviewed regarding his experience of group therapy, reflected on the positive relationship he had with his previous individual therapist. However, it was not until he attended the group and met other people with similar experiences that he was able to begin questioning where his voices were coming from.

"The individual sessions with Peter, we had a friendship, we had a bonding, I believe we did, but the group therapy, that was completely different that was because it was so many individuals' stories that I was listening to, but with the doctor it was just singularly mine and I genuinely thought that I was the only one going down to [CMHT base]". *(Edward, service user).*

<u>Influencing Therapist Characteristics</u>

A number of influencing service user and therapist characteristics contributed to **building the therapeutic relationship.** From a service user point of view, the demographics of their therapist were important for various reasons. Due to a history of child sexual abuse, for example, it was important for one participant to have a female therapist *(Adam, service user)*. Another participant said the age and gender of her psychologist were important to her.

"He [previous psychologist] was the same age as my daughter, he was about 36 then, my daughter's 34, I couldn't open up about certain things because he was a man and he was young" (Sophia, service user).

Some service users expressed that it was their therapist's *"personality" (Mark, Sophia, service user*s) that aided the development of their relationship. Some found it difficult to describe what enabled them to speak to their psychologist, *"I could just trust her, I can't put my finger on why" (Luke, service user).* Other service users described their therapists as *"patient and persistent" (Mark, service user)*, "*non-judgemental" (Sophia, service user)* and *"professional but not too stiff" (Thomas, service user).*

<u>Influencing Service User Characteristics</u>

A service user's current psychotic experiences and levels of distress were highlighted by both psychologists and service users as factors that could influence **building the therapeutic relationship** and an individual's capacity to engage with the process of **linking previous experiences with current ways of being.**

Researcher: "Do you feel like your formulation was developed in partnership with you?" Service user: "As much as she was able to, you know, I was quite psychotic at the time" (Mark, service user).

Psychologists suggested that there were particular characteristics that enabled their clients to engage in formulation. One psychologist felt that it was helpful if service users were able to *"exhibit some level of control"* over their psychosis *(Ruth, psychologist).* Both psychologists felt that clients who were *"less avoidant"* and more *"resilient"* appeared more readily able to start building a relationship with them and engage in the formulation process.

"I suppose it was the things about him, he was cognitively able, he's quite resilient, he was able to face difficult things with me" (Ruth, psychologist).

Working Together

Working together appeared to be important to service users and was conceptualised in the model as part **of building the therapeutic relationship**.

"It was good, it was working together, exploring things then her going away to type it up" (Thomas, service user).

Some service users found it difficult to describe how their relationships with their therapist felt collaborative, but all the service users interviewed felt that they worked with their psychologist to develop their formulation.

"Ruth let me have my say, she didn't put words into my mouth, she let me

have my say and that was good" (Mark, service user).

Some service users mentioned how key activities made formulation feel collaborative.

"I think it was the words she used, the information she had, the plan we made"

(Adam, service user).

Psychologists said they worked hard to ensure formulation was undertaken collaboratively with their clients and described how they did this.

"I say something like, "let's map out what you're telling me, let's take a look at

it together and see if it makes sense", I see that as laying the cards on the table, I

see it as co-thinking with someone" (Heather, psychologist).

Making Use of New Understandings

Service users spoke about how they came to understand their psychotic experiences differently as a consequence of formulation. This for many resulted in changes in thinking and behaving.

"I know now that they are a voice in my head now, if it happened again I would

get help" (Adam, service user).

Some service users spoke about how the formulation helped them to make sense of their experiences.

It helped me make sense of it [psychosis], so when I look at it [formulation

diagram] I think 'oh gosh that makes sense now', it helps a lot it does" (Simon,

service user).

Thinking Differently

Service users spoke about changes in how they were thinking generally, *"I'm*

looking at things more objectively and thinking twice about things" (Louisa, service

user). Service users also spoke about changes in how they were interpreting the

world and people around them as a result of using the products of formulation.

"Well looking at the diagrams reminds me of how people think, how I think

people think, it helps me to differentiate from what I think people are thinking from

what I worry they are thinking about, does that make sense? It helps a lot" (Simon,

service user).

Doing Things Differently

Many service users also made a number of behavioural changes which they

associated with the formulation process.

"Well before I found it hard to get on with people because I was away like from social

things, but now I feel better because I got into work and stuff like that, it [formulation]

has helped me to act more better, than like I used to, I don't let things get in my way

quite as much" (Simon, service user).

Some service users described this as a slow process. For example, one service use described how she first needed time to consolidate her new understandings but anticipated making behavioural changes.

"I'm being mindful of it [written formulation], but I haven't quite trusted it enough to go forward yet" (Louisa, service user).

For others behavioural changes appeared to have occurred sooner.

"One day he just turned up and said "I've been down [Name of charity shop] and I've got a job there next week, so I presume it was that, that helped him to feel less paranoid about things" (Heather, psychologist).

Reflecting Back

Many service users anticipated or had already begun reflecting back on their formulation. The reasons for this differed in service users. A few individuals kept their formulations close by to ensure they were easily accessible.

"I've got them [formulation diagrams] on my fridge with magnets so that I can look at them" (Louisa, service user).

Some individuals described their formulations as resources to draw on in the future. One individual hoped that he would look back on his formulation and see progress.

"One day when I'm working and things are going well, I'll pick em out, read em and think 'wow I've come a long way" (Matthew, service user).

Others anticipated that the written formulation would serve as a reminder of the past, rather than something they might compare their current situation with.

"I think they'll probably change [feelings], it [formulation diagram] will become like looking at an old photograph I think, a reminiscent tool, rather than a progress tool, I think" (Thomas, service user).

Most individuals interviewed felt that they would reflect privately on their formulations, rather than share it with others. For some this appeared to be related to stigma regarding mental health difficulties.

"Well basically I'll show it to doctors but I don't want to show it to others because I just don't want them thinking about me or seeing me in a different way" (Simon, service user).

Others spoke about particular pieces of information being in their formulation that they were keen not to share with others as they anticipated an emotional reaction. For example, *Louisa (service user)* said *"I don't want to worry them or upset them"* when asked if she might share her formulation with her family.

"But because it was in there [a particularly private piece of information], I didn't show my mum the letter because it was a bit more private to me you see? I thought its private to me, the things I been through that I didn't want my mum to know, because she's get like sort of judgmental" (Matthew, service user).

However, some individuals spoke about sharing their formulations with others and the positive impact on their relationships as a consequence, *"I think it made us more understandable to each other and able to talk about other stuff" (Adam, service user).*

Managing Emotion

Managing emotion emerged as an underpinning subcategory that contributed to, **linking previous experiences with current ways of being** and **building the therapeutic relationship.** This sub category describes how service users experienced and dealt with the emotions they experienced as a consequence of engaging in the core processes. For example, service users described feeling *"vulnerable" (Louisa, service user)* and becoming upset when discussing significant life events.

"I remember when I was going through the events, it was hard, it was really hard, and I would dissolve into tears" (Sophia, service user).

The same service user quoted above felt that speaking about the numerous losses she had experienced in her life when developing her formulation with her psychologist had helped her to *"process"* them.

Service users also described experiencing an array of emotions relating to seeing their written formulation. Some individuals said they felt *"surprised and reassured", "sad and vulnerable", "understood", "relieved", "elation", and "confused" (Mark, Louisa, Matthew, Adam, Simon, John, service users, respectively).* A small number of service users spoke specifically of experiencing both positive and negative emotions.

> *"I think it was a mix of emotions, some were sad, some were happy"*
>
> *(Matthew, service user).*

Psychologists also reflected on the diverse emotions their clients appeared to experience after the sharing of their written formulation including; *"overwhelmed", "surprised", "understood"* and *"anger" (Ruth, psychologist),* and *"relieved" and "anger" (Heather, psychologist).*

Both psychologist's spoke about clients who had been angered by the sharing of their formulations. One psychologist described how her client became angry after she made an interpretation relating to his alcohol consumption. In hindsight, she felt that her client was "avoidant" and may have benefitted from a gentler evolving formulation *(Ruth, psychologist).* Another psychologist spoke about how as a trainee she developed a detailed formulation outside of a session and presented it to her client. Her client's reaction was one of anger. She reflected on what she learnt from this.

"I realised what I hadn't done was really kind of agree it with her and she didn't feel part of the process, I was being a good trainee and getting it right technically but she was somewhere else completely, so I really remembered that, and after I've never produced huge formulations again" (Heather, psychologist).

Summary of Grounded Theory Model

Linking previous experiences with current ways of being and **building the therapeutic relationship** were defined as a core processes in formulation. The former process required service users to discuss significant life events, to notice patterns in their lives and to collaboratively formalise therapeutic discussions. Service users experienced and processed a range of emotional reactions (managing emotions) to discussing significant life events, and formalising therapeutic discussions in a written format. **The building of a therapeutic relationship** was an ongoing process which influenced - and was influenced by - the process of **linking previous experiences with current ways of being**. Some individuals experienced a *"deepening"* of the therapeutic relationship as a result of engaging with **linking previous experiences with current ways of being** and managing the emotions (managing emotions) produced by this process in the context of the therapeutic relationship. Having a good therapeutic relationship enabled service users to feel comfortable to explore the links between their past and current selves. **Building the therapeutic relationship** was also influenced by a number of service user and therapist characteristics. Many service users were able to move on to make use of their new understandings, describing psychological and behavioural changes arising from them. Some individuals anticipated or had already begun reflecting back on their written formulations.

Discussion

The current study sought to build a theoretical model to describe the psychological and behavioural processes that occur during the sharing of a formulation in individual therapy for psychosis. An emerging GT model including three categories and ten sub categories was developed based on a data set of 13 interviews. 'Linking previous experiences with current ways of being' and 'building the therapeutic relationship' were defined as core categories. Other important processes emerged from the data including 'making use of new understandings'.

A number of the findings from the current study were consistent with research exploring the use of formulation with individuals experiencing a range of mental health difficulties. This included the finding that the sharing of a formulation resulted in a "deepening" of the therapeutic relationship (Nattrass, Kellet, Hardy & Ricketts, 2014). However, this finding has not been evident in all studies. Service users described as 'difficult to treat', who took part in Evans and Parry's (1996) study, said that the sharing of a cognitive analytic therapy formulation enhanced their trust in their therapists. However, the quantitative outcome measures used in the study did not evidence any change in how the relationship was perceived. Further, service user perception of the therapeutic relationship did not change in Chadwick et al's (2003) study, although they did find that therapists' perceptions of the therapeutic relationship improved.

In the present study, service users experienced both positive and negative emotions after the sharing of a formulation. This is in line with previous research in the area (Redhead et al., 2006; Chadwick et al 2003), along with the finding that

service users often experienced contrasting emotions (Kahlon et al., 2014; Pain et al., 2008). Service users who took part in the current study also said their formulation helped them to move on and make use of new understandings. Similarly, Redhead et al. (2006), who interviewed service users about their experience of formulation after undertaking CBT for anxiety, found that formulation helped service users to move forwards from their difficulties.

Service users in the current study had already begun to - or anticipated that they would - reflect back on their formulation. Some participants saw their written formulation as a resource for the future, which again replicates previous research findings (Pain et al., 2008). However, more participants in Pain et al's (2008) study had already shared, or were anticipating sharing their formulation with others than in the current study. The samples of the two studies appeared similar, but given their small size, it is possible that individual preferences accounted for this discrepancy. The finding that some service users preferred to keep their formulations private due to concerns that others may become upset by them or due to perceptions of stigma is in line with previous literature (Read & Magliano, 2012). The recovery literature refers to people developing personal understandings that can be shared with others, implying the importance of others' perception of formulations or accounts of distress (Read & Magliano, 2012).

The therapeutic relationship has been highlighted as an important ingredient for effective therapy (Horvath, 2005). It is no surprise that this emerged from the current analysis as a core process in formulation. 'Building the therapeutic relationship' emerged as an ongoing process which both influenced and was influenced by 'linking previous experiences with current ways of being'. However, consistent with previous findings (Horvath, 2006), the therapeutic relationship alone

did not appear sufficient for service users to develop new understandings or make changes to their lives. For example, one participant spoke of having a positive relationship with his psychologist but how it was not until he attended a psychosis group he began to understand his experiences differently. However, conclusions are tentative since this this was only one service user's experience.

