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AN EXPLORATION OF THERAPY PROCESSES WITHIN THERAPEUTIC INTERVENTIONS FOR PEOPLE EXPERIENCING PSYCHOSIS

Section A: Therapy Processes that Occur during Psychological Interventions with People Experiencing Psychosis – A Literature Review
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Section B: Exploring how people experiencing psychosis make use of understandings and strategies developed during the joint activity of therapy
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Summary of the Major Research Project

Section A: A systematic literature review was conducted, exploring the area of research regarding processes in therapy for psychosis. Current research is limited and twenty studies were selected for detailed review. Six themes were prominent in the reviewed studies; Alternative Perspectives, Collaboration between Therapist and Client, Therapy as a 'Safe' Space, Improving Understanding through Education, Improving Social Interactions and Making Use of Skills and Strategies. Opportunities for future research are discussed in the context of the literature review.

Section B: Whilst psychological therapies for psychosis show promise in assisting people in recovering from psychosis, relatively little is known about the processes involved, specifically the processes worked through to allow clients to understand and adopt strategic approaches to their care. Semi-structured interviews were conducted with 11 participants (six psychologist-client pairs), with data analysed utilising Grounded Theory methodology. The model constructed presents multi-directional, dynamic interactions between three core categories; Enabling Personal Empowerment, Navigating a Collaborative Journey and Building Belief to generate Trust. The model is discussed in the context of previous research, with clinical implications and future research identified.

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Section A: Therapy Processes that Occur during Psychological

Interventions with People Experiencing Psychosis – A Literature Review

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Terms

For the purpose of this review, "change processes" in therapy for psychosis are defined as therapeutic activities and experiences which individuals engage in when attempting to alleviate distress from psychotic experiences or alter problem behaviours and negative thoughts. The individuals involved in these processes include therapists, clients and any other relevant party in the context of therapy, for example family members.

Abstract

Introduction: Change process research has provided indications of important processes which occur between therapist and client during psychological interventions. However, there is limited consistency in the findings regarding client, therapist and psychological model factors which could impact outcome, especially within therapy for psychosis. It is these factors and their potential impact on psychological therapy for psychosis that is to be explored further in the review of the current literature.

Methodology: Database searches were conducted utilising Web of Science, Ovid Medline, ASSIA, PsycINFO and Wiley Online to gather literature relevant to therapy process research in psychological interventions for psychosis. The search resulted in the selection of 20 studies for further detailed review.

Literature Review: Key process themes are proposed from the research explored and methodologies of the selected studies are compared and critiqued. The themes which emerged were Alternative Perspectives, Collaboration between Therapist and Client, Therapy as a 'Safe' Space, Improving Understanding through Education, Improving Social Interactions and Making Use of Skills and Strategies.

Future Direction of Research: Future areas of potential research are suggested and explored in the context of the literature review, in an attempt to highlight areas of potential development within research in therapy processes for psychosis.

Key Words: Psychosis, Grounded Theory, Therapy Process, Psychological Therapy

Therapy Processes in Psychological Interventions with People Experiencing

Psychosis – A Literature Review

The aim of this review is to summarise and critique current knowledge in relation to therapy processes that occur during psychological interventions with people experiencing psychosis. The author argues that gaining further insight into change processes in therapy for psychosis and how these bring about positive therapeutic change in clients is of critical importance. This insight could enable the refinement of psychological interventions to better elicit potentially important processes which may be occurring. In other words, if a clearer understanding exists regarding what actually happens in therapy to allow positive client change, psychological interventions could be tailored to help promote the use or occurrence of these processes.

The conceptualisation of psychosis, recommended psychological interventions and the specific debate surrounding Cognitive Behavioural Therapy for psychosis (CBTp) are outlined, laying the foundation for the justification of this review. Previous research examining change processes is summarised before the specific literature review is presented. Potential areas of further investigation are then identified where previous research has either demonstrated limited understanding or generated further questions to be addressed.

Understanding Psychosis

Psychosis is defined as representing a cluster of psychiatric disorders, including the specific diagnosis of schizophrenia, characterised by alterations in the way an individual thinks, feels, and understands their world (British Psychological Society; BPS, 2000). Psychiatric diagnoses are grounded in a medical model understanding of a person's symptoms and biological indicators (Frese, Knight, &

Saks, 2009). Currently, diagnoses rely on the use of the Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM-5, American Psychiatric Association; APA, 2013) and the International Classification of Diseases: Classification of Mental and Behavioural Disorders (10th ed.; ICD-10, World Health Organisation; WHO, 2014). However, conceptual and empirical limitations within the dominant process of assigning functional psychiatric diagnoses, such as psychosis, have been highlighted (Division of Clinical Psychology; DCP, 2013). The DCP argued that at the root of many issues relating to difficulties with psychiatric diagnoses, was the act of applying a physical disease model and medical classifications, to aspects of human nature such as thoughts, emotions and behaviours (DCP, 2013).

A recent publication stated that psychosis should now be viewed as eight genetically distinct disorders (Arnedo et al., 2014). However, the British Psychological Society [BPS] recently published a report promoting a more holistic understanding of psychosis (BPS, 2014), adding further complexity and division in the conceptualisation of psychosis.

This review does not specifically set out to address this debate, for reasons of brevity, and will therefore use the term 'psychosis' as a broad point of reference, consistent with clinical psychology publications and research within the UK. However, in support of the issues raised by the DCP, underlying the use of the term 'psychosis' in this review is the assumption that every individual will have a unique combination of experiences and symptoms. This requires an appropriately individual understanding and offer of treatment (National Institute for Health and Care Excellence; NICE, 2013a).

Psychosis is suggested to be within the top ten leading causes of disability (WHO, 2001). Comorbidity in psychosis has been widely documented, with

depression (Sundquist, Frank, & Sundquist, 2004; Warman, Forman, Henriques, Brown, & Beck, 2004), personality disorder (Keown, Holloway, & Kuipers, 2002; Moran et al., 2003) and alcohol and drug misuse (Haddock et al., 2003; Soyka, 2000) identified as potential co-occurring difficulties. These difficulties can be worsened by continuing stigma associated with the diagnosis, as well as common misconceptions regarding mental illness in the broader sense (Sartorius, 2002; Tan, Gould, Combes, & Lehmann, 2012; Thornicroft, 2006 cited in NICE, 2013a).

The idea of recovery from mental illness in general has become of growing interest within UK government policy initiatives (Department of Health; DoH, 2011), however, there is no single definition of a recovery approach. The view of psychosis as a chronic disorder, worsening in its progression and from which full recovery is uncommon (APA, 1994) has been challenged by researchers and service user campaigners. It is suggested that long-term outcomes may be more optimistic than previously thought (WHO, 2001; France & Uhlin, 2006). With this change in perspective it has become clear that medication on its own is not likely to lead to a full restoration of functioning for the majority of people experiencing psychosis (Haddock et al., 1998; Lauriello, Bustillo, & Keith, 1999; Morrison et al., 2014). A review of decision making and choice in people using mental health services found that service users wanted to be offered more than just antipsychotic medication (Warner, Mariathasan, Lawton-Smith, & Samele, 2006). Farkas, Gagne, Anthony and Chamberlin (2005) stated that one of the most important issues which needed to be addressed within the mental health field was the lack of knowledge about the types of services and interventions offered to help people recover from severe mental illnesses.

Current Psychological Treatment Options

NICE provide UK guidance to assist services and practitioners to improve physical and mental health outcomes across the population (NICE, 2013b). NICE concluded that specific psychological interventions, Cognitive Behavioural Therapy for psychosis (CBTp) and Family Intervention (FI), have demonstrated efficacy when engaged as an adjunct to antipsychotic medication (Krakvik, Grawe, Hagen, & Stiles, 2013; Kuipers et al., 1997; Lincoln et al., 2012; NICE, 2014). Since the beginnings of the service user movement in the early 1990s, there has been a growing development of a more integrative model of understanding biological, psychological and social factors which contribute to the onset and maintenance of psychosis (Bloy, Oliver, & Morris, 2011). Other NICE recommended interventions now include art therapy and supported employment (NICE, 2013a) and psychological interventions such as Acceptance and Commitment Therapy (ACT) and Mindfulness based CBT have started to build on early studies which demonstrated effectiveness in this population (Ashcroft, Barrow, Lee, & MacKinnon, 2012; Bloy et al., 2011).

However, at present, in spite of national recommendations by NICE to offer CBTp as routine treatment, there is a continuing debate about its effectiveness. The debate has become increasingly polarised and has spread from peer-reviewed journals to a more widely accessible public domain (British Broadcasting Corporation (BBC), 2014; Freeman & Freeman, 2014; Kinderman & Cooke, 2014; Laws, 2014). Tarrier and Wykes (2004) suggested that the effectiveness of CBTp should be accepted cautiously, and this caution seems to be prominent in why the debate for or against CBTp has become so divided.

Studies have demonstrated support for CBTp (Morrison et al., 2014; Pfammater, Junghan & Brenner, 2006; Pilling et al., 2002). Pilling et al. (2002) and

Pfammatter et al. (2006) conducted meta-analyses and suggested that CBTp significantly lowered psychotic symptom severity. They also suggested that CBTp led to lower dropout rates compared to standard care. However, consistent significant effects could only be established in trials of CBTp on persistent, positive symptoms. Morrison et al. (2014) suggested that CBTp significantly improved personal and social functioning, with some cognitive and physical aspects of delusional beliefs and voice hearing showing improvement. However, overall levels of distress related to delusional beliefs and voice hearing, self-rated recovery and depression were not lowered.

In opposition, other research has concluded CBTp was not effective or held no advantage over other treatments for psychosis, including FI and group therapy (Jauhar et al., 2014; Jones, Hacker, Cormac, Meaden, & Irving, 2012; Lynch, Laws, & McKenna, 2010). Lynch et al. (2010) reviewed data from published trials of CBT in schizophrenia, major depression and bipolar disorder. In relation to schizophrenia they concluded that CBT was not effective in decreasing symptoms or in preventing client relapse. Lynch et al. (2010) acknowledged that some positive symptom ratings showed a small but significant effect size in favour of CBT but claimed this advantage was a result of the lack of blinding in two of the trials.

Jones et al. (2012) conducted a meta-analysis which reviewed the effects of CBT for people with schizophrenia, comparing these findings with other psychological therapies. They concluded that there was no difference between CBT and other psychological therapies in relation to relapse prevention, avoiding rehospitalisation, improving mental state, reducing positive and negative symptoms, improving social functioning and improving quality of life for people experiencing schizophrenia.

More recently, Jauhar et al. (2014) found that CBTp only had a small therapeutic benefit for clients in relation to psychotic symptoms. This was reduced even further when blinding was controlled for, as previously identified by Lynch et al. (2010). They concluded that NICE should remove the recommendation of CBT for psychosis, however, included within this meta-analysis were studies involving group CBTp, which is not recommended by NICE.

Even with psychological therapy recommended as treatment for psychosis there is still limited insight more generally into how therapy might be successful. As Jones et al. (2012) concluded there appears to be no clear advantage of CBTp over other psychological interventions, a finding that has support in other areas of mental health research. For instance, Stiles, Barkham, Mellor-Clark and Connell (2008) compared outcomes in CBT, person centred therapies and psychodynamic therapies in a non-psychosis population and found that the theoretically different approaches tended to have equivalent outcomes. With the development of evidence based interventions continuing, Pfammatter et al. (2006) reflect on the questions that remain, particularly regarding the need to identify "specific therapeutic ingredients" (p.74).

Change Process Research

The term 'change process research' (CPR) was introduced in the 1980s as a result of increasing interest in the processes that occur during psychological therapy. CPR is focused on "identifying, describing, explaining, and predicting the effects of the processes that bring about therapeutic change" (Greenberg, 1986, p.4). Since this time, possibly as a result of the previously identified need to identify the 'specific therapeutic ingredients', research into therapeutic processes has seen further interest.