The findings discussed so far suggest that there may be experiences that occur as a result of sharing a formulation which are not unique to individuals experiencing psychosis. These include; experiencing a range of emotions (Redhead et al., 2006), experiencing contrasting emotions (Kahlon et al., 2014), feeling a deepening in the therapeutic relationship (Nattrass et al., 2014) and helping service users to move on from their difficulties (Redhead et al., 2006). The finding that service users anticipate - or had already begun - reflecting back on their formulations is so far unique to research exploring formulation in psychosis (Pain et al., 2008).

The proposition that formulations shared with service users in therapy for psychosis should evolve from simple, basic to detailed (Kinderman & Lobban 2000) was reinforced by the current study. One psychologist spoke of overwhelming her client with a complex formulation developed outside of a session. Service users also spoke of sometimes feeling confused by their written formulations. It is possible that evolving formulations, taking service user characteristics into account, may enable a greater sense of collaboration and understanding for service users.

A number of findings in the current study have not been reported elsewhere. This may be due to the limited research exploring formulation at present and the type of analysis used in research conducted so far. To the author's knowledge, the present study is the first to use GT to explore formulation, enabling an in depth exploration of the processes that occur. Novel findings from the current study

include identifying the core processes of 'linking previous experiences with current ways of being' and 'building the therapeutic relationship'. This study is also the first to observe how the former process requires service users to discuss significant life events and notice patterns in their lives, before 'formalising therapeutic discussions' in a written format. The current study also appears to be the first to suggest how key processes in formulation may be related.

Finally, the current study also seems to be the first to suggest that service users perceive collaboration in formulation as important. Collaborative formulation has been emphasised in the CBT literature (Johnstone & Dallos, 2015; Kinderman & Lobban, 2000) and UK clinical psychology professional literature (DCP, 2011) though the current evidence base appears to focus on the benefits of collaborative formulation for therapists. For example, Pain et al. (2008) found that collaborative formulation helps aid clinicians' understanding of their clients, however the importance of collaboration for the service user in this process has not been reported until now.

Limitations

The conclusions drawn from the current study are limited by the small sample utilized, the theory presented in this paper offers an emerging GT only. All service users were recruited from community mental health teams. The findings of the current study may not apply to other groups, for example, individuals experiencing first episode psychosis. Most participants were coming to the end of therapy or had completed therapy within the previous year.   Further, data on the amount of time elapsed since formulations were shared was not collected. Therefore it is unclear what long term processes occur after the sharing of a written formulation and

whether this changes over time. All of the service users who took part in the current study had experienced CBT based formulation. Although some therapists did draw from other models to inform their understanding of clients, it is unclear whether the processes identified are unique to CBT based formulations. Finally, at times in the interviews it became unclear whether participants were answering questions based on their experiences of formulation or their experience of the overall therapy process. Although, the researcher sought clarification from the service users when this was noted, separating formulation from therapy could be argued to be an artificial distinction and it must be considered to what degree the emerging model represents experiences of formulation specifically.

Clinical Implications

The findings of the current study have a number of clinical implications. The findings that service users perceive collaboration in formulation as important and that they can experience the process as confusing suggests that formulations should be developed collaboratively and presented progressively to service users to ensure understanding. Different service users expressed preferences for their formulation to be developed with them in the form of a letter or diagram, when working with service users such preferences should be taken into account. Therapist characteristics were seen as important to service users in the current study, therefore therapists may wish to explore any potential hindering features that may impede on the building of a therapeutic relationship. The current study suggests that it is also important to consider service user characteristics before deciding to share a written formulation, such as severity of experiences and distress, cognitive ability and personality style. Formulation appears to be an emotional process for service users, care and attention to the emotions that arise as a result should be given.

Research Implications

The current study offers an emerging GT model only. Further data collection would be necessary to reach theoretical saturation to extend this research and make firmer conclusions (Glaser & Straus, 1967). Further research exploring the long term processes that occur after the sharing of a written formulation, the differing impact of sharing diagrams and letters, as well as sharing formulations developed from other psychological orientations is necessary. This may further define the processes identified as being involved in formulation so far and how they relate to each other. Future research may also explore whether individuals with experience of first time psychosis experience formulation in the same way. It remains unclear how important it is for service users to receive a written document as part of the formulation process. This area also requires further exploration.

Conclusion

To the author's knowledge, this was the first study to develop a model of how service users experience and make use of written formulations during therapy for psychosis. A critical realist GT analysis of 13 interviews with service users and psychologists suggested that 'linking previous experiences with current ways of being' and 'building the therapeutic relationship' were core reciprocally influential processes in the sharing of a formulation. Participants who undertook this process were often able to move on to 'making use of new understandings'. Further research is necessary to elaborate our understanding of formulation given the importance placed on it in UK clinical psychology.

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Section C: Appendices of Supporting Material

Appendix 1: Summary of Each Study Included in the Literature Review

Researchers	Aims	Sample	Design	Method	Measures	Outcomes
Seikkula, Alakare & Aaltonen (2001a)	To describe the Open Dialogue (OD) approach using a case study.	One participant, described as experiencing 'psychosis'.	Case study	Siiri was interviewed two and five years post intervention.	N/A	• Two years after treatment Siiri did not express any 'psychotic' ideas. • Five years after she had not experienced any 'psychotic symptoms' during the previous three years.
Gromer (2012)	To combine research studies exploring the effectiveness of the OD approach to treating 'psychosis'.	The number of participants included in the seven studies reviewed ranged from 18-139.	Systematic review	A systematic review of the literature was undertaken. Seven studies were identified and included in the review.	N/A	• Outcomes from the OD approach were equal or superior to standard care. • Newer incarnations of OD were also equal or superior to older incarnations of OD.
Seikkula, Alakare, Aaltonen, Holma, Rasinkangas & Lehtinen (2003)	To compare the effectiveness of OD with previous incarnations of OD and standard care in treating 'psychosis'.	59 participants described as experiencing symptoms of first episode 'psychosis'.	Longitudinal design	Participants from the initial phrase of the OD the approach (n = 22) were compared with participants from the later stage of the OD	Participants fulfilled the Diagnosis Statistical Manual (DSM-III-R) criteria for Schizophrenia type 'psychosis'. Brief Psychiatric Ratings Scale (BPRS).	• Hospitalisations in the older incarnation of OD group were shorter than for participants within the newer version. • However, participants in the newer incarnation group spent fewer

				approach (n = 23).The two groups were also compared with participants diagnosed with 'schizophrenia' who were hospitalised and received treatment as usual (n = 14). Participants completed outcome measures before the intervention and two years later.	The Global Assessment of Function Scale (GAF). The Strauss and Carpenter (1972) instrument.	days in hospital, had more family meetings organised and took less neuroleptic medication. • Also, participants in the newer incarnation group experienced fewer relapses, residual 'psychotic symptoms', and they were more likely to be in employment.
Aaltonen , Seikkula & Lehtinen (2011)	To compare incidence of first contact 'psychoses' before and after the implementation of the OD system.	150 participants described as experiencing 'psychosis'.	Historical control design	Changes in the incidence of first contact 'psychoses' in two cities of Finland were compared with the incidence in the five-year periods before and after the OD system was fully	Participants fulfilled the Diagnosis Statistical Manual (DSM-III-R or DSM-IV-R) criteria for 'psychosis'.	• The occurrence of diagnosed 'schizophrenia' decreased. • Episodes of brief 'psychotic' reactions increased. • The occurrence of 'schizophreniform psychoses' remained the same. • The number of new long-stay

				established.		'schizophrenic' hospital 'patients' fell to zero.
Seikkula, Aaltonen, Alakare , Haarakangas , Keränen & Lehtinen (2006)	To evaluate the effectiveness of an OD approach for individuals experiencing first episode 'psychosis'.	59 participants described as experiencing 'psychosis'.	Longitudin al design	Participants from the initial phrase of the OD approach (n = 33) were compared with participants from the later stage of the approach (n = 42). Participants completed outcome measures and key psychosocial outcome measures were collected pre intervention and at a two and five year follow up.	Participants fulfilled the Diagnosis Statistical Manual (DSM-III-R) criteria for Schizophrenia type 'psychosis'. Brief Psychiatric Ratings Scale (BPRS). The Global Assessment of Function Scale (GAF). The Strauss and Carpenter (1972) instrument.	• In the recent incarnation the OD group, the mean duration of untreated 'psychosis' had declined. • Participants in that group also experienced fewer days in hospital and undertook fewer family meetings. • No significant differences emerged in the five year post treatment outcomes. • In the new OD incarnation group, 82% did not have any residual 'psychotic symptoms', 86% had returned to their studies or a full-time job, and 14% were on disability allowance.

						• 17% had relapsed during the first two years and 19% during the preceding three years. • 29% had used neuroleptic medication in some phase of the treatment.
Seikkula , Alakare & Aaltonen (2011)	To evaluate the effectiveness of an OD approach for individuals experiencing first episode 'psychosis'.	93 participants described as experiencing 'psychosis'.	Longitudin al design	Participants from the initial phrase of OD approach (n = 33) (1992-1993) were compared with participants from the later stage (n = 42) (1994-1997 group). Both were also compared with participants that experienced the OD approach later still (n = 18) (2003-2005).	Participants fulfilled the Diagnosis Statistical Manual (DSM-III-R or DSM-IV) criteria for 'psychosis'. Brief Psychiatric Ratings Scale (BPRS). The Global Assessment of Function Scale (GAF). The Strauss and Carpenter (1972) instrument.	• In the most recent incarnation of the OD approach, diagnosis of 'schizophrenia' decreased. • Also, the mean age of those diagnosed with 'schizophrenia' was significantly lower. • Length of untreated 'psychosis' shortened to three weeks and the outcomes remained as good as for the first two periods.
Seikkula, Alakare &	To evaluate the effectiveness of	78 participants diagnosed with	Mixed methods	Participants were divided	Participants fulfilled the Diagnosis	• Differences in the diagnosis and

Aaltonen (2001b)	an OD approach in good and poor outcome first episode 'psychosis' cases.	'psychosis'.		into two groups; good outcomes (n = 61) and poor outcomes (n = 17). Participants completed outcome measures and interviews before the intervention. They also completed a post treatment interview two years later.	Statistical Manual (DSM-III-R) criteria for Schizophrenia type 'psychosis'. Brief Psychiatric Ratings Scale (BPRS). The Global Assessment of Function Scale (GAF). The Strauss and Carpenter (1972) instrument.	length of 'psychotic symptoms', as well as in treatment processes in the two groups were observed. • Avoiding hospitalisation and using anxiolytics instead of neuroleptics was associated with a good outcome. • Overall, data on the OD approach were encouraging, as only 22% were identified as poor outcome cases.
Seikkula (2002)	To explore the quality of the dialogue in the treatment meetings of good and poor outcome first episode 'psychosis' participants.	20 participants described as experiencing symptoms of 'psychosis'.	Qualitative	Participants were divided into two groups; good outcomes (n = 61) and poor outcomes (n = 17). Participants were matched resulting in ten pairs. A dialogical sequence	N/A	• In good outcomes, the participants had both interactional and semantic dominance and the dialogue took place in symbolic language and in a dialogical form. • Further, in the first meeting the team responded to the participants words

					analysis was conducted comparing the two group's treatment meetings.		in a dialogical way.
Bargenquast & Schweitzer (2014)	To explore the effectiveness of Metacognitive Narrative Psychotherapy (MNP).	11 participants diagnosed with 'schizophrenia'.	Mixed Method	Participants undertook a 12–18 month trial of MNP. Participants completed interview based and self-report measures on general and treatment specific outcomes before, in the middle of, and after therapy.	Psychotic symptoms and psychotic disorders section of the Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I). Recovery Assessment Scale (RAS). Brief Psychiatric Rating Scale (BPRS). Indiana Psychiatric Illness Interview (IPII). Narrative Coherence Rating Scale (NCRS). Scale to Assess	• After therapy, participants' scores on RAS and MAS-SR significantly improved, with medium to large effect sizes. • Case study evidence: For some participants, symptom severity reduced on the BPRS, and narrative coherence and complexity increased on the NCRS and STAND.