Elliott (2009) described the two most commonly adopted methods of conducting CPR as the quantitative process-outcome design and the qualitative

helpful factors design. The process-outcome design treats the change process as a secure system where only the input and output are investigated, for example, through solely quantitative analysis of outcome measure data. It is the most widely used design but has caused concern as there are potentially multiple factors that can impact on change (Elliott, 2009). This method can also make the assumption of a dose-response effect, where providing more of an active ingredient is assumed to be better for client outcome (Barkham et al., 2006; Hansen, Lambert, & Forman, 2002). The helpful factors design is consistent with service user movement messages and involves asking people with lived experiences of mental health difficulties about their understandings. The helpful factors design increased in appeal due to its relative ease and how it promotes the service user voice, part of the growing critique of the drug metaphor model in process research (Hogue, Liddle & Rowe, 1996; Stiles, 2006; Stiles & Shapiro, 1994). However, the helpful factors design has faced criticism as participants can sometimes find it difficult to describe or explain their private mental experiences and can be subject to attributional errors by over-representing the importance of certain factors which may have had little impact (Elliott, 2009).

Llewelyn and Hardy (2001) conducted a review of change process research and suggested that there was little supporting evidence for therapist variables such as model compliance, theoretical orientation or personality characteristics. They suggested the way in which therapists' empathy and directedness was perceived by clients altered, depending on the individual. They also suggested therapists' actions were not as important as clients' own capacities to self-heal. In fact, the most clearly significant predictor of outcome was the therapeutic alliance, i.e. the relationship created between therapist and client.

More recently, Kazdin (2007) conducted a comprehensive review of 'mediators and mechanisms of change' in psychotherapy and similarly suggested that therapeutic alliance, as well as clients altering their depressive cognitions, were the most common predictors of successful therapy found by previous research. However, he stressed the point that despite this, these findings do not offer explanations as to how and why these components of therapy bring about therapeutic change. Kazdin (2007) concluded by promoting the need for 'next step' research which aims to clarify how identified mediating factors, such as the therapeutic alliance, actually lead to symptom improvement. He proposed that the "best patient care will come from ensuring that the optimal variation of treatment is provided" (Kazdin, 2007, p.23), which can be achieved through the evaluation of the specific steps or processes which occur in therapy.

Literature Review Rationale and Objectives

Whilst the author acknowledges the advantages of defining how psychosis is understood and establishing the most effective psychological treatments for this population, it is thought that the prospect of finding a consensus in these discussions is far from fruition. Rather than contributing to the already complex nature of defining psychosis and the increasingly polarised debate for or against CBTp, the author posits that it is in the best interests of people experiencing psychosis for research to focus on furthering understanding of key processes in therapy for psychosis. A greater insight regarding how and when these are likely to be most helpful is now required. It is hoped that a better understanding of the factors contributing to positive or negative experiences of therapy for psychosis would potentially allow the refinement of psychological interventions and services available. This appears to be a timely

requirement needing to be addressed within the mental health field (Farkas et al., 2005).

CPR has largely investigated quantitative analysis of outcome measurement data which followed a process-outcome design. Beyond the suggested importance of a positive therapeutic alliance and altering clients' depressive cognitions, there is limited consistency in the findings regarding other client, therapist and psychological model factors which could impact the change process (Elliott, 2009). This is especially pertinent in CPR exploring therapy for psychosis due to the limited amount of previous research in this field. Therefore, it is these factors and the potential impact throughout therapeutic interventions for psychosis which are to be explored further in the review of the current literature to consider:

1) What are the change processes currently identified as important within therapy for psychosis?

2) What research and clinical implications do these findings have?

Literature Review Methodology

Psychology based databases (ASSIA, Ovid Medline, PsycINFO, Web of Science: Core Collection and Wiley Online) were searched using relevant search terms. Specific inclusion and exclusion criteria were applied to identify peer-reviewed research that explored processes in therapy for psychosis (see Appendices 1 & 2). The search resulted in the selection of 20 studies for further detailed review (see Appendix 3). The selected studies comprised ten qualitative, four mixed methodology and six quantitative studies.

It is important to note that quantitative studies that focused solely on presenting results through quantitative, descriptive data analyses were excluded from the search. Whilst they investigated links between specific therapeutic factors and

changes over time, they did not offer explorations or discussions of how therapeutic factors may have enabled or hindered client change. Therefore, the author decided that these studies would not help elucidate the questions focusing this review. For example, the study by Garety et al. (1997) was the second of three papers resulting from the same randomised controlled trial (RCT) of CBTp, and was included in this review. However, publications one and three from the RCT were not included in this literature review for this reason.

The following sections aim to present key themes arising from the 20 studies in relation to therapy processes, summarise and critique the methods utilised and discuss the research and clinical implications arising from the review.

Key Process Themes Identified from the Literature Review

Semantic themes were developed following principles of an inductive thematic analysis technique, as described by Braun and Clarke (2006). Recurrent patterns and important findings regarding the interactions between therapist, client, and family members, where relevant, were identified in the studies. These were coded and categorised into broader themes based on similarities amongst the selected studies. This approach involved repetitive reading and comparison of the studies and the attributed codes to ascertain that the themes appropriately categorised and described the studies' findings.

Six themes were prominent in the reviewed studies; Alternative Perspectives, Collaboration between Therapist and Client, Therapy as a 'Safe' Space, Improving Understanding through Education, Improving Social Interactions and Making Use of Skills and Strategies. This section will summarise these key themes, in order of coding frequency, with the most prevalent presented first.

Alternative Perspectives

The act of the client adopting an alternative perspective on their difficulties or psychotic experiences appeared most often, with 14 studies describing this process. Dilks, Tasker and Wren (2008) described this core therapy process as 'building bridges to observational perspectives', defined as a process whereby therapists continually offered clients alternative ways to view their psychotic experiences or difficulties. The aim being that these alternative perspectives make apparent new possibilities for thought, feeling or action for the client to explore, in turn creating new options for them. Perceptual disturbances caused by psychosis are often the most confusing and troublesome aspect for people, so importance was placed on the individual client making sense of their experiences and integrating this perspective of their psychotic experiences into a newly defined sense of self (Dilks et al., 2008). This also reinforced their suggestion that it is not the specific perspective or explanation generated that is the important factor; it is the client's interpretation and the meaning they attribute to this perspective.

McGowan, Lavender and Garety (2005) concluded that the one consistent factor emerging in positive outcomes of therapy for psychosis was the clients' willingness to consider different explanations for psychotic experiences. Their second process category was titled 'moving to new and disregarding old understanding', in which they suggested the client needed to move on from the previous understanding held regarding their experiences, as this was often distressing and confusing. The main difference they identified between clients who progressed and clients who failed to progress in CBTp was the ability to understand, hold, and engage with the model of reality that the therapist presented to them. In conclusion, the authors identified that the most effective predictor of success in treatment was the ability to contradict

psychotic understandings by holding an alternative explanation. This was also supported by Garety et al. (1997), who concluded that clients who were willing and able to consider alternative explanations for their positive symptoms, mainly delusions, were more likely to respond well to CBTp. Wood, Price, Morrison and Haddock (2012) went one step further and suggested that there are different aspects of recovery and these are not necessarily grounded in a medical framework and understanding of the alleviation or removal of symptoms. Wood et al. (2012) use this as a platform to request further research focused on exploring service users' subjective experiences to encourage a wider perspective when considering appropriate treatments and services for individuals.

Karatza & Avdi (2010) highlighted the importance of the therapists' role in introducing a wider range of explanations regarding client experiences and identity. They found that within families of someone experiencing psychosis there was a strong medical underpinning to their understanding. In addition to introducing new ways of understanding their experiences, it was suggested that therapists could also encourage clients to identify positive roles that their psychotic experiences may play in their sense of self. An example provided was a therapist's suggestion that the client's positive symptom of hearing voices served a function for the client to swear on his behalf. This explanation was proposed in therapy as equally plausible to other suggestions and was made available for the client to explore and test out.

Allen, Burbach and Reibstein (2012) stated that the process of adopting a new perspective, through the understanding and discussion of multiple viewpoints, is critical. They suggested this is brought about by the development of a cognitive shift; a new positioning in the world, increasing personal responsibility, confidence and the feeling of being empowered through change. Newton, Larkin, Melhuish and Wykes

(2007) also described how it is a cognitive shift in clients' own explanations of their difficulties that allows them to get on with their life, rather than any alteration in the frequency or content of psychotic symptoms themselves. This seems to support the need to better understand how therapy enables people to change their perspective and explanation of their experiences, rather than using quantitative ratings of symptom reduction as an outcome measure to fuel the CBTp efficacy debate.

Similarly, from a narrative perspective, Lysaker, Lancaster and Lysaker (2003) suggested that the number of identified self-positions increased the longer their client was in therapy, but that the actual content of the client's narrative stayed the same. Lysaker et al. (2003) argued the way in which the narrative was told and understood by the client changed over the course of therapy to include different ways of understanding experiences and historical influences. Lysaker and Lysaker (2006) develop their thinking further by concluding that the narrative impoverishment represented by a 'monologue', whereby the client finds it difficult to alter one dominant self-position, could be improved by guiding the client towards a more cognitive focused approach. This cognitive approach could incorporate examining how a certain belief or perspective is experienced, for example, as unquestionable, and how this position was developed. Lysaker and Lysaker (2006) suggested the power of the dominant self-position could then be weakened, which could allow other self-positions to contribute to the conversation, thus opening up new perspectives for the client to consider. They argued that opening up new perspectives appeared to increase the clients' sense of control over their own actions, such as coping better with distressing voices, and enabled them to improve their confidence in their ability to understand and explain their own narrative.

This suggested increase in clients' sense of control was supported by other studies where client control was linked to owning their narrative (Karatza & Avdi, 2010), a better understanding of psychotic experiences (Wood et al., 2012) and therapists' use of general therapy skills, such as listening well and providing accurate feedback (Wittorf et al., 2013).

In summary, it appeared that the process of the client adopting an alternative, less distressing perspective on their individual experiences and difficulties, has been found to be important in therapy for psychosis.

Collaboration between Therapist and Client

Collaboration was suggested as an essential process in 13 of the studies. Smerud and Rosenfaub (2008) suggested that when clients worked closely with the therapist and developed a positive alliance, clients' relatives tended to be less rejecting of them and clients reportedly felt less of a burden on relatives who were assisting in their care. In addition, when relatives formed a positive alliance with the therapist, through family psychoeducation, clients were less likely to relapse or be admitted to hospital over a two year follow-up.

McGowan et al. (2005) found that the majority of clients who had progressed through therapy had engaged in a process of sharing a clear task with their therapist. This process was found to be mostly lacking with clients who found it more difficult to progress in their therapy. Dilks et al. (2008) also suggested the importance of collaboration in proposing that another main therapy activity was that of "negotiating shared understandings" (p.219). They suggested that this conversational process allowed the therapist and client to be constantly sharing views and discussing alternatives, which paved the way for developing shared, alternative perspectives on the client's distressing experiences.

Collaboration was also highlighted by Wittorf et al. (2013), who placed emphasis on the therapist's ability to use their skills in understanding and feedback to demonstrate to the client that they could understand their viewpoint. This in turn was suggested to enhance the client's experience of therapy and in particular the shared therapeutic alliance or bond created with the therapist. The same study also found that the technical CBT skill of 'guided discovery' actually showed negative associations with the client's alliance. Wittorf et al. (2013) suggested the use of active techniques, such as guided discovery, often challenged clients' particular ways of understanding psychotic experiences. These challenges were suggested to lower trust in the therapist and increased the risk of difficulties in developing a positive alliance (Wittorf et al., 2013).

Wood et al. (2012) described four key processes in therapy for psychosis, including "collaborative support and understanding" (p 254). This factor was generated through the perspectives of clients who felt that a key aspect of their recovery was the acquisition of positive and collaborative engagements with others and with services. Allen et al., (2012) suggested that conversations within sessions enabled therapists and clients to hold a reflective stance, allowing clients to share their difficulties and think about ways to improve their situation, resulting in increased client empowerment regarding their distressing experiences. This process of working together with the therapist suggested the importance of others, whether it be family, friends, or carers, being involved in the change process with the client and to share in the recovery process.

Other studies also suggested that collaboration between therapist and client is required to maintain benefits, especially in the early phases of therapy when an initial formulation is being jointly constructed (Karatza & Avdi, 2010; Lecomte, Leclerc,

Wykes, Nicole & Abdel Baki, 2014). Morrison and Barratt (2010) found that the recommended element of 'engagement', rated as of central importance by experts in the field of psychosis, included several factors explicitly stating the need for "collaborative feedback", "consistent collaboration throughout the sessions" and that "CBT should be implemented using a collaborative approach" (Morrison & Barratt, 2010, p.139). However, Dilks, Tasker and Wren (2012) highlighted that even though the process of therapy is collaborative, it was the therapist who assumed responsibility for sustaining the core process within therapy. This assumption was borne out of the efforts made by therapists to maintain dialogue within sessions and emerged as a separate category within their findings, titled 'working to maintain observational perspectives'.

In summary, collaboration in therapy was found to be beneficial in reducing drop-out rates, reducing hospital admissions and encouraging clients to include others such as family and friends, not just the therapist, in their individual recovery process.

Therapy as a 'Safe' Space

The therapist's ability to create and maintain an emotionally safe therapeutic environment for the client appeared in ten of the reviewed studies. The suggested therapeutic activity of "doing relationship" (Dilks et al., 2008, p.220) proposed the need for the therapist to take the lead in creating a comfortable therapy experience where the client could discuss their difficulties in a confiding context. For example, it was suggested that the therapist expressing concern for a client not only resulted in the client feeling cared about and improving their self-worth, but also contributed to the level of trust the client attributed the therapist. The process of "managing emotion" (Dilks et al., 2008, p220) also portrayed therapists as being responsible for

regulating the emotional intensity of sessions, to reduce the likelihood of clients becoming overwhelmed by their distress.

Allen et al., (2012) also indicated the importance of a shared, containing space. By containing they mean clients were heard, valued, and their behaviour normalised by therapists who were non-judgemental and neutral in their discussions, as identified by clients. The idea of containment was particularly pertinent when the therapist and client were engaging family in the therapy. Allen et al. (2012) stated this was an essential process in managing emotional states.

The importance of therapy as a safe space was echoed by Grant et al. (2014). They described how, at the start of their participant's therapy, the therapist fostered open and honest communication by reinforcing the sharing of thoughts, empathising, validating emotions and viewing the client's thoughts as important, warranting further exploration. In a group setting, Newton et al. (2007) presented one of their two core processes which indicated that group therapy was "a place to explore shared experiences". This core process comprised of subthemes including "a safe place to talk" and "normalizing and de-stigmatizing" (Newton et al., 2007, p.133). Lecomte et al. (2014) also suggested that in a group context it was essential for all participants to feel safe, to enable them to relate to other participants and the therapist. Braehler et al., (2013) proposed that a danger of not creating a containing environment was that clients may not discuss their difficulties, fearing the exposure of weakness leading to feeling vulnerable.

In summary, therapists were suggested as integral to creating a feeling of safety in therapy; hearing, valuing and validating clients' thoughts and experiences, enabling clients to feel able to talk openly about their difficulties.

Improving Understanding through Education

Nine studies described therapy as an educational process. Larsen (2007) explained how therapists, clients, and family members described engaging in a process of learning about psychosis. This included identifying symptoms and ways of coping with these. Particularly for clients, learning about psychosis improved their understanding about how they perceived themselves as a person experiencing mental health difficulties. This learning provided a base on which to develop clients' social negotiation and self-transformation, two key processes proposed by this study.

Messari and Hallam (2003, p.182) suggested that therapists were perceived by clients as being "respectful teachers", enabling clients to improve understanding of themselves, critically examine their beliefs and develop coping strategies. Similarly, Smerud and Rosenfaub (2008) described how 72% of the sessions examined focused on teaching communication skills, 6% on teaching problem solving, and 22% on teaching a combination of the two.

Grant et al., (2014) suggested that the shared task of developing a case conceptualisation within therapy allowed for in-depth reviews of psychotic experiences, for example, regarding the content of hallucinations. This led to a shared formulation identifying experiences, beliefs, consequent behaviours and emotions, which enabled both the therapist and client to improve their understanding of the links between these components.

De Chavez, Gutierrez, Ducajú and Fraile (2000) reported that outpatient clients involved in group therapy rated 'self-understanding' as an essential factor. Understanding of their psychological processes, along with understanding of their relationships with others in the group, indicated the importance of personal and interpersonal learning within therapy. This appeared to have implications for the

process of change throughout therapy and De Chavez et al. (2000) stressed the importance of remaining client-led. They also suggested that therapists should remain mindful that clients' needs and objectives regarding their education and understanding are dynamic and can change throughout the course of therapy.

In summary, accounts of therapists, clients and family members indicated the process of learning within therapy for psychosis, and how this educational process is needed to improve understanding about a range of topics, from psychosis in general to clients' sense of identity.

Improving Social Interactions

The process of improving social activities for clients and using interpersonal relationships to aid their recovery, within an individual, group and family intervention setting, appeared in seven of the selected studies. Analysis by Dilks, Tasker and Wren (2010) suggested that the category of 'managing the impact of psychosis' involved clients' active attempts to regulate and minimise the effects of experiencing psychosis on everyday life. This, in turn, had the aim of facilitating 'functioning in the social world'. In other words, the clients' act of managing their distressing experiences in public appeared to be motivated by their desire to "engage in ordinary relationships and activities" (Dilks et al., 2010, p.96).

Lysaker et al. (2003) also suggested that their case study client began to show improvement when his narrative accounts within therapy started to include more immediate persons, i.e. people the client had actually met in social situations, and fewer abstract groups, for example, talking about politicians he had never met. As a result, they suggested the narrative evolved to include a greater variety of self-positions which in turn facilitated the debate of multiple issues within the context of these newly formed interpersonal relationships.

In the study by Braehler et al. (2013), it was found that participants within the compassion focused therapy group showed the strongest associations between increasing their levels of self-focussed compassion and a lowering in depression and social marginalisation. It was claimed that these findings identified the important mechanisms of change associated with compassion focused therapy. They concluded that it could be viewed as initial evidence that an increase in an individual's affiliation to themselves and to others may decrease their sense of exclusion, isolation and shame.

In summary, it has been suggested that finding ways to improve clients' social interactions with others, and conduct their daily activities in a manner in which they desire, can promote individual recovery in therapy for psychosis.

Making Use of Skills and Strategies

Seven of the selected studies suggested the importance of both therapist and client making use of specific skills and strategies that they had identified as potentially useful for the benefit of the client during therapy. Three of the six main process categories proposed by McGowan et al., (2005) related to individual characteristics or abilities. The three categories identified were: 'ability to engage in clear, logical thinking', 'continuity in therapy' and 'remembering and understanding therapy'. These categories attributed importance to clients' abilities to think in a clear and logical manner, work on agreed goals over a period of weeks and operationalise the change process, respectively. This study suggested that clients who were able to execute these three processes throughout therapy were more likely to progress when compared to people who were less able. However, the study highlighted that it was difficult to be clear whether these abilities actually emerged during therapy as a result of certain processes or whether these abilities were indeed present at the start of

therapy. As no specific measures were used to index these abilities in this context, this was proposed as an area of potential research.

In terms of therapist skills and activities, Dilks et al. (2012) suggested strategies employed by therapists included the process of 'shifting perspective'. This involved therapists alternating their focus between session content and the processes unfolding in the room. This continuous switching of focus was suggested to be an important element of the role of the therapist. In addition to this, they suggested therapists were continuously monitoring themselves, as well as the client. This monitoring was proposed to involve a comparison with a standard of practice for psychologists working with people experiencing psychosis.

Dilks et al. (2012) also suggested that if therapists are viewed as 'experts' in the relationship this can be both beneficial and a possible hindrance to the therapeutic relationship and process outcomes. Assuming therapists are highly knowledgeable regarding successful therapeutic interventions for psychosis can provide clients with confidence in the intervention model adopted and maintain hope throughout the therapy that their goals can be achieved (Dilks et al., 2012). However, as one of their client participants articulated, knowledge brought by a therapist, no matter their credentials or quality of experience, may not always mean their perspective will be more accurate than the client's.

This issue of defining what is important to clients when it comes to how they view their therapist and how therapists act in therapy brings the attention back to the point made earlier by Wittorf et al. (2013). Therapists' general skills, rather than more technical, psychological model specific competences, accounted for the reported client improvements. Skills such as understanding, feedback, and collaboration were more preferable to clients in relation to improving self-esteem, mastery and

contentment in sessions, when compared to the more technical CBT skills, such as guided discovery, Socratic questioning and setting appropriately tailored homework (Wittorf et al., 2013). As the nature of CBTp involves active techniques which "dispute the dysfunctional cognitions" held by clients (Wittorf et al., 2013, p.707), this may increase the likelihood of rifts in the therapeutic alliance. In conclusion, their recommendation was for therapists to utilise their general skills in the initial phases of therapy to build the relationship with the client and to ensure containment, then once this had been achieved, to employ more technical skills grounded in psychological theory (Wittorf et al., 2013).

However, this could imply the idea that building a therapeutic alliance is one phase in managing a successful therapeutic experience, with a distinct start and finish point, as opposed to an ongoing, multidimensional process that requires active and continued attention on both sides. It also assumed that the technical CBTp activity of challenging particular client beliefs is necessary for a positive outcome, when previously identified aspects of therapy such as the client owning their own narrative to increase their sense of control (Lysaker & Lysaker, 2006) and promoting the importance of client subjective experiences (Wood et al., 2012) would go against this.

In summary, the theme of 'making use of skills and strategies' has suggested the use of therapy as an opportunity to identify aspects of both the therapists' and clients' strengths which can be utilised in therapy to assist the client in reaching their individual goals for recovery from distressing psychotic experiences.

This thematic review including 20 studies of processes in therapy for psychosis has suggested a number of key processes possibly linked to recovery that warrant further exploration. The themes which emerged were Alternative Perspectives, Collaboration between Therapist and Client, Therapy as a 'Safe' Space,

Improving Understanding through Education, Improving Social Interactions and Making Use of Skills and Strategies.

Critique of Studies

To place the key themes in context, this section provides a critique of the selected studies according to published frameworks for evaluating the quality of research (see Appendix 4). Qualitative studies were considered in line with published guidance specific to qualitative studies whilst both quantitative and mixed methodology studies were considered in line with published guidance for both quantitative and qualitative studies (Elliott, Fischer & Rennie, 1999). Each set of guidance consisted of seven criteria and to assist in synthesising the studies, the author generated a coding system, to rate how effectively each study met each criteria (see Appendix 5).

Qualitative Studies

Five out of the ten qualitative studies appeared to meet all seven criteria (Dilks et al., 2008; 2010; 2012; Karatza & Avdi, 2010; Newton et al., 2007). However, one study, (Lysaker et al., 2003), failed to meet a criterion and was rated as only partially meeting the requirements of three other criteria. In this study, whilst the data was situated in a single case study design and references made to different transcripts and periods throughout therapy, there were no 'in vivo' examples used or other direct quotes to help the reader understand how the authors' interpretations arose.

In addition, Lysaker et al. (2003) stated their aim but did not explicitly state their theoretical orientations or personal anticipations, in relation to 'owning one's perspective'. When considering 'providing credibility checks', the authors described how four additional transcripts were coded separately by two of the authors. However, one of the authors was the participant's therapist and was therefore not blind to the

material. Whilst these two criteria may not have had a significant effect on the research findings, it would have been beneficial for the reader to have had these more explicitly addressed. Therefore, when considering the overall coherence of the study and the resonance with the reader, this study performed least well, compared to the other nine qualitative studies.

Other studies were not as clear as they could have been when considering these same guidelines. McGowan et al., (2005) and Messari and Hallam (2003) could have benefited from being more explicit regarding their theoretical orientations and whilst Messari and Hallam (2003) stated that throughout the analysis the first author acknowledged the potential influence of her position as a mental health professional on participant accounts, no specific detail was provided regarding how this may have influenced the data or how the authors monitored or reflected on this.

In relation to credibility checking, Allen et al., (2012) described how the procedure for Interpretative Phenomenological Analysis (IPA) was followed. Their interview schedule acted as a guide, not a fixed procedure, and the schedule itself was developed in collaboration with a service user. Lysaker and Lysaker (2006) presented three case study examples from one clinic with the same therapist. They acknowledged that different observations might emerge regarding narrative impoverishment, potentially in the same individual within and between therapy sessions. However, both studies did not conduct any other form of credibility checking, for example through a reflective account, inter-rater reliability or checking emerging data with participants, as found in other studies (McGowan et al., 2005; Newton et al., 2007; Dilks et al., 2008).