					Narrative Development (STAND). Metacognitive Assessment Scale-Self Reflectivity (MAS-SR).	
Greben, Schweitzer & Bargenquast (2014)	To explore whether narrative reflexivity is a mechanism of therapeutic change in MNP.	Nine participants diagnosed with 'schizophrenia'.	Case study	Participants undertook a 12–18 month trial of metacognitive narrative psychotherapy. Recovery and narrative reflexivity were measured in the first, middle and last therapy session.	Psychotic symptoms and psychotic disorders section of the Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I). Narrative Processes Coding System (NPCS). Recovery Assessment Scale (RAS).	• Case study evidence: Seven participants demonstrated an increase on NPCS and RAS over the course of treatment. • For six participants, an overall increase on the RAS was associated with an increase on NPCS.
Schweitzer, Greben & Bargenquast (2017)	To explore the long term outcomes of MNP.	Eight participants diagnosed with 'schizophrenia'.	Case study	Participants undertook a 12–18 month trial of metacognitive narrative psychotherapy. Participants completed	Psychotic symptoms and psychotic 'disorders' section of the Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I).	• Case study evidence: Seven participants demonstrated improvement on one or more of the outcome measures.

				interview based and self-report measures on general and treatment specific outcomes before therapy and two years (22–30 months) after completion of therapy.	Recovery Assessment Scale (RAS). Brief Psychiatric Rating Scale-Extended (BPRS-E). Indiana Psychiatric Illness Interview (IPII). Metacognitive Assessment Scale-Self Reflectivity (MAS-SR).	• Four participants demonstrated an increase on the RAS. • Six participants demonstrated an improvement on the MAS-SR. • One participants' score on the MAS-SR decreased. • One participants' score on the RAS decreased.
Mehl-Madrona, Jul & Mainguy (2014)	To explore the effectiveness of transpersonal and narrative psychotherapy for 'psychosis' in individuals keen to reduce or eliminate medication.	51 participants described as experiencing 'psychosis'. Participants were required to have spent at least six months undertaking therapy and be keen to reduce or eliminate	Case series design	Participants took part in a narrative interview to determine 'symptoms'. Participants completed outcome measures before therapy and at quarterly intervals after.	The Positive and Negative Symptom Scale (PANSS). Brief Psychiatric Rating Scale (BPRS). BASIS-24 The Clinical Global Inventory (CGI). The Revised	• After therapy 38 participants managed psychosis without the use of medication (or with very occasional medication as sleeping assistance). • Another nine participants managed well on low dose medications.

					Behaviour and Symptom Identification Scale (RBSIS). The Hamilton Depression Rating Scale (HAM-D). The Montgomery-Åsberg Depression Rating Scale (MADRS).	• Three individuals required higher levels of medication. • One person became progressively worse and was involuntarily placed in the State Hospital.
Hamm & Leonhardt (2016)	To describe the effectiveness of integrative psychotherapy with a focus on interpersonal processes, metacognition and personal narrative.	One participant diagnosed with 'schizophrenia'.	Case study	Paper described the early stages and progress made by 'Simone' as she undertook therapy.	N/A	• Therapy was ongoing and in its early stages. • 'Symptomatically', Simone continued to experience high levels of positive and negative 'symptoms'. • However, compared to the beginning of therapy, interference from the 'symptoms' reduced enough to allow her to engage with occasional community activities.

						• 'Symptoms' also interfered markedly less in therapy sessions.
Lysaker, Davis, Eckert, Strasburger, Hunter & Buck (2005)	To explore whether measures of metacognition, narrative structure and content changed during a course of integrative psychotherapy.	One participant with a diagnosis of 'schizophrenia'.	Case study	Blind assessments of psychotherapy transcripts were conducted. Transcripts were assessed for narrative content, structure and metacognition. The assessment was conducted two times a month over a period of 32 months.	The Scale to Assess Narrative Development (STAND). Narrative Coherence Rating Scale (NCRA). The Metacognition Assessment Scale (MAS). The Positive and Negative Symptom Scale (PANSS).	• Significant changes in narrative structure, content and metacognition were found using the STAND and NCRA. • Analyses of time trends indicated that the degree of improvement in narrative structure from months four to 29 was significantly greater than the degree of improvement in narrative content on the STAND and NCRA, or on the MAS. • Themes of agency within narrative improved at a faster rate than awareness of illness on the STAND and NCRA.

Vassallo (1998)	To describe the implementation and outcomes of a narrative therapy group.	Nine participants with a history of 'psychosis'.	Case study	Paper described the process undertaken and progress made by participants who attended an 8 week narrative therapy group for two hours every other week.	N/A	• A qualitative independent evaluation of the group occurred. • Participants' said their lives had changed in a number of ways due to the group. • They had more confidence and had developed friendships.
Pain, Chadwick & Abba (2008)	To explore the effectiveness of case formulation during CBT for 'psychosis'.	13 participants diagnosed with 'schizophrenia'.	Qualitative	Participants and their therapists were interviewed two to three weeks after a written formulation had been shared. Content analysis was used to assess participants' experience of case formulation. In addition, therapists ranked seven documented	N/A	• Participants' reactions to case formulation were cognitively, behaviourally, and emotionally complex, and subject to change over time. • Participants were equally as positive as they were negative regarding the experience of formulation. For example, some participants described clear instances of

				benefits of case formulation.		• increased hopefulness while others experienced pessimism. • Therapists reported that they found the case formulation to be most useful in increasing their understanding of their participants.
Chadwick, Williams & Mackenzie (2003)	Experiment 1: To explore the impact of CBT case formulation on perception of the therapeutic relationship. Experiment 2: To assess the impact of CBT case formulation on strength of delusional and self-evaluative beliefs. Both experiments	Experiment 1: 13 participants diagnosed with 'schizophrenia'. Experiment 2: Four participants diagnosed with 'schizophrenia'.	Mixed method	Experiment 1: Participants completed outcome measures at four time points (before therapy, before case formulation, at the point of case formulation and after case formulation). Case formulation was developed over four sessions. It comprised a letter and a diagram. 11 of the participants	Experiment 1: The client and therapist versions of the Helping Alliance Questionnaire (HAq). The Hospital Anxiety and Depression Scale (HADS). Experiment 2: The HADS The psychotic symptom rating scales (PSYRATS). Beliefs About	• Experiment 1: Case formulation had no impact on participants' HAq score or HADS scores. • Therapists' HAq score increased. • Qualitative feedback from the interviews suggested that case formulation was viewed both helpful and unhelpful by different participants. For example, nine participants said they felt it had enhanced their understanding of

| | also assessed the impact of case formulation on symptoms of anxiety and depression. | | | also took part in semi-structured interviews after case formulation.

Experiment 2: Following a minimum of five baseline data points, three interventions were introduced in sequential phrases of at least four sessions; case formulation, cognitive re-structuring of self-evaluative beliefs and cognitive re-structuring of secondary delusions. Participants continued to complete outcome measures at regular intervals | Voices Questionnaire Revised (BAVQ-R). | their problems, while six participants described the experience as saddening, upsetting and worrying.

• Experiment 2: Participants scores on the BAVQ-R did not increase. |

				throughout the study.		
Dilks, Tasker & Wren (2008)	To explore therapy processes in 'psychosis' with an initial focus on reflexivity and how this might be expressed in therapy conversations.	Six psychologist client pairs.	Qualitative	Six psychologist client pairs supplied three tapes of therapy sessions spread out across the course of therapy. Each participant was separately interviewed on two occasions to ascertain their views of therapy and of the emerging grounded theory.	N/A	• A grounded theory was developed conceptualizing the processes and activities in psychological therapy in 'psychosis'.
Dilks, Tasker & Wren (2010)	To explore the links between therapy and recovery in 'psychosis'.	19 therapy session tapes. 23 interviews with psychologists and clients. 31 published personal accounts.	Qualitative	An initial sample of 19 therapy session tapes and 23 interviews with psychologists and clients engaged in psychological therapy in psychosis was collected and	N/A	• The study reports on specific elements of a larger grounded theory study that particularly relate to recovery processes in 'psychosis'. Specific categories of activity were conceptualised to theorise the key activities involved in

				analysed using grounded theory.

This data set was extended through the additional sampling and analysis of 31 published personal accounts of the experience of 'psychosis'. | | managing the impact of 'psychosis'. |
| Dilks, Tasker & Wren (2013) | To explore the therapist activities involved in maintaining an observational perspective during therapy and the links between these and other therapist activities. | 19 taped therapy sessions.

23 interviews with psychologists and their clients.

Three interviews with psychoanalytic ally aware psychologists. | Qualitative | An initial sample of 19 taped therapy sessions and 23 interviews with psychologists and their clients was collected. This sample was extended through the collection of three further interviews with psychoanalytical ly aware psychologists. | N/A | • A grounded theory model of therapy processes in 'psychosis' was developed that conceptualized therapist actions as providing an observational scaffold to support the client's efforts in moving to new perspectives on their situation.
• Consistent with the understanding of the core therapy |

						activity as a dialogical process, this set of therapist actions was understood as occurring alongside other therapist activities involved in managing emotion and building a relationship in therapy.
Van Os, Altamura, Bobes, Gerlach, Hellewell, Kasper, Naber & Robert (2004)	To examine whether providing 'patients' with an opportunity to identify and discuss their needs using the Two-Way Communication Checklist (2-COM) would improve communication and induce changes in care.	134 patients diagnosed with 'schizophrenia'.	Randomised controlled trial.	Participants were randomly allocated to standard care or use of the 2-COM. Before seeing their clinician for a routine follow-up, participants in the active intervention group were given 2-COM, a list of 20 common needs, and told to indicate the areas they wanted to	2-COM. The Global Assessment of Function Scale (GAF).	• Using 2-COM induced a stable improvement of participant reported quality of 'patient doctor' communication (B = 0.33, P = 0.031), and induced changes in management immediately after the intervention (OR = 3.7, P = 0.009; number needed to treat, 6). • Treatment change was more likely in patients with more reported needs, and

				discuss with their doctor. Outcomes were assessed immediately.		needs most likely to induce treatment change, displayed stronger associations with non-medication than with medication changes.
Priebe, McCabe, Bullenkamp, Hansson, Lauber, Martinez-Leal, Rossley, Salize, Svensson, Torres-Gonzales, Van Den Brink, Wiersma & Wright (2007)	To explore the effectiveness of a computer mediated intervention structuring patient and clinician dialogue (DIALOG) focusing on patients quality of life and needs for care.	451 participants diagnosed with 'schizophrenia' or related 'disorders'.	Randomised controlled trial.	134 key workers were allocated to DIALOG or treatment as usual. Every two months for a year clinicians asked participants to rate satisfaction with quality of life and treatment, and request additional or different support. Responses were fed back immediately on screen displays, compared with previous ratings	Manchester Short Assessment of Quality of Life (MANSA). Camberwell Assessment of Need Short Appraisal Schedule (CANSAS), patient rated version. Client Satisfaction Questionnaire (CSQ-8). The Positive and Negative Symptom Scale (PANSS).	• Participants receiving the DIALOG intervention had better subjective quality of life, fewer unmet needs, and higher treatment satisfaction after 12 months.

				and discussed.		
Priebe, Kelley, Omer, Golden, Walsh, Khanom, Kingdon, Rutterford, McCrone & McCabe (2015)	To explore the effectiveness of a computer mediated intervention structuring patient and clinician dialogue (DIALOG+).	179 participants diagnosed with 'schizophrenia' or related 'disorders'.	Randomised controlled trial.	49 clinicians were allocated to DIALOG+ or a control condition. The caseloads of clinicians were screened to identify eligible participants. Clinicians were asked to use DIALOG+ every month for a period of six months. Responses were fed back immediately on screen displays, compared with previous ratings and discussed. All outcomes were measured at baseline and at the three, six and 12 month follow-ups.	Manchester Short Assessment of Quality of Life (MANSA). Camberwell Assessment of Need Short Appraisal Schedule (CANSAS), patient rated version. Client Satisfaction Questionnaire (CSQ-8). The Positive and Negative Symptom Scale (PANSS).	• Patients in the DIALOG+ arm had better subjective quality of life at three, six and 12 months (p = 0.035, 0.058 and 0.014, respectively; Cohen's d = 0.29–0.34). • They also had significantly fewer unmet needs at three and six months, fewer general psychopathological symptoms at all time points, and better objective social outcomes at 12 months.
Sousa,	To examine the	90 participants	Randomis	Participants	LORS-discrepancy,	• For participants in