Nine of the ten studies provided clear and specific suggestions for future research. However, Lysaker and Lysaker (2006) made no specific suggestions

regarding future research implications. Whilst stating a hope that future studies include diverse individuals in diverse settings, recommendations which looked to further their specific case study examples were not provided and would have been welcomed.

Quantitative and mixed methodology studies

There were four criteria where all ten studies were considered to have effectively met the requirements for good quality quantitative and qualitative studies: 'explicit scientific context and purpose', 'appropriate methods', 'specification of methods' and 'clarity of presentation'.

All studies provided clear contextual summaries of previous research and important findings to assist the reader in understanding where the research fitted into the wider context of therapy for psychosis. This provided a platform for the authors to justify, both theoretically and clinically, the purpose of their own study, with clear aims provided. Garety et al. (1997), provided a much briefer context for the reader, however, the reader was directed to the first published paper regarding this study's data for full details.

Building on the theoretical and clinical relevance, each study provided justification for why their chosen method was appropriate for use. This ranged from following clinical trial guidance from the Medical Research Council and National Institute for Health Research (Braehler et al., 2012), to promoting the specific insight offered by a single case study design (Grant et al., 2014).

All studies also specified the methods used including descriptions of measures and referencing their reliability and validity. The most commonly used measure was the Brief Psychiatric Rating Scale (Overall & Gorham, 1962), implemented by Garety et al. (1997), Smerud and Rosenfarb (2008) and Lecomte et al. (2014). A variety of

other valid measures were also used and were specific to the aims of the studies. For example, Wittorf et al. (2013) used the Cognitive Therapy Scale for Psychosis (Haddock et al., 2001) to assess therapist competence in delivering CBTp, and Braehler et al. (2012) used the Clinical Global Impression-Improvement Scale (Guy, 1976) to assess client improvement/exacerbation of symptoms relative to baseline.

All studies presented their research in a clear and logical manner, especially in relation to the presentation of findings and procedures followed. This was particularly pertinent for the two studies which employed a Q-methodological approach (De Chavez et al., 2000; Wood et al., 2012), and the 'Delphi method' (Morrison & Barratt, 2010). These methods comprise various different stages and clarity in their explanation improves the reader's understanding which aids replicability.

There were three studies where there was only partial information provided regarding the 'respect for participants' (Grant et al., 2013; De Chavez et al., 2000; Smerud & Rosenfarb, 2008). Consideration towards participants was demonstrated through the process of recruitment, for example by including a stabilisation phase before accepting participants (Smerud & Rosenfarb, 2008) and through detailed participant inclusion and exclusion criteria (De Chavez et al., 2000). However, unlike the other seven studies, there was no information provided regarding the process of obtaining informed consent or providing participants with information regarding confidentiality and their rights as participants.

Most of the studies provided a thorough discussion regarding their findings, making links to previous research and theoretical implications. However, two studies were highlighted as being not as comprehensive as the others (Smerud & Rosenfarb, 2008; Larsen, 2007). Smerud and Rosenfarb (2008) provided a breakdown of their results, however, their discussion consisted of one paragraph providing brief

descriptions of implications before presenting the study's limitations. After providing a comprehensive discussion regarding the implied importance of social negotiation and self-transformation, Larsen (2007) suggested that new research hypotheses were generated. However, he does not summarise these for the reader, compared to other studies which provided clear and specific suggestions for further research.

In relation to the final criterion of 'contribution to knowledge', most of the studies justified their main findings and provided specific suggestions on how to build on their research. However, like Larsen (2007), four other studies could have benefited from providing more specific recommendations on where future research could be targeted (De Chavez et al., 2000; Garety et al., 1997; Smerud & Rosenfarb, 2008; Lecomte et al., 2014).

Future Direction of Research

Six key themes have been identified by the reviewed studies, but questions remain regarding the individual nature of processes that occur in the relationship between therapist and client during therapy for psychosis. As a means of progressing research in this area to the 'next step' (Kazdin, 2007), the author proposes that future studies could specifically examine the synthesised themes from this review. For example, these themes could be used as a guiding framework to establish interview schedules or focus group discussion points. It has been suggested that "qualitative research is most useful, not for testing theories of how change occurs in therapy, but for developing those theories in the first place" (Elliott, 2009, p.128). Subsequent qualitative exploration could help illuminate the suggested importance of these themes and explore theoretical possibilities for how these processes may interact within therapy for psychosis.

Whilst this review has presented potentially important themes synthesised from previous research, there is still a lack of consistency regarding how clients use therapy to reach their idea of personal recovery. Further exploration is needed into the processes involved in how clients actually make use of how they understand their experiences and implement different strategies developed during therapy to assist in attaining their personal definition of recovery. A qualitative study adopting a helpful factors design could utilise grounded theory to identify potential important processes reported in qualitative data. In addition, both therapists and clients could participate, to provide different perspectives on the same therapy experience.

The majority of clients involved in the reviewed studies were motivated to overcome their experiences, willingly accepted assistance, and entered into a shared process of therapy with their therapist. However, the author suggests it is equally important to explore why some individuals find it difficult to shift perspectives and how positive change can be achieved with these individuals. Further research involving clients who did not complete therapy or were unwilling or unable to contemplate alternative perspectives could explore this. This population may have negative views of therapy as a result of their experiences and therefore may prove difficult to engage in a study. Emphasising the opportunity to talk about their difficulties with a neutral interviewer or conducting indirect observations of therapy session notes or recordings from 'unsuccessful' treatments could assist with this difficulty.

The studies reviewed also provided an insight into the processes within both individual therapy and family interventions. Further research could explore the similarities and differences between these two types of therapy. This may help

provide further information regarding whether the intervention model affects the type or intensity of process experienced.

Conclusion

Continuing stigma and social exclusion associated with psychosis, as well as common misconceptions regarding mental illness in the broader sense (Sartorius, 2002; Thornicroft, 2006 cited in NICE, 2013a;WHO, 2001), have continued to impact negatively upon the lives of people experiencing psychosis. A greater understanding of the therapeutic processes active throughout therapy for psychosis could enable an improvement in the level of understanding and acceptance in wider society (BPS, 2000).

Despite the acknowledged limitations of the reviewed research, and the subsequent tentative presentation of key process themes, the exploration of processes within therapy for psychosis is at a stage where a base is being created on which further research can build. Importantly, future research should acknowledge these limitations and allow for these considerations in the design of further investigations. A central issue to this type of research is the difficulty of exploring the complex interactional process of therapy. However, directing research efforts at addressing this is critical to developing a clearer understanding of processes in therapy for psychosis in order to improve the therapeutic interventions available to this significant group of people.

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Section B:

Exploring how people experiencing psychosis make use of

understandings and strategies developed during the joint activity of

therapy

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Terms

For the purpose of this study, "psychosis" is defined as representing a cluster of psychiatric disorders, including the specific diagnosis of schizophrenia, characterised by alterations in the way an individual thinks, feels, and understands their world (British Psychological Society (BPS), 2000).

In relation to the aim of this study, by using the term "understandings", the author means the degree to which the client was satisfied with their level of knowledge regarding aspects of their mental health. For example, how a client made sense of psychotic experiences and how these experiences affected them.

By "strategies" the author means a plan of action, incorporating techniques or activities, designed to achieve a certain aim. For example, if an aim of therapy is to improve client understanding about their psychotic experiences, the strategy might be to help them make sense of how their thoughts, behaviours, emotions and physical sensations interact by drawing them out in a diagram.

Abstract

Objectives: Whilst psychological therapies for psychosis show promise in assisting people in recovering from psychosis, relatively little is known about the specific processes involved. This study aimed to explore how people experiencing psychosis made use of understandings and strategies developed during therapy.

Design: This study reports an in-depth, qualitative interview-based exploration of processes in therapy for psychosis and employed a critical realist approach.

Methods: Semi-structured interviews were conducted with 11 participants (six psychologist-client pairs) towards the end, or recently after finishing, therapy for psychosis. Transcribed interviews were analysed using grounded theory.

Results: The model constructed presents dynamic interactions between three core categories; Enabling Personal Empowerment, Navigating a Collaborative Journey, and Building Belief to generate Trust.

Conclusions: This study explored how processes are enacted during therapy to help clients better understand and implement strategies introduced in therapy. A model for the conceptualisation of processes in therapy for psychosis was generated, grounded in client and psychologist accounts of therapy.

Key Words: Psychosis, Grounded Theory, Therapy Process, Psychological Therapy

Practitioner Points:

- Therapy processes should be acknowledged within the design and delivery of psychosis services.

- More consideration should be given to encouraging and empowering clients to confront their difficulties by overcoming avoidance.

- More opportunities for reflection on the impacts of therapy processes should be provided within psychosis services.

Exploring how People Experiencing Psychosis Make Use of Understandings and

Strategies Developed During the Joint Activity of Therapy

The World Health Organisation (WHO), (2001) claimed that psychosis is a leading cause of disability. Approximately 1% of the UK population develop psychosis over a lifetime, with initial symptoms mostly starting in young adulthood (National Institute for Health and Care Excellence, (NICE), 2014). Currently an estimated 500,000 people in the UK have received a diagnosis of psychosis (British Psychological Society (BPS), 2014), with a predicted incidence rate within England and Wales of 8,686 new cases per year (Kirkbride et al., 2012).

However, there continue to be differences in how psychosis is understood, with recent publications adding further complexity to the conceptualisation of psychosis. Arnedo et al. (2014) suggested that psychosis is actually eight genetically distinct disorders and claimed this finding will help in streamlining the trial and error nature of finding medication which suits the individual. However, the BPS promoted a more psychologically minded understanding of psychosis (BPS, 2014). This report stated that psychotic experiences are understandable in the same ways as 'normal' experiences and that professionals should be client-led in how they provide individual support, rather than promoting one viewpoint.

There is a growing interest around 'recovery' from mental illness in general (Davidson, 2003; Department of Health (DoH), 2011), however, no single definition of recovery exists. A review of decision making and choice found that people using mental health services wanted to be offered more than just antipsychotic medication (Warner, Mariathasan, Lawton-Smith, & Samele, 2006). This point raises the issue of choice, as one of the most important concerns needing to be addressed within the mental health field and the lack of knowledge about the types of services and

interventions that can be offered to help people recover from severe mental illnesses
(Farkas, Gagne, Anthony & Chamberlin, 2005).

In the UK, NICE recommend the use of individual cognitive behaviour
therapy for psychosis (CBTp) and family interventions (FI), amongst other
psychological and pharmacological interventions. Predominantly randomised
controlled trials (RCTs) of CBTp have been deemed by NICE to have demonstrated
efficacy. However, there is continued debate regarding the most suitable interventions
for this population, most notably arguments for (Morrison et al., 2014; Pfammater,
Junghan & Brenner, 2006; Pilling et al., 2002) and against (Jauhar et al., 2014; Jones,
Hacker, Cormac, Meaden, & Irving, 2012; Lynch, Laws, & McKenna, 2010) CBTp.

Despite NICE promoting the use of psychological interventions, Jones et al.
(2012) concluded there was no clear advantage of CBTp over other psychological
interventions and there is still limited insight into how therapy produces beneficial
client outcomes (Pfammatter et al., 2006). With the reliance on evidence based
interventions, Pfammatter et al. (2006) reflect on unanswered questions, particularly
the need to identify "specific therapeutic ingredients" (p.74).

One way these ingredients could be identified is through change process
research (CPR), as this focuses on "identifying, describing, explaining, and predicting
the effects of the processes that bring about therapeutic change" (Greenberg, 1986,
p.4). Comprehensive reviews of CPR studies, which investigated therapy processes in
non-psychosis populations, have concluded that factors such as the therapeutic
alliance and altering clients' negative cognitions (Kazdin, 2007; Llewelyn & Hardy,
2001), are important for client recovery. However, there is relatively little CPR
conducted within the psychosis field.

Therapeutic Processes within Therapy for Psychosis

The author conducted an exhaustive, systematic literature search to review current knowledge regarding what processes were suggested as important within therapy for psychosis. Twenty studies were reviewed and semantic themes were developed based on their findings, following principles of an inductive thematic analysis technique (Braun & Clarke, 2006). Themes which emerged were Alternative Perspectives, Collaboration between Therapist and Client, Therapy as a 'Safe' Space, Improving Understanding through Education, Improving Social Interactions and Making Use of Skills and Strategies.

Dilks, Tasker and Wren (2008) suggested a core therapy process as 'building bridges to observational perspectives', defined as a process whereby the therapist continually offered the client different ways to view their experiences, with the aim of creating new possibilities for thought, feeling or action for the client to explore. Allen, Burbach and Reibstein (2012) also promoted the importance of exploring shared perspectives and suggested this is brought about by the development of a cognitive shift; a new positioning in the world which allowed the client to contemplate different strategies to help achieve their goals.

McGowan, Lavender and Garety (2005) identified a consistent factor emerging in beneficial outcomes of therapy for psychosis as the clients' readiness to reflect on a different explanation for psychotic experiences, with an emphasis placed on "moving to new and disregarding old understanding" (p.519). This was supported by Karatza and Avdi (2011) who claimed clients' abilities to understand, hold and engage with a model of reality presented by the therapist was found to be crucial in client progression. Importantly, McGowan et al. (2005) and Karatza and Avdi (2011) appeared to suggest that the client should be presented with one alternative

perspective; the therapists' view of reality. However, Allen et al. (2012) and Dilks et al. (2008) appeared to suggest the importance of the client considering multiple perspectives to enhance their recovery.

Wittorf et al. (2013), explored associations between therapist skills and clients' experiences of change processes throughout CBTp. They suggested the therapists' ability to use general skills, such as listening and feedback, were important in demonstrating to clients that they could understand their viewpoint and cope with the distress and confusion this generated. In conclusion, their recommendation was for therapists to utilise their general skills in the initial phases of therapy to build the relationship with the client and to ensure 'containment'. Once this had been achieved, they suggested the therapist could then employ more technical skills grounded in psychological theory, such as guided discovery (Wittorf et al., 2013). Creating a 'safe' environment where the client felt able to talk openly and share their experiences has also been suggested as an important process, especially early in therapy (Lecomte et al., 2014; Newton et al., 2007).

However, these findings implied that building a therapeutic alliance and creating a safe environment are distinct phases in therapy with specific start and finish points, as opposed to ongoing processes. It also assumed that the technical CBTp activity of challenging particular client beliefs is necessary for a positive outcome. Previously identified aspects of therapy would oppose this, such as the suggested importance of the client owning their own narrative to increase their sense of control (Lysaker & Lysaker, 2006) and promoting the importance of client subjective experiences (Wood, Price & Morrison, 2012).

Other specific factors have been studied in attempts to explore potentially important aspects of therapy for psychosis. For example, Grealish, Tai, Hunter, &

Morrison (2011) explored what empowerment meant to young people with psychosis. They found that being listened to, understood and taking more control were highlighted as contributing to the process of empowerment in recovery.

Summary

Previous research regarding therapy for psychosis has suggested the importance of processes such as negotiating shared understandings, testing out different perspectives, creating an emotionally safe environment and encouraging clients to take more control of their actions. The suggested benefits of these different processes were that they allowed clients to adopt new perspectives which were more balanced and less anxiety provoking. They also allowed clients to feel more able to talk freely about their difficult experiences and they increased clients' personal responsibility and sense of empowerment regarding their recovery.

Rationale for this Study

Whilst psychological therapies show promise in assisting people in recovering from psychosis, relatively little is known about the processes involved that may impact on clients' understandings and implementation of strategies developed during therapy. Building on the point made by Farkas et al. (2005), the author posits that it is in the best interests of people experiencing psychosis for research to focus on furthering our understanding of the key processes in therapy for psychosis. It is hoped that a better understanding of the factors contributing to positive or negative experiences of therapy for psychosis would potentially allow the refinement of psychological interventions and services available, to promote the use and occurrence of seemingly important processes.

Aim and Research Questions

This study aimed to explore how people experiencing psychosis made use of understandings and strategies developed during the joint activity of therapy, leading to a grounded theory (GT) model to further inform research and practice of therapy for psychosis. Existing literature was examined to generate research questions used as sensitising concepts (Strauss & Corbin, 1998). These questions guided the study and construction of theory but are not specifically addressed, consistent with the position of using existing theory as a starting point for focusing an enquiry:

- What are the valued components of therapy?

- How is understanding of experiences established?

- How do therapists and clients perceive their roles in relation to each other during therapy?

Method

Participants

Six clients and five psychologists participated in this study (Table 1), with one psychologist (Gemma) interviewed twice regarding different clients (see Appendix 6 for psychologist/client pairs). Inclusion criteria stated that all participants should be: towards the end of therapy for psychosis (to enable reflection on their involvement), aged over 18, able to provide informed consent and fluent in English. Ongoing discussions with psychologists raised the opportunity to recruit recently finished clients. As a result, two pairs had recently finished therapy (within one month) and were confident in recalling and reflecting on their experiences. Exclusion criteria for client participants stated that clients should not participate if they were currently experiencing a serious deterioration in their mental health or experiencing suicidal

ideation and/or thoughts of harm to themselves or others, assessed by their

psychologist.

Table 1: Participant demographic characteristics

Psychologist (pseudonyms)	Gender	Age (range)[1]	Ethnic Group (self-identified)	Years qualified
Gemma	F	26-30	White British	3
Adam	M	31-35	White British	8
Jane	F	31-35	White English	5
Michael	M	31-35	White Irish	3
Jo	F	41-45	Response withheld	20

Client (pseudonyms)	Gender	Age (range)	Ethnic Group (self-identified)	Duration of psychotic symptoms (years)	Time since diagnosis (years)
Eve	F	46-50	White British	15	14
Carly	F	56-60	Black British	16	16
Ted	M	41-45	Black British	12	10
Andy	M	21-25	Black African	3	3
Selena	F	56-60	Somali	18	18
Arianna	F	56-60	Mixed: White & Black African	28	2

[1]Due to the small sample size, to help maintain anonymity, age ranges were used instead of specific ages.

Design

This study used semi-structured interviews in a qualitative design. Interviews

were fully transcribed and analysed by the author, using a GT approach within a

critical-realist framework (Willig, 2001). Critical realism and GT are highly

compatible, sharing a focus that adopts a commitment to fallibilism and the

connection between theory and practice (Oliver, 2011). This approach encourages the

researcher to acknowledge preconceptions and make an effort to set them aside in

analysis by utilising methods of open coding, constant comparison and questioning

the data, encouraging the researcher to a position beyond their initial understandings

(Corbin and Strauss, 2008).

Interview Schedule

A semi-structured interview schedule was used (Appendix 7). Open-ended questions intended to create a conversational feel, generate rapport and elicit rich data (Willig, 2001). Guidance was sought from a member of a service user research group (Salomons Advisory Group of Experts) regarding the type of questions and accessibility of language. All interviews were conducted by the author who adapted to each participant's responses, using their language and asking follow-up questions to elicit elaboration when necessary.

Procedure

Participants were initially recruited across three psychosis services in one NHS Trust. Service managers were contacted regarding the study and provided permission for psychologists to be contacted individually. Psychologists were provided with a participant information sheet (Appendix 8) and asked to identify potentially suitable client participants. Psychologists spoke with clients to introduce the study, provide interested clients with an information sheet and obtain clients' permissions to be contacted directly by the author. With permission to be contacted, the author made contact by telephone with potential client participants and answered any questions regarding participation. If at this stage the client was happy to participate, the author arranged a meeting to sign the consent form. Once consent was obtained, at least one week was left before completing the interview to allow for further questions and ensure participants did not feel pressured to participate. Both the meeting to sign the consent form and to conduct the interview took place at the service location which each client was already familiar and comfortable with. Rooms were booked by the author at each location in advance of the meetings.

Recruitment was extended to a second NHS Trust, across two further services, after difficulties in recruiting sufficient participants.

Data Analysis

GT is useful for exploring under-researched phenomena, experiences, behaviours and attitudes, in which theory is 'grounded' in raw data as opposed to forcing a viewpoint (Strauss & Corbin, 1998). The technique of 'constant comparison' (Glaser & Strauss, 1967) is used to achieve this and involves simultaneous data collection and analysis. The researcher moves back and forth between the data and all coding stages to ensure the emerging theory reflects the data accurately. This study's analysis followed stages based on Charmaz's (2006) description of GT analysis:

- **Initial Coding:** Line-by-line coding helped to stay close to the data. Active codes (gerunds) and in vivo codes (participants' own words) assisted in encapsulating processes and subjective meaning in the data. Initial coding was conducted for the first six transcripts with analysis of the remaining transcripts commencing at focused coding.

- **Focused Coding:** Re-coding data using the most frequent or analytically significant initial codes enabled larger segments of data to be synthesised in a more conceptual manner. Previous interviews were also revisited and re-coded when new focused codes emerged in later interviews, to ensure the developing theory was applicable to each participant. (see Appendix 9 for an example focused coded transcript).

- **Theoretical Coding:** To develop focused codes into subcategories and subsequent core categories, memo-writing and diagramming were used

throughout analysis by exploring the potential relationships between codes

(Appendix 10).

Quality Assurance

To ensure quality, qualitative research guidelines were considered (Elliott,

Fischer & Rennie, 1999). To aid reflexivity, a reflective diary was kept throughout

(Appendix 11) and the author regularly communicated with two supervisors and a GT

interest group to remain alert to the influence of the author's own assumptions on data

interpretation. Additionally, the author utilised the constant comparison method and

extracted direct quotations from participants to encapsulate codes and categories when

establishing the theoretical model (Williams & Morrow, 2009).

Ethical Considerations

To conduct this study, ethical and R&D approvals were obtained from the

Canterbury Christ Church University Research Ethics Board (Appendix 12) and the

two NHS Trusts involved (Appendix 13). Participant demographic information was

not initially collected at interviews. The approval of a minor study amendment

enabled the author to re-contact participants for this purpose (see Appendices 14 &

15). All participants provided informed consent (Appendices 16 & 17) and were

informed that all study related information collected would be kept confidential and

only the author had access to securely stored, non-anonymised data. A summary of

this study was sent to Ethics, R&D departments and participants (Appendix 18).

<div align="center">Results</div>

Transcripts were analysed to consider what clients and psychologists revealed about

their experiences of therapy for psychosis. Initial coding produced 2,961 open codes

which were subsumed into 48 focused codes, subsequently grouped into nine

subcategories. Six of these subcategories demonstrated overlaps between client and

psychologist accounts, two were exclusive to clients and one to psychologists. All data were eventually subsumed into three core categories, as shown in Table 2 (see Appendix 19 for coding table).

Table 2: Core Categories with Comprising Subcategories

| Psychologist experience |
| Shared experience |
| Client experience |

Core Category	Subcategory
Enabling Personal Empowerment	Establishing a "deeper understanding"
	Increasing sense of empowerment
	Creating a new perspective
	"Make friends with the hole"
Navigating a Collaborative Journey	"Working it out together"
	Managing the evolving relationship
Building Belief to Generate Trust	Committing to therapy
	Having a space to talk
	Holding the psychologist in high regard

A theoretical model (Figure 1) was constructed detailing multi-directional interactions between;