Corriveau, Lee, Bianco & Sousa (2013)	effectiveness of the LORS-Enabled Dialogue (LED) in reducing the discrepancy between clinicians' and patients' ratings of the severity of symptoms of 'psychotic disorders', improving adherence to medication, and improving functioning.	described as experiencing 'psychotic disorders' (inpatients and outpatients).	ed controlled trial.	were randomly assigned to the LED intervention (n = 50) or a control group (n = 40). They were assessed on measures of symptom awareness, functioning and medication adherence before and at four post baseline monthly assessments. The LED intervention was provided weekly for inpatients and monthly for outpatients.	LORS-clinician, LORS-patient. The Positive and Negative Symptom Scale (PANSS). Kemp Compliance Tool.	the LED intervention, a decrease in psychopathology, as measured by the PANSS and LORS clinician scores, and an improvement in functioning were noted, along with a decrease in LORS-discrepancy scores.
Lysaker, Ringer, Maxwell, McGuire & Lecomte (2010)	To explore whether fuller narrative accounts are linked to wellness in daily life,	103 participants diagnosed with 'schizophrenia'.	Cross-sectional study	Participants were enrolled in a larger study seeking to develop a cognitive behavioural	Psychotic symptoms and psychotic disorders section of the Structured Clinical Interview for DSM-IV Axis I Disorders	• Greater STAND total scores were associated with more frequent social contacts. • Correlations between narrative

independent of other factors including symptoms, hope, self-esteem and general intellectual functioning.			therapy targeting increasing employment. Participants completed interview and self-report measures. The Indiana Psychiatric Illness Interview (IPII) interview was audio recorded and transcribed. Ratings of the transcripts were made using the Scale To Assess Narrative Development (STAND).	(SCID-I). The STAND. The Quality of Life Scale (QLS). The IPII. The Beck Hopelessness Scale (BHS). The Positive and Negative Symptom Scale (PANSS). The vocabulary subtest of the Wechsler Adult Intelligence Scale WAIS-III).	and social function remained significant after controlling for self-esteem, hope, positive and negative symptoms and general intellectual functioning, although the magnitude of the association between foundations and conception and alienation were only modest after these correlates were accounted for. • On the STAND, agency, lack of alienation and social worth were associated with a high frequency of social contacts. These subscales, along with coherence of illness conception were linked to capacity for social relationships.

						• When self-esteem, hope, symptoms and intellectual function were accounted for, sense of connection to others remained associated with frequency of social relationships and sense of agency. Personal worth also continued to be associated with capacity for social connection. • The other STAND subscales remained significantly correlated with social function. However, these relationships were considerably weaker when the covariates were accounted for. • Finally, for frequency of social relationships, exploratory analyses suggested

						that alienation was able to explain an additional 10% of the variance beyond 20% explained by positive and negative symptoms.
- With regards to the capacity for social relationships, agency and social worth were able to explain an additional 13% of the variance beyond 32% explained by negative symptoms and general intellectual function.
Moe, Breitborde, Shakeel, Gallagher & Docherty (2016)	To compare idea density in the life story narratives of people diagnosed with 'schizophrenia' with controls.	32 participants diagnosed with 'schizophrenia' and 15 control participants	Cross-sectional study	Idea density was assessed via a computerised measure in both groups. In the 'schizophrenia' group, associations between idea density and narrative	Schedule for Affective Disorders and Schizophrenia (SADS). Indiana Psychiatric Illness Interview (IPII). CPIDR 5.1. The Scale To Assess Narrative	- Findings suggest that idea density was reduced in individuals diagnosed with 'schizophrenia' compared to controls.
- A trend level association was found between idea density and the positive symptom

				qualities were rated via a manualised measure, and psychiatric symptoms were also explored.	Development (STAND). The Positive and Negative Symptom Scale (PANSS). The Global Assessment of Functioning (GAF) from the DSM-IV-TR.	subscale (lack of spontaneity, flow of conversation and motor retardation) of the PANSS. • Idea density was positively correlated with overall STAND score, illness awareness (IPII) and agency. • Participants diagnosed with 'schizophrenia' with richer idea density tended to have more developed insight into illness, they also had higher levels of depression, anxiety, and avolition.
Raffard, D'Argembea, Lardi, Bayard, Boulenger & Van der Linden (2010)	To compare the narratives of people diagnosed with 'schizophrenia' to healthy controls through the recall of self-defining memories.	81 participants diagnosed with 'schizophrenia' and 50 controls participants.	Cross-sectional study	Participants completed all experimental measures in two experimental sessions, over two consecutive days.	Self-defining memories (SDMs) questionnaire. Positive and negative affective states (PANAS). Beck Depression Inventory (BDI).	• The narratives of participants diagnosed with 'schizophrenia' were less coherent and elaborate than those of controls. • They were more severely impaired in their ability to make

					National Adult Reading Test (NART). The classification system and scoring manual for coding events in self-defining memories. Coding manual for connections. Narrative coherence coding scheme.	connections with the self and extract meaning from their memories, which significantly correlated with illness duration. • They exhibited an early reminiscence bump. The period of the reminiscence bump was characterized by fewer achievements and more life-threatening event experiences. • A negative correlation was found between negative symptoms, number of self-event connections and specificity of narratives.
Allé, Potheegado, Köber, Schneider, Coutelle, Habermas, Danion &	To compare life narratives and ability to integrate and bind memories of personal events into a	27 participants diagnosed with 'schizophrenia' and 26 controls	Cross-sectional study	Participants completed all measures.	Positive And Negative Syndrome Scale (PANSS). Calgary Depression Scale	• In participants diagnosed with 'schizophrenia' the cultural biographical knowledge was preserved, whereas temporal coherence

Berna (2015)	coherent narrative in people diagnosed with 'schizophrenia' and controls.				for Schizophrenia (CDSS). Beck Depression Inventory (BDI). State-Trait Anxiety Inventory (STAI). The Rosenberg Self-Esteem Scale (RSES). The Trail-Making Test (TMT, Part A and B). The semantic and phonologic verbal fluency tasks. Life narratives protocol developed by Habermas and de Silveira. Subjective Sense of Coherence Scale (SSCS).	was partially impaired. • Furthermore, causal-motivational and thematic coherence was significantly impaired: participants had difficulties explaining how events had modelled their identity, and integrating different events along thematic lines. • Impairment of global causal-motivational and thematic coherence was significantly correlated with patients' executive dysfunction, suggesting that cognitive impairment observed in 'patients' could affect their ability to construct a coherent narrative of their life by binding important

						events to their self.
Allé, d'Argembea, Schneidere, Potheegado, Coutellea, Daniona & Berna (2016a)	To compare two complementary aspects of self-continuity, namely phenomenological and narrative continuity in individuals diagnosed with 'schizophrenia' and controls.	27 participants diagnosed with 'schizophrenia', and 27 controls	Cross-sectional study	Participants were asked to identify important past events and to narrate a story from their life that included these events. They were also asked to imagine important events that might happen in their future and to build a narrative of their future life. The vividness of these important life events and the proportion of self-event connections in the narratives were used as a measure of phenomenological and narrative continuity,	Positive And Negative Syndrome Scale (PANSS). Calgary Depression Scale for Schizophrenia (CDSS). Beck Depression Inventory (BDI). State-Trait Anxiety Inventory (STAI). The Rosenberg Self-Esteem Scale (RSES). The Trail-Making Test (TMT, Part A and B). The semantic and phonologic verbal fluency tasks.	• Participants diagnosed with 'schizophrenia' experienced less vivid representations of personally significant events (p = .02) for both temporal directions (past and future) (p b .001). • In addition, their ability to make explicit connections between personal events and self-attributes in life narratives was also impaired (p = .03), but only in the case of past narratives (p b .001).

				respectively.		
Allé, Gandolphe, Dobad, Köbere, Potheegado, Coutellea, Habermase, Nandrinod, Daniona, Berna (2016b)	To compare the temporal structure of 'patients' life narratives through different narrative elements in individuals diagnosed with 'schizophrenia' and controls.	Study One: 9 participants diagnosed with 'schizophrenia' and 21 controls. Study Two: 11 participants diagnosed with 'schizophrenia' and 12 controls.	Cross-sectional study	Life narratives were collected by two different methods; a free recall in study one and a more structured protocol, aiming at reducing the cognitive task demands in study two. All narratives from the two studies were analysed using the same methods.	Psychotic symptoms and 'psychotic disorders' section of the Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I). The Positive and Negative Symptom Scale (PANSS). Life narratives protocol developed by Habermas and de Silveira. French National Adult Reading Test (F-NART). Wechsler Adult Intelligence Scale-Revised (WAIS-R).	• Both studies showed that global temporal coherence was significantly reduced in participants diagnosed with 'schizophrenia' (ps .02). • The study also observed significant correlations in the 'patient' groups between global temporal coherence and executive dysfunction (p=.008) and their higher tendency to temporally deviate from a linear temporal order in their life narratives (pb.001).
Holm, Kirkegaard Thomsen & Bliksted (2016)	To compare self-continuity in people diagnosed with 'schizophrenia' and controls.	25 participants diagnosed with 'schizophrenia' and 25 matched controls.	Cross-sectional	All participants undertook tests of neuro-cognition and their 'symptoms' were rated.	The Common Mental Disorder Questionnaire (CMDQ). The Scale for the	• Participants diagnosed with 'schizophrenia' rated their life story chapters more negatively.

				Participants identified and rated life story chapters and self-defining memories on emotional valence, causal coherence, and self-continuity. The temporal coherence and temporal macrostructure of the memories and chapters were also assessed.	Assessment of Positive and Negative Symptoms (SANS/ SAPS). The Brief Assessment of Cognition in Schizophrenia (BACS). Identification and rating of up to 10 life story chapters and three defining memories.	• There were few significant differences regarding temporal coherence, temporal macrostructure, causal coherence and self-continuity in the groups. • In participants diagnosed with 'schizophrenia', poorer neurocognitive function and a higher degree of negative 'symptoms' were associated with less causal coherence and lower self-continuity in relation to the life event chapters.

Appendix 2: Table of Service User Clinical and Demographic Information

Service User (Pseudonyms)	Gender	Age (Range)	Ethnic Group (extracted from notes)	Duration of Psychosis (years)	Time since Diagnosis (years)	Therapy Mode	Therapy Length (months)	Psychologist (Pseudonyms)	Interview Setting
Louisa	F	56-60	White/ Black (African)	17	12	Individual	3	Lucy	In person
April	F	61-65	White (British)	31	31	Individual	11	Jane	In person
Mark	M	56-60	White (British)	18	18	Individual	10 & 9	Ruth	In person
Matthew	M	46-50	White/ Black (Caribbean)	45	45	Individual	7	Lucy	In person
Sophia	F	56-60	Black (British)	33	33	Individual	8	Heather	In person
Edward	M	61-65	Black (Caribbean)	9	8	Group	3	Lucy	In person
Thomas	M	51-55	White (British)	32	32	Individual	8	Charlotte	Telephone
Luke	M	21-25	White (British)	2	2	Individual	2	Charlotte	Telephone
John	M	46-50	Black (African)	14	14	Individual	8	Ian	Telephone
Adam	M	61-65	Mixed (European)	30	15	Individual	6	Charlotte	Telephone
Simon	M	36-40	White/ Black (African)	16	16	Individual	11	Timothy	In person

Appendix 3: Service User Interview Schedule

As the interview is semi-structured, follow up questions will be asked if necessary at the time of interviewing. Not all questions will be relevant to all participants due to their differing therapy experiences, therefore questions in the interview will be omitted or modified when necessary throughout.

Thank you for coming today and agreeing to take part in the research project. Firstly, I thought it might be helpful to remind you that the purpose of this study is to find out about your experience of a particular time during your therapy. Throughout therapy, you, your therapist and possibly family or other group members worked together to learn more about your experiences. You might have spoken about particular events in your past that may have caused your difficulties and why it is your difficulties have continued. This is called a formulation. Your therapist may have given you a written summary of this work. You may have received this in the form of a letter, a report or a diagram, though it may or may not have been titled 'formulation'. Equally you may have taken part in verbal discussions whereby different psychological understandings of your experiences were discussed. I would like to find out how it feels to be part of such discussions [and receive a written summary of this work- delete if not applicable] and whether it influenced the way you felt or what you did in anyway.

Development of the formulation
- What do you remember about the discussion of your formulation with your therapist (and group and family members if applicable)?
  Follow up questions might include:
    - Did your therapist share a letter, a report or a diagram with you about your experiences?
    - Did your therapist use the word formulation? (Interviewer to use the words of the participant to describe formulation from here on (once sure of mutual understanding).
- Can you tell me how were you involved in the development of the formulation?
  Follow up questions might include:
    - Do you feel your formulation was developed in partnership with your therapist?