- Client and psychologist

- Subcategories, and

- Core categories.
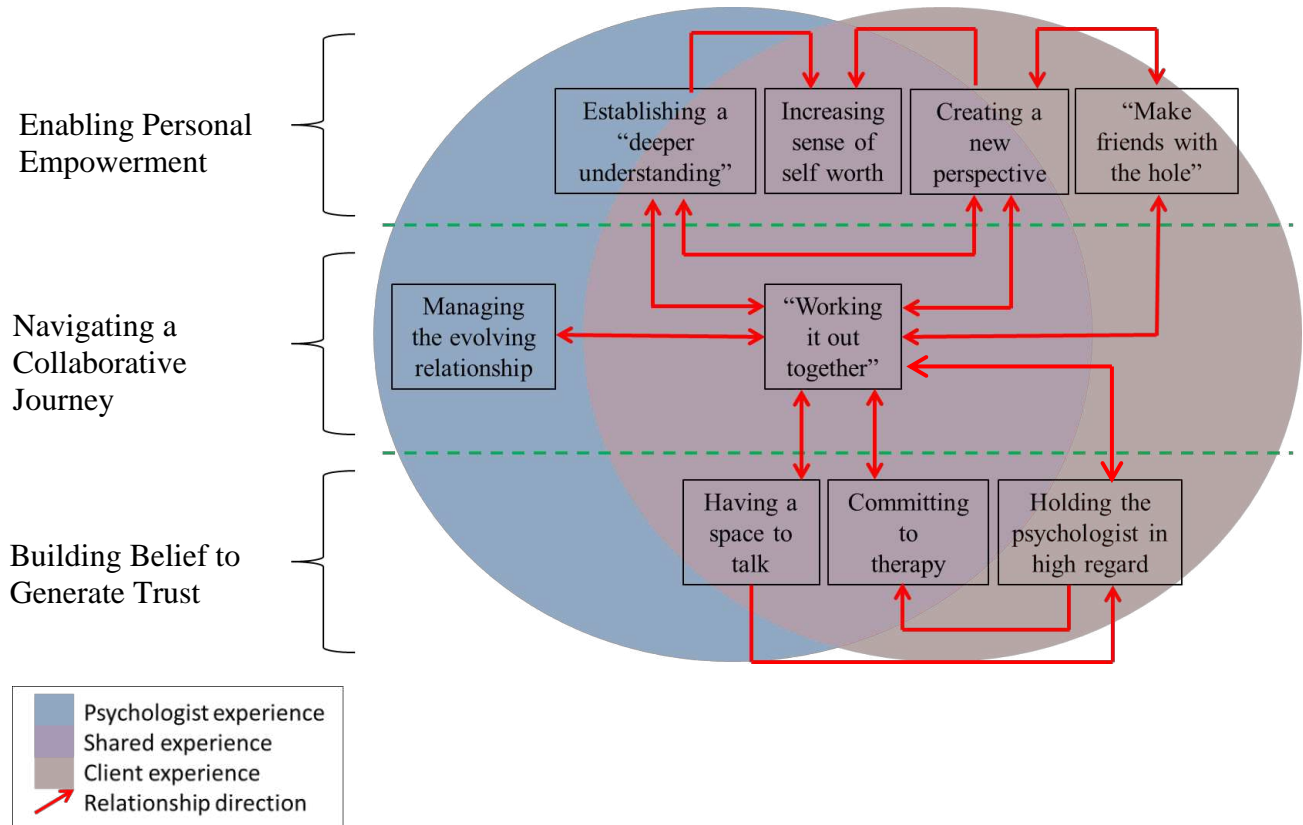
Figure 1 Theoretical Model of Client and Psychologist Experiences Within Therapy

for Psychosis

As demonstrated in Figure 1, it appeared that the three core categories

represented interactional processes, with reciprocal and multi-directional relationships

(Figure 2).
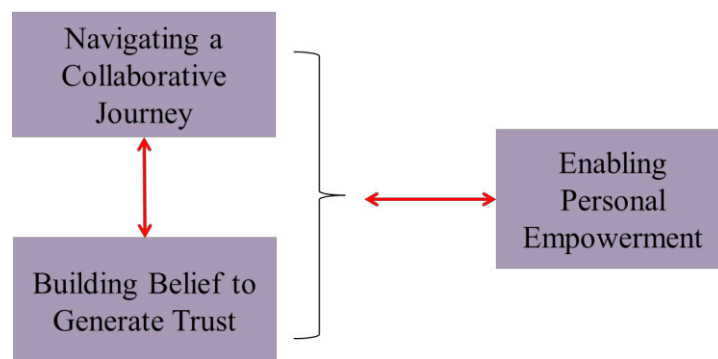
Figure 2 Diagram Demonstrating Multi-Directional Relationships between Core
Categories

The three core categories will now be presented followed by descriptions of subcategories, with quotations from transcriptions illustrating categorisation. To aid readability where quotations are made, [P] indicates a psychologist and [C] indicates a client.

Core Category 1: Enabling Personal Empowerment

Emerging from the data appeared to be descriptions of client change involving personal growth. Clients spoke about the psychologist performing a 'motivating guide' role. This appeared to enable clients to realise solutions for themselves, in turn boosting client confidence in their abilities to self-manage their future care. Embedded in participants' accounts were four subcategories which appeared to reflect this and seemed to influence each other;

- Establishing a "deeper understanding" (shared experience)

- Increasing sense of self-worth (shared experience)

- Creating a new perspective (shared experience)

- "Make friends with the hole" (client experience)

Subcategory: Establishing a "deeper understanding". Across all interviews, an early task within therapy appeared to be an attempt to make sense of clients' current situations. Often clients reported being confused about their specific mental health difficulties, so initial sessions offered a chance to explore this with the psychologist: "...she's really got my thoughts and my feelings and taken them, we sort of dissected everything, because that's what you need to do...you can make sense of your problems a bit more, because it's like you have a deeper understanding…" (Carly-[C], L211-218).

Psychologists recalled the initial contact as a time to be listening and attempting to fully understand clients' thoughts and behaviours through establishing a

shared understanding of client difficulties: "… it was more hearing her for two or three sessions, and then me saying well it sounds like, we talked about a few different things, can I pull it all together on the page?" (Gemma-[P], L358-360).

These accounts seemed to imply that certain strategies were introduced by psychologists, for use with clients during sessions. In these examples, dissecting client problems into more manageable parts and pulling information together on a page appeared to assist in improving understanding of clients' difficulties. Psychologists also referred to using psychological theory in facilitating client understanding, implying it was used as a framework for the intervention: "…we developed a good CBT model of OCD and talked about the fact that it was her appraisals of her intrusions, rather than the intrusions themselves that are the problem, and developing that sort of cycle and understanding…" (Gemma-[P], L80-85).

Explicit links between clients' previous life experiences and current difficulties appeared to be made by psychologists. This seemed to allow psychologists and clients to organise information to initiate thinking about what might be going on for the client:

...we pulled the threads together a little bit with these different experiences, there were three main events which he talked a lot about, and we talked about what was similar about them, and in each of them they involved other people making decisions that he felt he had no control over, and we started to wonder what might be going on there... (Adam-[P], L127-131)

Like Gemma's account, it appeared that Adam used similar strategies with his client to help improve understanding. By pulling information together and identifying common factors within the client's experiences, an underlying feeling of a lack of control in decision making was revealed. This creation of a shared understanding

appeared to enable clients to recognise different aspects of their life and experiences which they had previously been unaware of: "All these doors that I thought were closed were then opened one by one since we were talking together" (Selena-[C], L85-87).

Subcategory: Increasing sense of self-worth. For lasting change to be achieved, it appeared the psychologist should facilitate a stronger sense of empowerment in the client:

...my role was to support him in taking some responsibility for his life, for his recovery, for helping him to reflect on what he did with his mind, how he related to *his mind and recognising and noticing thinking habits that were unhelpful*... (Adam-[P], L415-417)

Psychologists appeared to maintain hope for clients during difficult times which in turn seemed to enable clients to experience a sense of hope for themselves: "…maybe holding the hope a bit in a stronger way, whereas I think she holds hope herself now. But being very explicit that if you do this, umm, there is a very high likelihood it's going to improve things…" (Michael-[P], L278-280); "Well mainly it made me feel more hopeful about life. It helped me feel like maybe someday I would have more of a life…" (Andy-[C], L124-127).

A sense of empowerment within clients appeared to be achieved through what was described by psychologists as a shift in control:

...her relationship to those difficulties is fundamentally altered so that she now will think well this is an internal experience umm, or it could be something else, but *either way I'm in control* – I think *that the metaphor she uses is 'I'm the captain of the ship'* (Michael-[P], L 28-30)

This shift in control seemed to influence clients' ability to feel "stronger" and "more able" to manage their difficulties: "...she didn't just say to me *"you've got to do this, you've got to do that"*, she helped me realise myself, and helped me come up with ideas myself…more so that I would be stronger and more able to cut down on the number of rituals I was doing…" (Eve-[C], L216-219).

Subcategory: Creating a new perspective. Establishing a new understanding of their experiences appeared to enable clients to work with the psychologist to find different ways of viewing themselves and their difficulties. Psychologists appeared to employ a strategy of "reframing" experiences by offering, rather than imposing, different perspectives:

...the main thing we formulated together was the reframing of past events and the impact of those on how she's feeling now, why she might be feeling that way about herself in relation to self-blame and trying to think a different way about some of those feelings and how they are affecting her. (Jo-[P], L 46-50)

Both psychologists and clients made reference to the concept of making a distinction between the 'old client' and 'new client' when adopting new beliefs: "…so then we developed 'old [client]' … and we said well if these are the old beliefs, what do you want the new beliefs to be? And then we developed a list of 'new [client]' beliefs…" (Jane-[P], L975-978);

… what keeps me going is that I do recognise that I've changed from the person who started with him to the person I am now with him and even if I roughly, *erm, fall back, I don't think I'd be falling back to a zero…* (Ted-[C], L466-469)

This new perspective was potentially related to the development of clients' sense of agency. Eve experienced severe OCD and through creating a new perspective, whereby her previous internal focus on completing rituals was viewed as

unhelpful, she was able to feel "empowered" and "stronger": "…I felt empowered and I felt excited, I thought, you know, I'm getting stronger because I'm actually getting out of myself more, I'm looking out of myself, I was too internally focused…" (Eve-[C], L186-188).

   Subcategory: "Make friends with the hole". This in vivo category represents clients' realisations of the need to face up to their difficulties, comprised of three proposed points in time. Firstly, clients' accounts of life before therapy seemed overwhelmingly difficult: "…before therapy I'd just got into a cycle…partly to do with being unemployed and partly because I allowed myself to be isolated, basically I was at home just folding in on myself" (Selena-[C], L119-121).

   Secondly, clients realised something had to be done to improve their lives, without necessarily contemplating therapy: "…that was when I started to ask for help because I realised the fact that I'd said it to my friend…you realise there's something wrong and something's got to be done about it…" (Arianna-[C], L399-402).

   Thirdly, clients engaged in therapy, valued the experience and were overcoming their fears by facing up to their difficulties, which could be seen as a strategy in itself, "make friends with the hole"; "…make friends with the hole. So that's exactly what I did with my anxiety, my paranoia, a lot of the things, I don't fear them because I've sort of made friends with them…" (Carly-[C], L244-246) (see Appendix 10, point 8, for further explanation).

Core Category 2: Navigating a Collaborative Journey

Two multi-directional subcategories appeared to form this core category;

- "Working it out together" (shared experience)

- Managing the evolving relationship (psychologist experience)

The ways in which participants perceived the therapeutic relationship appeared to promote the importance of being collaborative. Both clients and psychologists described the way in which they were "working it out together" (Jane-[P], L373-374). Psychologist accounts described acts of managing the changing relationship through continued monitoring of clients and external factors.

Subcategory: "Working it out together". Participants spoke about how they worked together to make sense of client difficulties. This appeared to involve the psychologist listening to the clients' descriptions, facilitating a process of focusing the client back to what appeared to be important to them and then working together on these specific aspects:

*"...I think I started and then she took it over. So I had in my head four or five things I thought I'd gathered from the few sessions that I'*d heard from her, so I was, *kind of, priming her and saying, well one thing you've talked about is this, do you* think this is something that needs to go down there, but we were working it out *together..."* (Jane-[P], L370-374)

For psychologists, it appeared this sense of collaboration was achieved through "coming alongside" the client: "...there was an interested, validating, empathic curiosity, a sort of coming alongside her and normalising, trying to reframe together…" (Jo-[P], L 279-280).

This shared effort appeared to increase clients' trust in their psychologist and enabled clients to feel more comfortable, increasing client confidence in therapeutic

strategies: "…certain things were very, very personal, like women's things…I felt like I could trust her…it's very important to be able to trust your therapist…" (Eve-[C], L764-767).

Subcategory: Managing the evolving relationship. Psychologists specifically identified the need to continually monitor the way in which they related to clients, to ensure they were enabling them to "make the best use of therapy". The sense of 'finding a balance' appeared across accounts, with the implied threat being, for example, that if psychologists were to become too friendly, clients may feel less able to share their thoughts, possibly to avoid disagreeing with the psychologist:

...reflecting on the balance of being friendly and warm and inviting but not wanting it to bridge into too much friendliness or blurring that boundary such that *she then couldn't make the best use of the*rapy and be very open with me... (Gemma-[P], L463-466)

The way in which psychologists reacted to client or external changes also seemed important in effectively managing the therapeutic relationship: "I think during the course of therapy, events overtook our initial plans, because she had some very significant life events and our goals changed around those" (Jo-[P], L 135-136).

In addition, making the client aware that the psychologist was committed to sharing the effort in therapy, appeared to maintain clients' hope and instil confidence in the work:

...it's been a long journey and I think that through that I've shown him a sense of commitment to him and willingness to sit out and struggle with him at times *through difficult periods...I've tried to maintain ho*pe for him at times when ther*e's* not been a lot of hope... (Adam-[P], L430-435)

Core Category 3: Building Belief to Generate Trust

It appeared that through establishing a "safe" and "containing" space to talk (Michael-[P], L61&62), clients felt a personal connection with, and an increased respect towards, their psychologist. As this occurred, it seemed that clients and psychologists began to believe in a possible successful outcome, leading to a more explicit commitment to therapy. As such, a degree of trust was established in the relationship which appeared to be reinforced for the client through the psychologist demonstrating their commitment to therapy. It therefore appeared appropriate to subsume the following three sequential subcategories into one core category, 'Building Belief to Generate Trust';

- Having a space to talk (shared experience), leading to;

- Holding the psychologist in high regard (client experience), leading to;

- Committing to therapy (shared experience).

Subcategory: Having a safe space to talk. Participants spoke of therapy as an opportunity to talk about their difficulties. Talking appeared to be facilitated by a view of therapy as a 'safe' space. Often clients recalled that before starting therapy they had become increasingly isolated, unable to talk to anyone about their psychotic experiences as they struggled to convey these in words: "…at the beginning we spent time thinking about her problems, because this wasn't something she'd done before, so just having time for her to tell her story, to try to put it in some kind of order…" (Jo-[P], L 21-23).

By psychologists providing a 'safe' space for clients to talk and be heard, it appeared to enable them to work together to create a shared understanding of client experiences and difficulties:

...it was about her having a safe space to kind of talk through things in a fairly, *not structured but, I don't know, containing way, and I actually think that, well* later on it turned out that she felt she gained quite a lot of understanding into her difficulties, just by having that talk*ing space... (Michael*-[P], L 62-66)

Subcategory: Holding the psychologist in high regard. Across all client accounts there appeared to be an appreciation and admiration of their psychologist. There were common descriptions of appreciating the time psychologists provided to clients: "…he always seemed to have time for me, he didn't cancel any appointments, he was always positive, even when I thought I was negative he was always able to put a positive spin, turn it around..." (Ted-[C], L 394-396).

This opinion of their psychologist appeared to be linked with clients' capacity to trust their psychologist and feel confident in the work they were doing. Trust appeared to encourage progression within therapy, but also appeared to develop into a deeper bond being created whereby the psychologist was seen as 'special': "... she's just been there through all these things...and if I hadn't had [psychologist] I don't know how I would have coped…I think she was a godsend..." (Arianna-[C], L 191-192).

Subcategory: Committing to therapy. Psychologists and clients acknowledged the commitment required to persevere with therapy and described how therapy was often viewed as an opportunity not to be wasted: "…I've been given this chance and I'm going all the way with it and I did go all the way with it, but it was very difficult…" (Eve-[C], L363-365).

Clients reported they had underestimated the hard work needed to realise positive change, but that they demonstrated a degree of perseverance throughout the therapy:

The only problem is that I thought at first it was going to be easy but it, erm, I find it pretty difficult myself, erm, yes I find it very difficult, I think other parts of my problems keep inv*ading what I'm being told by* [psychologist], especially when I'm more depressed, but I kept going... (Ted-[C], L 11-14)

This commitment was recognised by psychologists in their descriptions of clients: "She just really absorbed things, really took it on board and went with it…she was very up for the process, she was very motivated and engaged..." (Michael-[P], L 211-218).

Participant Demographic Considerations

In separate analysis of the data, demographic information was considered alongside participant transcripts. This analysis employed the same constant comparison method adopted in the initial data analysis (Corbin and Strauss, 2008). Transcripts were analysed based on dichotomising the sample, with mean values used to generate these divisions. For example, the mean number of years psychologists had been qualified was 7.8. This generated a divide between Gemma (3 years), Michael (3) and Jane (5), and Adam (8) and Jo (20). Dichotomising discrete or continuous variables is common in psychological research as it allows researchers to investigate whether there are differences between groups who might be at the extreme ends of the variable being explored (Dancey & Reidy, 2014).

One argument against dichotomising is that it can reduce the sensitivity of any subsequent quantitative statistical analysis (Altman & Royston, 2006; Streiner, 2002). However, as the author employed a qualitative method of analysis in the form of grounded theory, no quantitative statistical analysis was performed. In the context of this study's data exploration, dichotomising the demographic data acted as a method of simplifying the management of the data and also helped the author to acknowledge

their assumptions regarding the demographic and interview data. For example, the author acknowledged an assumption that psychologists who had been qualified for longer, would demonstrate more flexibility in therapy, reacting better to client changes. This analysis yielded no apparent relationship between psychologists' interview data and years since qualifying, with all psychologists demonstrating similar therapeutic activities.

In fact, overall, no differences appeared to emerge in relation to therapy processes in relation to demographic differences, but there were interesting observations. In the interests of not omitting these due to potential concerns with dichotomising data (Dawson & Weiss, 2012), these are described below.

It was noted that Arianna had experienced her symptoms for 28 years, much longer than any other client participant, but had the shortest time since receiving a formal diagnosis (two years). Interview data for Arianna and her psychologist, Jo, revealed how during the course of therapy, external events overtook their initial plans, meaning they had to alter their goals accordingly. Whilst no firm conclusions can be drawn, it was interesting to note that the client with the longest duration between first experiencing psychosis and receiving a diagnosis, was the client whose therapy appeared to be affected most by external life events.

When considering age, Andy was the youngest client participant, in his early twenties. Andy was the only client to begin treatment with what could be interpreted as a pessimistic attitude towards therapy: "Even until recently I wasn't really thinking I needed it, but I kept going for my mum. But now after a bit of time with it I can see that it has helped me and I'm doing it for myself more" (Andy-[C], L 313-315). This has potential clinical implications, albeit tentative, regarding a possible lack of knowledge in younger people about what mental health services offer and what

psychological therapy involves. However, the author recognised there could have been other factors involved which were not alluded to in the data.

In relation to gender, Eve was the only participant to mention the benefit of seeing a psychologist of the same gender, feeling more able to share intimate details of her difficulties with another woman.

In addition, the author found it interesting that the topic of ethnicity was not mentioned within participants' data gathered at interview. There appeared to be a division between the predominantly white ethnic grouping of the psychologists and the predominantly black ethnic grouping of the clients. Firstly, this could highlight the topic of service provision for the client population. Specifically, this information could reflect the immediate population which have access to these specific services, or it could suggest there are wider influences on who presents at these services. These wider influences could possibly involve differences in cultural beliefs about mental health difficulties or differences in help seeking behaviours between different clients. This could potentially have an impact on who is assigned a label of psychosis, as contact with psychosis services could depend on the individual's beliefs about, and understanding of, their mental health experiences.

Secondly, questions could be raised regarding the homogeneity in ethnic grouping of the psychologists. Is it a coincidence that, with the exception of Jo's withheld response, all psychologists self-identified as white, or does this small sample reflect more significant concerns regarding access and desire to train as a psychologist? Ethnic identification is argued to be something which is subjectively meaningful to each individual and the factors involved in what constitutes an ethnic group are reported to be multi-faceted (Office for National Statistics, 2003).

Therefore, without further investigation, no firm conclusions from this study's data can be drawn.

Summary

A GT analysis of the data distinguished client, psychologist and shared processes of therapy for psychosis. An initial model was proposed to conceptualise these processes, which were understood to interrelate through multi-directional interactions across subcategories. Interlinking shared processes seemingly allowed the client to develop a greater understanding for, trust in and implementation of, therapeutic strategies developed within therapy.

Three core categories were presented in the model; Enabling Personal Empowerment; Navigating a Collaborative Journey; and Building Belief to Generate Trust. These comprised of subcategories identified through open and focused coding.

<div align="center">

Discussion

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The model developed attempted to capture core therapeutic processes in therapy for psychosis as identified by, and grounded in, participants' experiences of therapy. The findings will be explored in relation to the study's aim and in the context of previous research, with the study's limitations and implications also discussed.

The proposed model adds new insight into how previously identified processes in therapy for psychosis could interrelate, through dynamic interactions between subcategories and subsequently core categories. The author suggests that this model of understanding is not something which could have been realised through quantitative, linear data analysis from, for example, an RCT, on which the debate for (Morrison et al., 2014; Pfammater, Junghan & Brenner, 2006; Pilling et al., 2002) or against (Jauhar et al., 2014; Jones, Hacker, Cormac, Meaden, & Irving, 2012; Lynch, Laws, & McKenna, 2010) CBTp has rested.

The data appeared to reflect processes whereby helping clients to understand their problems as partly one of belief and interpretation, fostered trust in the psychologist and resultantly enabled both parties to feel comfortable to work together to make sense of client experiences. This appeared to enable the creation of a new perspective and increased client empowerment. This study suggests that the core categories of Navigating a Collaborative Journey and Building Belief to Generate Trust interrelated through contributing subcategories, which in turn facilitated the core category Enabling Personal Empowerment. However, Enabling Personal Empowerment did not subsume the previous two core categories as the author acknowledged how the data did not suggest a direct causal relationship, but that all three interrelated. This was demonstrated by the back and forth relationships between the subcategories of "Working it out together", Establishing a "deeper understanding", '"Make friends with the hole"' and Creating a new perspective.

It appeared that strategies were predominantly implemented as a means to 'Establishing a "deeper understanding", a specific subcategory of Enabling Personal Empowerment. Participants spoke of using strategies such as dissecting their difficulties (Carly-[C]), pulling information together on a page (Gemma-[P]), identifying common factors (Adam-[P]) and reframing past events (Jo-[P]), which were then utilised by the clients to improve understanding regarding their difficulties. The prominence of psychologist descriptions of strategy use could imply that although strategies were engaged in jointly throughout therapy, it was predominantly psychologists who introduced potentially suitable strategies for clients to test out, based on what clients had spoken about in sessions. However, strategies could also exist separately, as demonstrated by the client strategy of "Make friends with the hole". It is also important to note here that it was not only the individual

understandings held by clients, but the psychologists' demonstration of their understanding regarding unique client situations, which was a seemingly important process. This appeared to show clients that psychologists shared the effort, which seemed to increase client commitment to therapy and trust in their psychologist.

Although not an explicit aim, this study's findings have seemingly added support to previous research into the identification of processes experienced during therapy for psychosis. In particular, adopting alternative perspectives (Allen et al., 2012; Dilks et al., 2008; Karatza & Avdi, 2011; McGowan et al., 2005), collaboration between psychologists and clients (Dilks et al., 2008; Wittorf et al., 2013), creating a safe therapeutic environment (Lecomte et al., 2014; Newton et al., 2007) and increasing clients' sense of empowerment (Grealish et al., 2011).

It appeared that by 'Establishing a "deeper understanding" of their experiences, clients were able to test out and adopt different ways of thinking in order to adapt their view of their own lives, thus 'Creating a new perspective'. This is in line with previous research (Allen et al., 2012; Karatza & Avdi, 2011; McGowan et al., 2005) and more specifically is consistent with the core therapy process described by Dilks et al., (2008) as 'building bridges to observational perspectives'.

The psychologist offering different perspectives and ways of understanding for the client to test out seemed to demonstrate the importance of letting the 'old client' go and developing the 'new client'; a finding proposed by both McGowan et al., (2005) and Karatza and Avdi (2011). However, where McGowan et al., (2005) appeared to place importance on clients' abilities to engage with a model of reality that the therapist presented to them, this study's findings are more in line with Allen et al. (2012) and Dilks et al. (2008) who suggested the client and therapist engaged in a joint process of meaning making, which enabled the client to establish perspectives

which felt appropriate for them. Promoting that individual understanding, without imposing a set perspective, appeared to increase clients' sense of self-worth and was also a central message within the recent BPS report on understanding psychosis (BPS, 2014).

There was a considerable amount of overlap between participants' accounts, both within the psychologist-client pairs and between psychologists and clients. Six of the nine subcategories were grounded in data from both psychologist and client interviews. This suggests processes in therapy for psychosis were largely collaborative and therefore viewed in a very similar manner by clients and psychologists, in line with previous findings (Dilks et al., 2008; Wood et al., 2012; Wittorf et al., 2013).