The therapeutic relationship
- How would you describe your relationship with your therapist (and other group members)?
- Can you tell me how you felt about your relationship with your therapist after you received your written formulation?
- Can you tell me how you felt about other group/family members/ the therapist after discussing different psychological understandings about your experiences? For example hearing other group members/ family member's views about this?
  Follow up questions might include:
    - Did you feel differently about the relationship?

Reactions to the sharing of the written formulation
- How did you feel; when you first received your written formulation? Or: after having been involved in discussions exploring ways of understanding your experiences?
  Follow up questions might include:
    - Where were you when you received it?
    - Do you think you're likely to re-read your formulation?
    - Can you tell me about whether your feelings about it have changed since?

Influence
- Can you tell me how you felt about therapy after receiving your written formulation? Or: after discussing different psychological understandings of your experiences?
- How do you feel receiving your formulation influenced what you did outside of the therapy room?
- Did the way you understood your experiences change in anyway?
- Did you share your formulation or new understanding with anyone else?

Comparing experiences of formulation from different modes of therapy
- Can you tell me in what way your experience of individual/ group/ family therapy was similar/ different?

- Can you tell me how your experience of therapy could have been made [more] helpful for you?

Appendix 4: Therapist Interview Schedule

As the interview is semi-structured, follow up questions will be asked if necessary at the time of interviewing. The same questions will be asked when discussing both a case the therapist felt went well and another they felt went not so well, unless otherwise specified.

Thank you for coming today and agreeing to take part in the research project. Firstly, I thought it might be helpful to remind you that the purpose of this study is to find out about your experience of formulating with clients during therapy for psychosis. To explore this it would be helpful if you could tell me about a case where you feel like the formulation process went well and another case where you felt it did not go so well, starting with the former.

Development of the formulation
- Can you tell me how the formulation was developed with your client?
  Follow up questions might include:
    - What model/s did you draw on when formulating?
    - Did you use the word 'formulation'?

The therapeutic relationship
- How would you describe the relationship you had with your client before sharing a written formulation with them?
- Do you feel like the sharing of the formulation impacted on your relationship in any way?

Reactions to the sharing of the written formulation
- How did you judge when it was an appropriate time to share a written formulation with your client?
- How did you go about it? / approach the task?
- How did your client react when you shared the written formulation with them?
  Follow up questions might include:
    - Where were they when they received it?
    - Did they ask to make any changes?

Influence
- Can you tell me about any ways that you felt the sharing of the formulation influenced your client outside of therapy?
- Do you think that your client's understanding of their experiences changed as a result of sharing a formulation with them?
- Has the formulation been referred to again since by either of you? In what ways?

- Is there anything else that we haven't already discussed that you feel impacted on how the formulation process went with your client?

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Canterbury Christ Church University
1 Meadow Road
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Kent
TN1 2YG

Participant Information Sheet   m.r.gibbs415@canterbury.ac.uk

IRAS Project ID: 215516

Title: An exploration of service users' views of developing psychological understanding in therapy

My name is Melanie Gibbs and I am a trainee clinical psychologist at Canterbury Christ Church University. I would like to invite you to take part in a research study, but before you choose whether you would like to take part, I would like to let you know why the research is taking place and what your involvement would be. I would be grateful if you would take a little time to read the following information carefully. Please ask me if there is anything that is not clear or if you wish to know more. You should only take part if you want to. It will not affect your care in any way if you choose not to take part.

What is the purpose of the study?

The purpose of this study is to find out more about your experience of a particular time during your therapy.

If you undertook individual therapy, you and your therapist likely worked together to learn more about your situation and how your difficulties may have developed. This is called formulation. Your therapist may have given you a written summary of this work. You may have received this in the form of a letter, a report or a diagram.

Alternatively, you may have undertaken group or family therapy whereby different psychological understandings of your experiences may have been discussed. Again, this process is called a formulation, you may or may not have received a written summary of this work.

I would like to find out whether your experience of formulation influenced the way you felt or what you did in any way. This may help to improve how therapists undertake therapy.

Who am I asking to participate?

I am asking people who are currently involved in therapy, aged 18 years and older.

What are the benefits for you of taking part?

As a "thank you" each person who takes part will be given a £10 voucher. There are no other direct benefits; however by helping you will contribute information which could help people experiencing similar difficulties.

What will the study involve for you?

If you agree to take part you will be asked to attend one interview which will take about thirty minutes to one hour. I would also like to collect some demographic information about you (e.g. age, ethnicity and length of time in therapy etc) to help with the study. You will be asked to agree to this before taking part in the interview.

The interview will take place during, or after completing therapy. The interview will take place where you usually meet with your therapist. Alternatively, you could undertake the interview via telephone. The interview will include questions about how it felt to discuss different psychological understandings of your experiences and, if applicable, receive a written summary of this work. The interviews will be audio recorded, then typed up in full for analysis.

Should an important area that we did not talk about be raised in my interviews with other people, I may contact you again to see if a second interview would be possible. However, you can choose not to take part in this second interview.

What are the risks?

Some of the questions asked during the interview may touch on sensitive topics. If you feel uncomfortable with any of the questions, you do not have to answer them. If you want to stop the interview you can do so at any time without giving any reason.

Is confidentiality guaranteed?

All personal information about you is kept strictly private. Only I will be able to link the information you have given to your name, in order to collect and organise all the data. Your therapist will not see any of the information you provide. All the information about you will be anonymised (you will not be identifiable in any of the study data). This ensures that good standards of security and confidentiality are in place.

The audio recording of the interviews will be securely held on an encrypted memory stick and then deleted once fully typed up. Your personal details will be kept separately to your interview data. Your personal details will be destroyed as soon as the research is complete. The anonymised data collected will be held safely for five years as this is a requirement of the university.

The only time I would consider breaking confidentiality would be if you tell me something which may place you or someone else at risk of harm, though I will try to discuss this with you first.

What will happen if you wish to withdraw from the study?

You are free to withdraw from this study without giving a reason by contacting me using the details at the top of this letter. Withdrawal will not affect the treatment you receive from the NHS. If you decide to withdraw or have to withdraw for any other reason I would like to use the anonymised data collected so far.

What will happen to the results of the research study?

I aim to publish the results of the study in a relevant psychological journal. I will use anonymous quotes from the interviews in the write up of the study, and I will make sure that you are not identified by removing any personal information from the quotes. Towards the end of the study I aim to provide each participant with an opportunity to have a look at my findings and make comments if they would like to, to help me complete the research.

Who is organising and funding the research?
Canterbury Christ Church University and South London & Maudsley NHS
Foundation Trust.

Who has reviewed the study?
This study has been reviewed and given favourable opinion by an independent NHS
Research Ethics Committee. Please see the top of this letter for the relevant study
number.

If this study has harmed you in any way and you would like to make a complaint, or
for further advice and information, you can contact me directly using the details at
the top of this information sheet. Alternatively you can contact an independent
member of the research team based at Canterbury Christ Church University, Paul
Camic, either at the above address or by telephone on 01227 927070, or contact the
NHS South London and Maudsley Patient Advice and Liaison Service (PALS) on
0800 731 2864.

Thank you for your time, please contact me should you have any further questions.

Kind regards,

Melanie Gibbs

Salomons Centre for Applied Psychology
Canterbury Christ Church University
1 Meadow Road
Tunbridge Wells
Kent
TN1 2YG

Therapist information sheet   m.r.gibbs415@canterbury.ac.uk

IRAS Project ID: 215516

Title: Developing a grounded theory of how service users experience and make use of formulations in therapy for psychosis.

My name is Melanie Gibbs and I am a trainee clinical psychologist at Canterbury Christ Church University. I would like your help recruiting service users to take part in interviews regarding their experiences of formulation in therapy for psychosis. I would like to recruit service users who have undertaken individual, group or family therapy. Service users must have been involved in discussions whereby different psychological understandings of their psychotic experiences were discussed. They may, or may not have received a written summary of this work.

Rationale for the study

Research exploring service user reactions to formulation during therapy for psychosis is in its early stages. The research available suggests that service users feel ambivalent, as well as finding them helpful, encouraging and reassuring, and increasing trust in their psychologist, service users also experienced them as saddening, upsetting, frightening, overwhelming and worrying (Chadwick et al., 2003; Evans & Parry, 1996).

Research suggests that formulation increases psychological understanding in clients, though little is known about the psychosocial processes that occur as a result (Chadwick et al., 2003). More research is needed to explore how service users experience and make use of formulations in therapy for psychosis. Research in this area will encourage therapists to consider the implications of sharing formulations in therapy and may influence how the task is undertaken in the future.

Your role

Your role will be identify and introduce the study to service users currently in therapy for psychosis. I am interested in 'normal' practice, that is to say, I would like to explore experiences of service users who you feel the formulation process went well or not so well with.

Therapists will provide interested service users with an information sheet and obtain their permission to be contacted directly by me. With permission, I will contact service users by telephone to answer any questions and arrange to complete the consent form and conduct the interview.

Should a service user you work with agree to be interviewed, you will be asked to provide some details about yourself including: your age, gender, ethnicity, therapeutic modality and how long you have been qualified. You will also be asked to collect information on the service user you are working with from the electronic

system including; age, gender, ethnicity, how long ago they received a diagnosis of psychosis and how long they have been in therapy with you. Both you and your client will be asked to consent to this separately.

Inclusion criteria
- Service users must be aged 18 or over.
- Able to provide informed consent.
- Fluent in English.
- Currently in, or recently completed therapy for psychosis (individual, group or family therapy).
- Ideally you would be planning to share, or have recently shared, a written (or diagrammatic) formulation with the service user.
- Alternatively, the service user must have been part of discussions whereby different psychological understandings of their psychotic experiences were discussed.

Exclusion criteria
Service users will be excluded from taking part if they are;
- Experiencing a serious deterioration in their mental health.
- Experiencing suicidal ideation and/or thoughts of harm to themselves or others.

Who is organising and funding the research?
Canterbury Christ Church University and South London & Maudsley NHS Foundation Trust.

Who has reviewed the study?
This study has been reviewed and given favourable opinion by an independent NHS Research Ethics Committee. Please see the top of this letter for the relevant study number.

Defining a verbal formulation for the purpose of this study
- Service users must have been part of discussions whereby different understandings of their psychotic experiences were discussed. Discussions may have taken place within individual, group or family therapy.
- Service users may, or may not have received a written formulation as part of this process.

Defining a written formulation for the purpose of this study
- A letter (addressed to the service user) or
- A diagram or
- A therapy report or
- A combination of any of the above
- It may or may not be titled 'formulation' but you will have identified that a formal product of formulation has been produced and will be/ has been shared.

Introducing the study to service users
Please see the attached document outlining areas to discuss with service users
when introducing the study.

Thank you for your time, please contact me should you have any further questions.

Kind regards,

Melanie Gibbs

Introducing the study to service users

This information is supplementary to the participant information sheet. It is important that the following areas are discussed with service users when introducing the study.

Explaining formulation and the study to service users
- The purpose of the study is to find out more about your experience of a particular time during therapy.
- During therapy we have worked together [along with your family or other group members- delete as applicable] to learn more about your situation, this is called formulation.
- Therapists often produce a summary of this work. It can take the form of a letter, a report or a diagram. I plan to give you/ I have given you a written copy of your formulation which will take/ took the form of a [letter, report, diagram - delete as appropriate].
- The researcher would like to find out how it feels to be part of formulation discussions and receive a written formulation [delete the latter if not applicable] and whether this influenced you in any way.

Taking part
- If you agree to take part a researcher called Melanie Gibbs will contact you to answer any questions you may have, and if you agree, arrange a date to sign a consent form and be interviewed.
- The interview will take between thirty minutes to one hour.
- As a "thank you" you will be given a £10 voucher for taking part.
- You should only take part if you want to, I will not receive any direct benefit or loss if you choose not to.
- You should also know that anything you discuss in the interview with Melanie will not be shared with me or any other member of the team here unless there are concerns about your safety, or the safety of someone else, though Melanie will try to speak to you about this first.

Appendix 7: Service User Consent Form

Title of Project: Developing a grounded theory of how service users experience and make use of formulations in therapy.

IRAS Project ID: 215516

Name of Researcher: Melanie Gibbs   **Please initial box**

1. I confirm that I have read and understand the participant information sheet for the above   study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.

3. I agree to my interviews being audio recorded.

4. I agree for my demographic information (age, ethnicity and gender) and clinical information (length of time in therapy and length of time experiencing mental health difficulties) to be collected and used for analysis.

5. I agree to my information being kept anonymously while the research is being conducted.

6. I agree that anonymous quotes from my interview may be used in published reports of the study findings.

7. I agree to take part in the above study.

Name of Participant: _____ **Date:** _____

Signature: _____

Name of Person taking consent: _____ **Date:** _____

Signature: _____

Appendix 8: Therapist Consent Form

Title of Project: Developing a grounded theory of how service users experience and make use of formulations in therapy for psychosis.

IRAS Project ID: 215516

Name of Researcher: Melanie Gibbs **Please initial box**

1. I confirm that I have read and understand the psychologist information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

☐

2. I understand that providing my demographic information (age, gender, ethnicity and length of time since qualifying as a clinical psychologist) is voluntary and that I am free to withdraw from the study at any time without giving any reason.

☐

3. I agree for my demographic information (age, ethnicity and gender and length of time since qualifying as a clinical psychologist) to be collected and used for analysis.

☐

4. I agree to my demographic information being collected, kept anonymously while the research is being conducted and used for analysis.

☐

Name of Participant: _____ **Date:** _____

Signature: _____

Name of Person taking consent: _____ **Date:** _____

Signature: _____

Appendix 9: Data Collection Sheet

Participant ID: _____

Date information collected: _____

Psychologist

Gender: Male   Female

Age:

18-20 years old	51-55 years old
21-25 years old	56-60 years old
26-30 years old	61-65 years old
31-35 years old	66-70 years old
36-40 years old	71-75 years old
41-45 years old	76-80 years old
46-50 years old	81 years or older

Ethnicity: White

English

Welsh
Scottish
Northern Irish
British
Irish
Gypsy or Irish Traveller

Any other White background, please state:

_____

Mixed / Multiple ethnic groups

White and Black Caribbean

White and Black African
White and Asian

Any other Mixed / Multiple ethnic background, please state:

_____

Asian / Asian British

Indian
Pakistani
Bangladeshi
Chinese

Any other Asian background, please state

_____

Black

African
Caribbean
British

Any other Black / African / Caribbean background, please

_____

state:
Other ethnic group   Arab
Any other ethnic group,
please state: _____

Therapeutic modality:
Please circle the therapeutic model / approach adopted during therapy with your client?

Cognitive Behaviour Therapy
Psychodynamic Psychotherapy
Family / Systemic Therapy
Integrative (please state which modalities adopted): _____
Any other therapeutic modality, please state: _____

Duration of therapeutic treatment:
At the point of completing the interview for this study, how long had you been engaged in therapy with your client?

From _____ (Month and year) to _____ (Month and year).

Qualified Experience:
How many years has it been since you qualified as a Clinical Psychologist?
_____ years.

Your Client

Gender: Male   Female

Age: 18-20 years old   51-55 years old
                21-25 years old   56-60 years old
                26-30 years old   61-65 years old
                31-35 years old   66-70 years old
                36-40 years old   71-75 years old
                41-45 years old   76-80 years old
                46-50 years old   81 years or older

Ethnicity: White   English
                                  Welsh
                                  Scottish
                                  Northern Irish
                                  British
                                  Irish
                                  Gypsy or Irish Traveller

                Any other White
                background, please   _____
                state:
                Mixed / Multiple   White and Black Caribbean
                ethnic groups

                                  White and Black African
                                  White and Asian

                Any other Mixed /

Multiple ethnic background, please state:	_____
Asian / Asian British	Indian Pakistani Bangladeshi Chinese
Any other Asian background, please state	_____
Black	African Caribbean British
Any other Black / African / Caribbean background, please state:	_____
Other ethnic group	Arab
Any other ethnic group, please state:	_____

Duration of psychosis:

How many years has your client experienced symptoms of psychosis? _____ years.

How many years has it been since your client received a diagnosis of psychosis? _____ years.

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TN1 2YG
m.r.gibbs415@canterbury.ac.uk

IRAS Project ID: 215516

Title: Developing a grounded theory of how service users experience and make use of formulations in therapy for psychosis.

My name is Melanie Gibbs and I am a Trainee Clinical Psychologist at Canterbury Christ Church University. I would like your help with my research project exploring service user experiences of formulation during therapy for psychosis. As part of my project I am interviewing service users and therapists about their experiences of formulation. I would appreciate you spending a few minutes of your time reading the information below detailing why the research is taking place, the inclusion criteria and what your role would entail if you decided to take part.

Rationale for the study
Research exploring service user reactions to receiving a written formulation during therapy for psychosis is in its early stages. The research available suggests that service users feel ambivalent. As well as finding them helpful, encouraging and reassuring, and increasing trust in their psychologist, service users also experienced them as saddening, upsetting, frightening, overwhelming and worrying (Chadwick et al., 2003; Evans & Parry, 1996). More research is needed to explore how service users experience and make use of formulations in therapy for psychosis. Research in this area will encourage therapists to consider the implications of sharing formulations in therapy for psychosis and may influence how the task is undertaken in the future.

Inclusion criteria
I would like to interview therapists with experience of formulating with clients during therapy for psychosis. Therapists must work within one of the teams in the Promoting Recovery Pathway, in South London and Maudsley NHS Foundation Trust, to be eligible to take part.

Your involvement
I would like to interview you regarding your experiences of formulating with clients during therapy for psychosis. To explore this I would like to hear about a case where you feel the formulation process went well and one where you felt it did not go so well. You will also be asked to provide some details about yourself including: your age, gender, ethnicity, therapeutic modality and how long you have been qualified.

Before being interviewed you will be required to sign a consent form. You will have an opportunity to ask any questions you may have about participation before signing the consent form. Interviews will take place at your normal place of work or over the telephone, whichever is most convenient to you. The interview will last between 30 minutes to one hour. All interviews will be audio recorded and transcribed for analysis.

Defining formulation for the purpose of this study
- A letter (addressed to the service user) or
- A diagram or
- A therapy report or
- A combination of any of the above
- It may be formulated from any therapeutic modality
- It may or may not be titled 'formulation' but you will have identified that a formal product of formulation has been produced and will be/ has been shared

Confidentiality
All personal information about you is kept strictly private. Only I will be able to link the information you have given to your name, in order to collect and organise the data. All information about you will be anonymised. The audio recording of the interview will be securely held on an encrypted memory stick and then deleted once transcribed. Your personal details will be kept separately to your interview data. Your personal details will be destroyed as soon as the research is complete. The anonymised data collected will be held safely for five years as this is a requirement of the university.

Withdrawal from the study
You are free to withdraw from this study without giving a reason by contacting me using the details at the top of this letter.

What will happen to the results of the research study?
I aim to publish the results of the study in a relevant psychological journal. I will use anonymous quotes from the interviews in the write up of the study, and I will make sure that you are not identified by removing any personal information from the quotes.

Who is organising and funding the research?
Canterbury Christ Church University and South London & Maudsley NHS Foundation Trust.

Who has reviewed the study?
This study has been reviewed and given favourable opinion by an independent NHS Research Ethics Committee. Please see the top of this letter for the relevant study number.

Thank you for your time, please contact me should you have any further questions.

Kind regards,

Melanie Gibbs

Appendix 11: Therapist Participant Consent Form

Title of Project: Developing a grounded theory of how service users experience and make use of formulations in therapy.

IRAS Project ID: 215516

Name of Researcher: Melanie Gibbs   **Please initial box**

1. I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason.

☐

3. I agree to my interviews being audio recorded.

☐

4. I agree to provide my demographic (age, ethnicity and gender) and professional (years since qualifying and therapeutic model/s adopted) information, and for this to be used for analysis.

☐

5. I agree to my information being kept anonymously while the research is being conducted.

☐

6. I agree to anonymised quotes from my interview being published in reports of the study findings.

☐

7. I agree to take part in the above study.

☐

Name of Participant: _____ **Date:** _____

Signature: _____

Name of Person taking consent: _____**Date:**_____

Signature: _____

Salomons Centre for Applied Psychology, Canterbury Christ, Church University, 1 Meadow Road, Tunbridge Wells, TN1 2YG. Tel: 01227 927070
www.canterbury.ac.uk

Appendix 12: Sample Transcript with Open Coding Annotations

This has been removed from the electronic copy.

Appendix 13: Table of Developing Codes and Categories

Category	Subcategory	Focused Code
Linking previous experiences with current ways of being	Discussing significant life events	Discussing childhood
		Going over the past
		Exploring whole life
		Telling life story
		Remembering previously forgotten things
		Revisiting traumatic events
		Answering questions about childhood
		Discussing life experiences with therapist
	Noticing the patterns	Identifying the links to childhood
		Relating "then and now"
		Noticing vulnerable periods
		Noticing patterns
		Seeing the patterns of behaviour
		"Spotting the patterns"
		Looking for enduring patterns
	Formalising therapeutic discussions	Summarising therapeutic sessions
		Formulating, a summary of sessions
		Describing formulation as a written summary of therapy
		Feeling forced to "step back"
		Describing formulation as an achievement
		Turning point
		Formalising discussions
		Marking a new beginning
Building the therapeutic relationship	Influencing service user characteristics	Finding the formulation difficult to understand

		Describing a positive relationship with therapist
		Feeling psychosis creates problems in formulation
		Influencing personal characteristics'
		Influencing personal circumstances
		Favouring visual illustrations
		Reflecting on severity of service users' distress
	Influencing therapist characteristics	Reflecting on therapists' personal characteristics'
		Describing psychologist as independent
		Describing importance of trust within the therapeutic relationship
		Describing positive characteristics of psychologist
		Describing therapists' personal qualities
		Highlighting the importance of gender
		Reflecting on characteristics of the therapist
		Going "above and beyond"
		Acknowledging the importance of consistency
		Complementing therapists' personal characteristics
		Reflecting on therapists' patience
		Prioritising therapists' gender
	Working together	Joining forces
		Collaborating with therapist
		Describing formulation as a conversation aid
		Feeling role in formulation is limited by psychosis
		Describing characteristics of collaboration
		Emphasising collaboration
		Working towards a shared understanding of psychotic experiences
		Working collaboratively
		Reflecting on difficulties collaborating due to illness
		Describing role within formulation process

		Feeling heard
		Coming to a shared understanding
		Acknowledging importance of the therapeutic relationship
		Collaborating
Making use of new understandings	Thinking differently	Understanding things differently
		Reflecting on changes in thinking
		Understanding people differently
		Increasing confidence confident
		Comparing formulation with diagnosis
		Arriving at a new understanding
		Seeing the world differently
		Challenging hallucinations
		Coming to a new understanding
		Finding meaning in psychosis
	Doing things differently	Building up confidence to move forward
		Putting the formulation into action
		Making big changes
		Anticipating future impact on behaviour
		Feeling more comfortable in social situations
		Moving forwards
		Describing how formulation impacted behaviourally
		Developing coping skills
		Making long term changes
	Reflecting back	Revisiting formulations
		Anticipating emotional reaction from family
		Keeping the formulation handy
		Anticipating conditions of revisiting formulation
		Describing formulation as a prompt
		Anticipating reflecting on progress

		Anticipating mothers feelings towards the formulation
		Formulating as private
		Sharing formulation with family
		Anticipating looking back on formulations in the future
		Sharing formulation with friends
		Keeping formulation private
	Managing emotions	Acknowledging emotions
		Feeling hopeful
		Acknowledging feelings of vulnerability
		Acknowledging the emotional impact
		using imagery to describe feelings
		Experiencing contrasting emotions
		Experiencing negative feelings
		Feeling a deepening in the therapeutic relationship
		Acknowledging mixed feelings towards longitudinal formulation
		Acknowledging positive and negative feelings as a result of formulation
		Processing feelings
		Describing emotional impact of discussing life events
		Working through emotions
		Acknowledging feelings of relief
		Acknowledging feelings of confusion

Appendix 14: Table of Developing Codes and Categories with Quotes

Category	Subcategory	Focused Code	Quote
Linking previous experiences with current ways of being	Discussing significant life events	Discussing childhood	"She asked me some questions going way back to childhood, which erm […], I felt quite vulnerable about" (P01)
		Going over the past	"Yeah, we talked about my past" (P02)
		Telling life story	"You start off when your young, then you go right the way through, telling her all about your experiences right up until the present day" (P04)
		Revisiting traumatic events	"I remember when I was going through the events it was hard, it was really hard, because I would dissolve into tears" (P05)
	Noticing patterns	Identifying the links to childhood	"You can see from childhood a pattern of, of, you know, of different psychological explanations why it probably came about, so that was helpful" (P03)
		Noticing vulnerable periods	"P: My daughter noticed it, she noticed that I was very down, in May I got down, that's when my dad died, and in October, that's when my mum died" (P05)
		"Spotting the patterns"	"It was quite positive spotting the patterns of the way things happened throughout my life" (P07).
		Looking for enduring patterns	"Before I see a client, I read all their notes to begin formulating, I see what their patterns are and that helps with formulating" (PT01).
	Formalising therapeutic discussions	Summarising therapeutic sessions	"I could talk to her about different things, and summarising it up in the letter was just like talking to her again about, about my feelings" (P02)
		Feeling forced to "step back"	"Your being given a erm an understanding, a written understanding of yourself that you may contributed towards

			that's subjective, that's out there in the world on paper and you can read it over and whether you agree or don't agree, it, it, you're forced to step back from your life" (P03)
		Favouring visual illustrations	"Yeah it helped me visualise what she was talking about, seeing it visually in a diagram" (P04)
		Preferring the formality of letters	"It [formulation letter] seemed you know more important like, when you see illustrations [diagrams], they are just drawings" (P11)
Building the therapeutic relationship	Influencing service user characteristics	Finding the formulation difficult to understand	"No the only thing is when he put it in the diagram, I told him it was quite complex to read it you know?" (P09)
		Influencing personal characteristics'	"I suppose it was the things about him, he was cognitively able, he's quite resilient, quite a resilient man, he was able to face difficult things with me" (PT01)
		Influencing personal circumstances	"It was helpful, but I just felt like my personal situation was beyond reach" (P08)
		Reflecting on severity of service users' distress	"He wasn't someone who was completely in the grip of it, whereas I've met people who you know aren't going to be able to exert any kind of control over it and so you don't get the outcomes, so it was that he could exert some kind of control over it and that made a difference" (PT02)
	Influencing therapist characteristics	Reflecting on therapist's personal characteristics'	"We were in the same age group, same age group, she wasn't judgemental, she was down to earth, and she built up that rapport with me, so that was good" (P05)
		Describing therapist's personal qualities	"She didn't have an 'airs and graces' and she seemed fairly open and honest herself" (P07).
		Complementing therapist's personal	"Yeah I sort of liked his personality, yeah, that helped" (P09)

		characteristics	
		Prioritising therapist's gender	"Yeah, I had to wait a while for *** to come along because I only wanted a lady to do it with me" (P10)
	Working together	Joining forces	"No it was something that we were doing together" (P08)
		Working collaboratively	"****, you know, gave me an opportunity say, what did I think of it and did I agree with it, or not, and that erm that she was happy to discuss any of it" (P03)
		Feeling heard	"Well, **** let me have my say, she didn't put words into my mouth, no she didn't put words into my mouth, she let me have my say, and that was good" (P05)
		Collaborating	"No, no it was developed with me, as we spoke through things, she discussed things and each time she gave me a different diagram" (P04)
Making use of new understandings	Thinking differently	Understanding things differently	"I thought I was being gassed but it was anxiety" (P04)
		Understanding people differently	"Well looking at the diagrams reminds me of how people think, how I think people think, it helps me to differentiate from what I think people are thinking from what I worry they are thinking about, does that make sense? It helps a lot" (Simon, service user).
		Seeing the world differently	"I'm looking at things more objectively and thinking twice about things" (Louisa, service user).
		Coming to a new understanding	"I know now that they are a voice in my head now, if it happened again I would get help" (P10).
	Doing things differently	Building up confidence to move forward	"I'm being mindful of it [written formulation], but I haven't quite trusted it enough to go forward yet" (P01).
		Making big changes	"One day he just turned up and said "I've been down [Name of charity shop] and I've got a job there next week, so I presume it was that, that helped him to feel less paranoid

			about things" (PT02).
		Feeling more comfortable in social situations	"Well before I found it hard to get on with people because I was away like from social things, but now I feel better because I got into work and stuff like that, it [formulation] has helped me to act more better, than like I use to, I don't let things get in my way quite as much" (P11).
		Making long term changes	"He said I think I better knock the drinking on the head, which is such a surprise when you work in [service name] that someone makes changes, but he did make changes and he was discharged from our service and he hasn't come back" (PT02)
	Reflecting back	Revisiting formulations	"Each visit I have the formulation from the week before, or the report, and erm I've just been going through them during the week" (P01)
		Anticipating conditions of revisiting formulation	"It might be when I'm feeling depressed, but erm maybe in general out of curiosity to see the shape of my life, it's quite, quite useful" (P07)
		Anticipating reflecting on progress	"Yeah one day I will, yeah one day, when I'm working, when I'm working and things are going well I'll pick em out read them and I'll think 'wow I've come a long way' (P04)
		Keeping formulation private	Well basically I'll show it to doctors but I don't want to show it to others because, it's not because it's not their business but I just don't want them thinking about me or seeing me in a different way" (P11)
	Managing emotions	Acknowledging emotions	"Quite vulnerable, they were big boxes that hadn't been open for years, sitting on shelves […], erm quite vulnerable" (P01)
		Acknowledging the emotional impact	"It was quite emotional to, to erm, because it's basically your relationship you have with yourself, you know, to, erm

			[..], yeah so it was [..] it through up a lot of feelings you know?" (P03)
		Experiencing contrasting emotions	"I think it was a mix of emotions, some were sad, some were happy, yeah" (P04)
		Processing feelings	"They [feelings] did require some processing, it bought up things and feelings I hadn't felt, haven't experienced since then" (P05)

Appendix 15: Examples of Analytic Memos

1. Influencing Service User and Therapist Characteristics
There appears to be a number of service user characteristics that contribute to building the therapeutic relationship. Therapists also appear to consider some of these characteristics when deciding how to share a written formulation with their clients. These characteristics include their clients; first language, cognitive ability, personality style, severity of psychotic symptoms, resilience and how much control they are able to exert over their symptoms.

Example Quotes
- PO9: Line ref: 143-144- "P: No the only thing is when he put it in the diagram, I told him it was quite complex to read it you know?".
- PT01: Line ref: 274-278-" P: I suppose it was the things about him, so he is cognitively quite able, he's quite resilient, quite a resilient man, erm, he was able to face difficult things with me, he was able to say difficult things to me, so not super, super avoidant, erm yeah so because of that he was able to use these things that I was giving him".

2. Influencing Therapist Characteristics
Service users have highlighted certain therapist demographic characteristics that influenced the building of a therapeutic relationship, for example, age and gender. Service users have also described a number of personal characteristics their therapists exhibited that they felt enabled them to trust their psychologist and start building a therapeutic relationship. These characteristics include; patience, being professional, open and non-judgmental. Some service users found it difficult to describe what it was about their psychologist that enabled them to trust them and attribute it to their psychologists 'personality'.

Example Quotes
- P10: Line ref: 63- "P: Yeah, **** had a lot of patience with me actually".
- P03: Line ref: 552-555- "but also throughout that time the therapeutic relationship still felt safe, for some reason, I don't know why, maybe **** personality or, or what have you, erm it felt safe and erm, so I kept with it".
- P07: Line ref: 55- "P: Yeah, yeah, but in terms of our relationship, she was professional but not too stiff".
- P10: Line ref- 52- "P: Yeah, I had to wait a while for *** to come along because I only wanted a lady to do it with me".

3. Developing the Formulation Together
In all the transcripts coded so far, participants have said that they felt their formulations were developed with them. Some people have described in what ways developing their formulations felt collaboration (P10). The psychologist below questions how collaborative formulation can be (PT01), it will be interesting to see if any service users mention this.

Example Quotes
- P10: Line ref: 115- "P: I think it was the words she used, the information she had, the plan I think".

- PT01: Line ref: 10-11- "P: Ok, ok, sure, ok, so the process of formulating, interesting, err so, he had two pieces of therapy, and we arrived, I arrived, we arrived (laughs), at a lengthy narrative formulation".

4. Building on Previous Therapy Experiences

- There appears to be a pattern emerging whereby previous experiences of therapy are important platforms to build on, both for the client and for the psychologist but in different ways. A few participants spoke about their previous experiences of individual or group therapy. It seemed for some that this all came together to help them. Both psychologists spoke about having read their clients notes before meeting with them. For example, this psychologist noticed that her client's psychotic symptoms appeared symbolic of the child sexual abuse he experienced which helped her to start formulating.

Example Quotes

- P10: Line ref: 229-230- "P: Whilst we were in the hospital we had group sessions and what have you, and they sort of like taught us tools to use, so the tools, I started to use those".
- PT01: Line ref: 18-21- "from his notes, and from him, I think he was quite open about it, that he had experienced child sexual abuse whilst in care, and so for me, some of the stuff that he was experiencing in this psychosis was very, was really symbolic of the abuse".

Formalising Therapeutic Discussions

- The idea that formalising therapeutic discussions on paper makes it more powerful is evident in the transcripts coded so far. There seems to be something important about the sense of permanency this provides. Service users appear to appreciate this for different reasons. One psychologist described how formalising the abuse that her client experienced as a child let him know that she believed him which was very powerful. She felt that he viewed the formulation as a kind of witness testimony. Other service users described their formulations as almost certificate or as marking a new start.

Example Quotes

- PO5: Line ref: 311- "R: It feels like an accomplishment, it's like at last I've dealt with the underlying issue".
- P10: Line ref: 131-132- "Once the letter came and I read it, it was erm, I knew it was, it was a new start for me".

Deepening of the Therapeutic Relationship

- Some service users are describing a deepening of the therapeutic relationship after the sharing of their written formulations. P05 (see below) said that her therapist left personal information out of the formulation, though they did not discuss this beforehand. She later went on to say this led to an increase in trust and her opening up even further in therapy. For others this change of relationship appears to be more subtle e.g. see P07.

Example Quotes
- P05: Line ref: 194-198- "P: Yeah I did, when I read it I thought 'oh **** didn't mention it' because in your data, everyone knows all your business because they can read everything and when I was disclosing things I thought 'I wondering if she's going to put that down?', and then I read the formulation and she didn't, and its good.
- P05: Line ref: 208-212- "R: How did that make you feel towards her? P: That I could trust her, I felt I could open up more.
- P07: Line ref: 72- "P: I don't think it changed much, but maybe just deepened a bit".

Distinguishing Diagrams from Letters
- Different individuals appear to prefer diagrams and letters for different reasons, for example, one individual reported that he preferred diagrams because he found the letters too complicated and another preferred his letter because it contained more information and was more formal.

Example Quotes
- P04: Line ref: 47-49- "P: Yeah she gave me errr like a summary, err a written summary, a letter that included everything that we had discussed, she rit it so, I understood it, bits of it were quite complicated like to understand".
- P11: Line ref: 296-297- "P: It seems like you know more important like, when you see the illustrations they are just drawings".

2. Seeing Things Differently
A number of service users have described thinking differently as a consequence of the sharing of their written formulations.

Example Quotes
- P01: Line ref 171- "Hmm huh, […] in the sense I'm looking at it more objectively and thinking twice about things".
- P10: Line ref: 267-272- "I know that they, are a voice in my head now. If it happened again I would get help, I've got the emergency numbers. R: And where do you think that change of understanding came from? P: From the different therapies, particularly the individual sessions, it was all helpful".

2. Referring back
All the service users interviewed so far anticipated or had already began referring back to their written formulations. The reasons for this appeared to differ, for example, some anticipate using it as a progress tool and others a resource for the future.

Example Quotes
- P01: Line ref: 23- "Hmmmm, hmmmm, yes, it's just easy, it reminds me of where I'm at".
- Line ref: 155-159- "P: It will become like looking at an old photograph I think, a reminiscent tool, rather than a progress tool, I think".
- PT01: Line ref- 268-"He had a sense of this being a resource for him in the future".

Appendix 16: Extracts from Reflective Diary

April 2017

I undertook my first interview today and it went well. However, it felt strange to be meeting with service users as a researcher rather than therapist. I wasn't sure how much I should draw on my therapy skills. It was also difficult deciding how much to diverge from the interview schedule. From a therapists point of view I found the interview uplifting as the service user had experienced formulation positively, making both psychological and practical changes as a result.

June 2017

I undertook my third interview today. I felt more able to use my therapy skills to elicit further information from the participant.

July 2017

On the way home from an interview I was thinking about how at times it felt like the participant could be talking about therapy rather than formulation. When I noticed this I asked for clarification. However, I began to think about how difficult it is to discriminate between therapy as a whole and formulation for therapists let alone service users without training in therapeutic interventions. I will have to remain mindful of this throughout subsequent interviews.

October 2017

Recruitment is not going well. We have decided that I will submit a substantial amendment to enable me to recruit service users with experience of discussing different psychological understandings of psychotic experiences within a group setting or family based intervention. It will be helpful to triangulate my data by doing this, however, I am keen to keep the focus on my study on how service users feel and make use of written formulations in therapy for psychosis. I have also requested to make other changes to my study too, such as being able to undertake interviews over the telephone.

December 2017

I attended the cohort Grounded Theory (GT) group today. Everybody seemed unsure about undertaking GT, it was new to all of us. It was a relief to find that I was not the only person to be finding it difficult to get to grips with it. In fact, I even felt like I was able to be helpful to some people by sharing what I knew. We all shared an example of one of our interview transcripts open coded. I was surprised by how different this looked for each of us. This was probably because we are all taking different stances on our interpretation of the data, but also because we all had different ways of going about the task.

December 2017

Today I was thinking about how much I have been avoiding MRP. I'm feeling overwhelmed. Will I hand this in on time? I'm questioning why I chose GT. It's so complex!

December 2017

Whilst open coding one of my interview transcripts I began thinking about how much I can be sure that the categories and codes are naturally emerging from the data or how much my questions and the way I have structured the interviews have influenced this. I guess this is one of the many reasons why I have taken a critical realist perspective, enabling me to reflect on how this has impacted on my analysis.

December 2017

I'm starting to become concerned about recruitment now. I have submitted another substantial amendment to enable me to interview psychologists about their experiences of undertaking formulation within individual therapy. I anticipated doing this in my initial proposal and feel it would be helpful to have this triangulation of data at this point.

January 2018

Today I focused coded an interview with a participant where I experienced difficulties communicating with him because English was not his first language. Throughout the interview the participant makes the same point very clearly on a number occasions, which was how confusing he found his formulation. The importance of adapting formulations for individual service users has arisen in some of my other interviews too.

January 2018

After having to cope with some difficult personal circumstances, I have found it helpful and distracting to transcribe my interviews.

January 2018

A few psychologists have been in touch regarding potential participants. I have my remaining participants booked in now. It feels odd to say that I no longer need any more participants given how desperate I was a month ago. Part of me feels I should do further interviews but the more rational part of me knows I need to stop and focus my attention on analysing data and writing my part A.

February 2018

Today, I was thinking again how much my questions in the interviews with service users and the things I think are important about formulation have influenced the design and analysis of my project. I have realised there are certain areas that I anticipated were going to be important, for example, how the sharing of the formulation may change the therapeutic relationship. However, I also anticipated that people's feelings towards their formulations may evolve over time, as found in one of the two qualitative studies conducted already in this area, but this does not seem to be the case with my participants. Though this could also be to do with my sample, formulations had been shared with my service users within the last year, and most were more recent than that.

February 2018

So far all of the service users I have interviewed have previously undertaken group or individual therapy before their more recent course. I am getting a sense that these experiences build up and amalgamate with new experiences of support. This perception was reinforced last night when one of our lecturers sent out his thoughts on key papers we had been reading as part of a reading seminar. Within the notes the lecturer had highlighted a comment made in a paper about previous therapy not working for the individual described in a case study. He questioned whether the therapy 'did not work' and suggested that the support the service user received may have had a cumulative effect, contributing to the individuals more recent therapy and positive psychosocial outcomes.

March 2018

I have been using my memos to help develop my GT categories. I'm so glad that I kept clear memos with quotes whilst analysing my data. I can feel the model starting to emerge too. I'm quite surprised at how clear the interview data is in my head and how fluidly the model seems to be coming together. My supervisor did say that if I trusted the process that this would happen. The following images depict this process, the final image is a precursor to the emerging GT model presented in the paper.
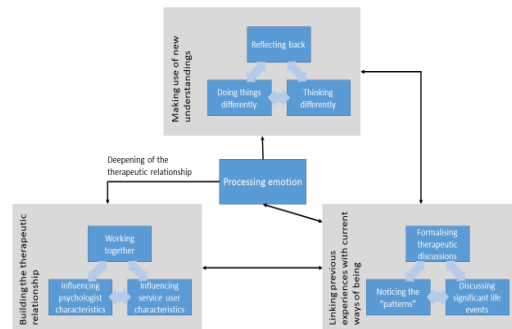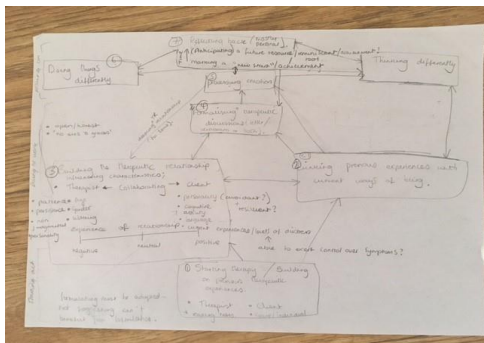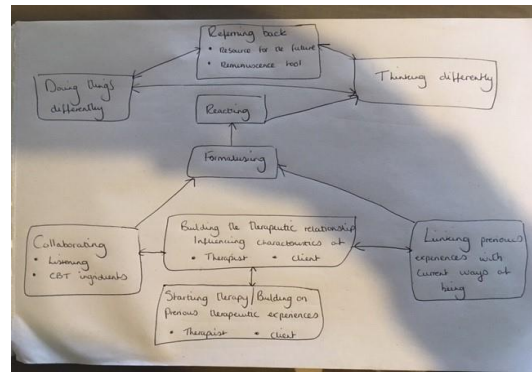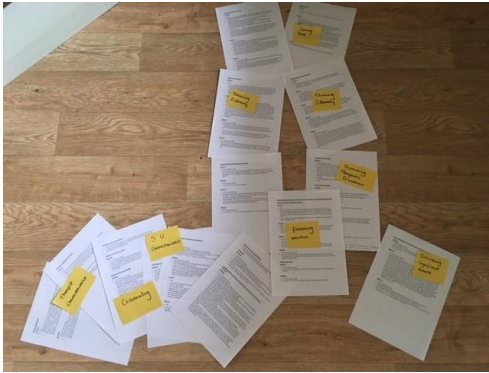
Appendix 17: NHS Health Research Association Approval

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Appendix 18: NHS R&D Approval

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Appendix 19: Substantial Amendment (2nd November 2017)

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Appendix 20: R&D Substantial Amendment (19th January 2017)

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Exploring Psychological Understandings Developed During Therapy for Psychosis

Rationale

Formulation is a fundamental component in many of the psychological therapies practised within the NHS (e.g. Cognitive Behavioural Therapy). It is seen as a starting point for the process of intervention. However, despite the importance placed on formulation, it is under researched. Research exploring reactions to formulation in therapy for psychosis suggest service users feel ambivalent about it. As well as finding formulation helpful, encouraging and reassuring, service users also experienced them as saddening, upsetting, frightening, overwhelming and worrying. More research is necessary to understand the psychological and behavioural processes that occur after the sharing of a formulation during therapy for psychosis.

Aim

The study aimed to explore how service users feel about and make use of formulation during therapy for psychosis.

Methods

Semi-structured interviews were undertaken with 11 service users and two clinical psychologists regarding their experiences of formulation. Interviews were analysed using Grounded Theory from a critical realist perspective.

Results

Core processes during the sharing of a formulation were identified. A model was constructed to describe the interactions between the processes (Fig 1). 'Linking previous experiences with current ways of being' and 'building the therapeutic relationship' were identified as reciprocally influential core processes. 'Making use of new understandings' was also identified as an important process in the sharing of a formulation.

'Linking previous experiences with current ways of being' required service users to discuss significant life events, to 'notice patterns' in their lives and to collaboratively formalise therapeutic discussions. Service users experienced and processed a range of emotional reactions ('managing emotions') to 'discussing significant life events' and 'formalising therapeutic discussions'. 'Building the therapeutic relationship' was an ongoing process which influenced - and was influenced by - the process of 'linking previous experiences with current ways of being'. Some individuals experienced a *"deepening"* of the therapeutic relationship as a result of engaging with the process of 'linking previous experiences with current ways of being' and managing the emotions ('manging emotions') produced by this process in the context of their therapeutic relationship. Further, having a good therapeutic relationship enabled service users to feel comfortable to explore the links between their past and current selves. 'Building the therapeutic relationship' was also influenced by a number of service user and therapist characteristics. Many service users were able to move on to make use of the new understandings they developed through engaging with the core processes. Some individuals anticipated or had already begun 'reflecting back' on their written formulations.
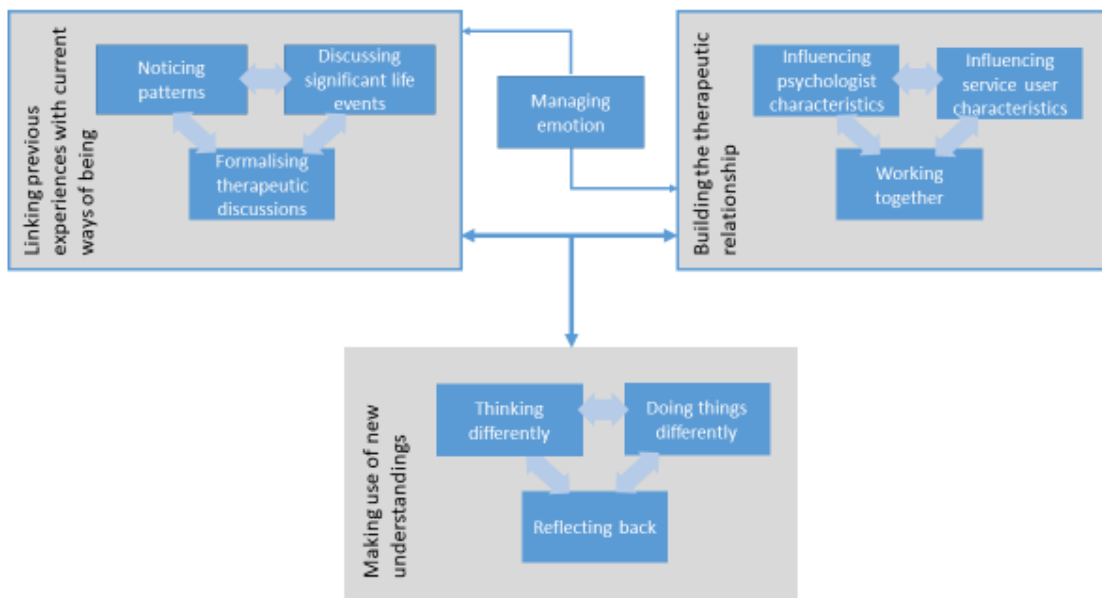
Figure 1. Emerging theoretical model detailing the interactions between the categories and subcategories.

Implications

The findings of the current study have a number of clinical implications. The findings that service users perceive collaboration in formulation as important and that they can experience the process as confusing suggests that formulation should be developed collaboratively and presented progressively to service users to ensure understanding. Different service users expressed preferences for their formulation to be developed with them in the form of a letter or diagram, when working with service users such preferences should be taken into account. Therapist characteristics were seen as important to service users in the current study, therefore therapists may wish to explore any potential hindering features that may impede on the building of a therapeutic relationship. The current study suggests that it is also important to consider service user characteristics, before deciding to share a written formulation, such as severity of experiences and distress, cognitive ability and personality style. Formulation appears to be an emotional process for service users, care and attention to the emotions that arise as a result should be given. Further research is necessary to elaborate our understanding of formulation given the importance placed on it.

Thank you for you participation in this study, please do not hesitate to contact me with any questions, comments or concerns.

Kind regards,

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Appendix 22: Author Guidelines for 'Psychology and Psychotherapy: Theory Research and Practice' Journal

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Appendix 23: Practitioner Points Required by Journal

- Formulations should be developed collaboratively and presented progressively to service users to ensure understanding.

- Service users should be given a choice regarding the presentation of their formulation e.g. letter or diagram.

- Service user preferences for certain demographic characteristics in their therapists should be taken into account where possible to ensure service users feel comfortable to begin the process of formulation.

- Care and attention should be given to the emotions that arise as a result of sharing a formulation.