The view of therapy as a safe space also supported previous research (Lecomte et al., 2014; Newton et al., 2007). It appeared that talking about their difficulties helped clients manage their distress, despite this being difficult at times. This might imply that it may not necessarily require professionals, including psychologists, for providing a 'space to talk' to be beneficial. This was proposed by Davidson (2003) when considering the importance of listening to what people diagnosed with schizophrenia say about their difficulties.

The facilitation of clients' sense of empowerment throughout therapy also appeared to be an important process within this study's findings. Factors such as clients' increased confidence in their own abilities and increased understanding of their experiences contributed towards this sense of Enabling Personal Empowerment. This core category encapsulated a sense of increased client control over managing their difficulties and confidence regarding their ability to cope with future difficulties, supporting previous findings (Karatza & Avdi, 2011; Grealish et al., 2011).

An interesting finding from this study is the subcategory of 'Holding the psychologist in high regard', which could have remained a contributing factor towards the subcategory "Working it out together". However, the way in which clients described their psychologist as being 'special', raised its importance as a separate subcategory in itself. In relation to this, psychologist accounts often noted the importance of managing inter-personal boundaries with clients, finding a balance between creating a warm and accepting relational style, whilst maintaining professionalism, enabling clients to use therapy as a neutral space. For this reason, 'Managing the evolving relationship' was conceptualised as a psychologist-only experience.

Clinical Implications

By proposing a theoretical model the author hopes this adds to an emerging understanding of processes in therapy for psychosis as dynamic and interconnected. Acknowledging the proposed dynamic relationships between the core categories could provide insight for clinicians regarding how psychological interventions could be tailored to reflect the processes suggested to be occurring. Psychologists referred to incorporating psychological theory as a framework in their efforts to facilitate client understanding. However, it was interesting to note that psychologist accounts largely did not focus on aspects such as CBT model adherence, with accounts appearing to place the therapeutic relationship as a higher priority. It therefore seems appropriate to highlight this, possibly through clinician training. More consideration to particular activities arising from this study, such as encouraging and empowering clients to confront their difficulties, creating shared understandings and new perspectives specific to the client and demonstrating the sharing of effort to clients, might help

develop and maintain a positive alliance within the dynamic interactional system of therapy.

The author suggests there is a risk of current debates, regarding conceptualising psychosis and establishing the most effective treatments, detracting from the suggested importance of active processes which can occur in therapy. Providing more opportunities for reflection in clinical services, possibly through supervision or peer learning, which allow consideration of the impacts of processes, could further enable the provision of support structures in adopting this focus within services. This could assist in facilitating clinicians' capacity to establish and manage evolving client relationships more effectively. Literature on the ability to reflect indicates possible benefits for clinicians and clients regarding establishing shared understandings through effective formulation (Johnstone & Dallos, 2013).

An advantage of the increased debates mentioned is that the topic of psychosis can reach a wider public audience. There is a possibility that more people who experience psychosis and who are not currently in contact with services may recognise an individual need to "Make friends with the hole" i.e. address their difficulties. This would place more importance on widening access to psychosis services throughout the UK. This study's findings, such as the suggested importance of having a space to talk, committing to therapy and facilitating client trust in clinicians, could contribute to an acknowledgement of processes in initial client assessments. By acknowledging these processes this could contribute to knowledge about the types of services and interventions that can be offered to help people recover, as suggested by Farkas et al., (2005).

Limitations

Due to recruitment constraints, theoretical sampling was not carried out to further refine the model. Efforts were made to ensure 'sufficient saturation' was achieved in the continued analysis of the data but the proposed model cannot claim to represent a robust GT.

This study utilised a relatively small sample of 11 participants who, although recruited from five separate services in two different NHS Trusts, represent a small group of people who have experienced therapy for psychosis. Therefore, the transferability of these findings, for example to other services across the UK, is unclear.

The clients interviewed had nearly completed/completed a course of therapy. This implied that clients were engaged in the intervention and could have a more positive view of therapy. Therefore, it is unclear how the proposed model might apply to people who did not complete therapy or did not find therapy as beneficial.

In addition, this study interviewed people about subjective experiences of activities within therapy, rather than directly observing, i.e. via session recordings. There are methodological limitations of interviewing to gather data, such as complexities through unconscious processes, ambivalences and contradictions (Hollway & Jefferson, 2013). Where interpretations inferred relationships and meanings behind statements, efforts were made to test these interpretations from different participant data and to utilise self-reflective strategies to try to minimise researcher bias. However, as part of the model construction, the author's preconceptions remain likely to have influenced these interpretations in some form.

Future Research

      The question remains why some individuals find it difficult to shift perspectives and how positive change can be achieved with these individuals. Further research involving clients who did not complete therapy or were unwilling or unable to contemplate alternative perspectives could explore this. This population could have negative views of therapy as a result of their experiences and therefore might prove difficult to engage in a study. Emphasising the opportunity to talk about their experiences with a neutral interviewer or conducting indirect observations of therapy session notes or recordings from 'unsuccessful' treatments could assist with this difficulty.

      Despite not selecting participants based on the therapeutic modality adopted, all pairs had engaged in CBTp. Theoretical sampling of therapists, clients and family members working within an FI approach could further explore this study's findings to clarify if the model has wider applicability beyond CBTp. In particular, the processes indicated in the model could act as a framework to determine whether or not the same processes are deemed important in FI.

      Interesting observations were noted in relation to demographic variables, however, further explorations of the potential relationships between therapy processes and demographic factors could be conducted. In order to increase the applicability of the findings, the author suggests a similar qualitative study with a larger participant population is conducted.

      GT approaches enable the establishment of emerging theory grounded in the data. However, there are benefits in using other qualitative methods, such as discourse analysis. This could help explore issues such as subjectivity, therapist roles,

transformation of meanings and the role of power and wider socio-cultural discourses in therapy for psychosis.

Conclusion

This study presents a critical realist model of psychologist and client experiences of therapy for psychosis, acknowledging the importance of increasing client empowerment, collaboration in the therapeutic relationship, and valuing trust and belief. The model suggests a dynamic interconnectedness between core categories which emerged from the direct accounts of people who have experienced therapy for psychosis. Psychologists and clients shared common perspectives of the therapy factors important to them, and this study suggests the importance of acknowledging these relational factors when considering how people experiencing psychosis make use of understandings and strategies developed during therapy.

This study demonstrated support for previous findings from therapy process research in psychosis, suggesting further research which builds on this work would be of value. Further exploration could enhance our understanding of what processes contribute to helpful and unhelpful experiences of client change in therapy for psychosis. It is hoped that this understanding could then be used to refine psychological interventions to promote the use and occurrence of these seemingly crucial processes.

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Section C: Appendices of supporting material

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Appendix 1
Literature Search Strategy and Inclusion/Exclusion Criteria

An initial literature search was conducted between August 2013 and October 2013, with the final systematic literature search conducted between September 2014 and October 2014. A boolean search was employed in order to focus the search criteria. The specific terms psychosis OR schizophrenia AND therapy process OR change process were searched for within the title, abstract, key words and key concepts of studies within the following subject-based databases; Web of Science: Core Collection, Ovid Medline, ASSIA, PsycINFO and Wiley Online.

This produced a total of 2,463 results. An initial screen of the study titles and abstracts was conducted on all results. This involved the author reading the titles and abstracts of the 2,463 returned studies to decide whether or not a study could be potentially included in the literature review. This produced 144 potentially relevant studies. Inclusion and exclusion criteria were then applied to the 144 studies, which produced 35 studies. Duplicates between databases were then removed which produced 15 studies. References were then checked which produced a further 5 studies. The final total of selected studies for the literature review was 20.

Inclusion criteria:
- Peer reviewed paper.
- Published between 1986 and 2014, in line with Greenberg's (1986) definition of the emergence of change process research (CPR).
- English language.
- Involve any form of therapy intervention (e.g. Individual or Group CBT, Psychodynamic, Family Intervention).
- Involve clients with a diagnosis of psychosis, to include schizophrenia.
- Involve experiential accounts/self-report measures of involvement in therapy intervention for psychosis (client and/or therapist).
- Involve an exploration and discussion of therapeutic activities/processes which occurred during therapy interventions for psychosis.
- Any methodology or analysis (e.g. quantitative, qualitative or mixed method).

Exclusion criteria:
- Treatment efficacy evaluations.
- Medication efficacy evaluations.
- Service evaluations.
- Neurocognitive evaluations.
- Scale validity or reliability evaluations.
- Non-therapy based accounts of recovery in psychosis (e.g. an individual client's account of their overall recovery journey or experiences of psychosis).
- Measuring a specific construct (e.g. satisfaction or symptom reduction, rather than experiential accounts).
- Post-treatment follow-up, where no experiential account of therapy was explored.
- Focus on the nature and classification of psychosis.
- Focus on prevalence of psychosis.
- Focus on comorbidity interaction with psychosis.

Appendix 2
Table of Search Results

Subject Based Databases	Search results	Initial screen of Title and Abstract	Applied Inclusion and Exclusion Criteria	Duplicates removed	References checked	Final Studies Selected
Web of Science (Core Collection)	337	32	10			
Ovid Medline	423	28	8	15	5	20
ASSIA	589	36	8			
PsycINFO	331	20	0			
Wiley Online	783	28	9			
Total	2463	144	35	15	5	20
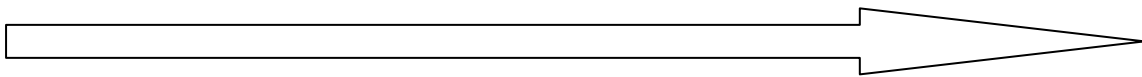
Appendix 3
Table of Selected Studies

Study	Sample	Methodology	Findings
1. Lysaker, P. H., Lancaster, R. S., & Lysaker, J. T. (2003). Narrative transformation as an outcome in the psychotherapy of schizophrenia.	One unemployed, never-married male in his 40s, who experienced symptoms of schizophrenia and was involved in voluntary psychotherapy for psychosis.	Qualitative, single case study. Content and thematic analysis.	Narratives in schizophrenia may gain complexity and dynamism, but changes do not entail the creation of a new story or the 'awakening' of an 'old' self. The hypothesis that narrative transformation may occur in terms of growth in the richness of the internal dialogue that produces narrative is posed for future research.
2. McGowan, J. F., Lavender, T., & Garety, P. A. (2005). Factors in outcome of cognitive-behavioural therapy for psychosis: Users' and clinician's views.	Eight therapeutic dyads: Four CBT Therapists and eight of their clients, involved in using CBT methods to treat psychotic symptoms.	Qualitative, semi-structured interviews. Grounded Theory analysis.	A number of major categories differentiated the two client groups, including ability to let go of distressing beliefs, logical thought, holding therapy, and presence of a shared goal. Overall, clients who progressed were better able to move into the therapist's frame of reference. Therapists and clients also felt that non-specific benefits accrued from the therapy for both groups.

Study	Sample	Methodology	Findings
3. Dilks, S., Tasker, F., & Wren, B. (2008). Building bridges to observational perspectives: A grounded theory of therapy processes in psychosis.	Six pairs of therapist-client. Psychologists identified clients who had been given diagnostic labels associated with obtaining NHS psychological therapy for experiences identified as psychotic (schizophrenia and schizoaffective disorder).	Qualitative, transcribing therapy tapes and semi-structured interviews. Grounded Theory analysis.	They proposed the core social psychological process in therapy for psychosis as being one of "building bridges to observational perspectives", defined as a jointly negotiated process, enacted in the conversation between psychologist and client, based on the psychologist repeatedly demonstrating the activities involved in observing, or standing back from, experience during the course of conversation with the client" (p.216).
4. Dilks, S., Tasker, F., & Wren, B. (2010). Managing the impact of psychosis: A grounded theory exploration of recovery processes in psychosis.	Dilks et al., (2008) data set extended through the additional sampling and analysis of 31 published personal accounts of the experience of psychosis.	Qualitative, therapy session tapes, semi-structured interviews, and review of published accounts of psychosis. Grounded Theory analysis.	"'Functioning in the social world' was defined as people aspiring to engage, without experiencing distress, in the roles, relationships and activities regarded by them as representing the ordinary life of a person living in their particular social world" (p94). They developed this concept further into the category 'managing the impact of psychosis', which involves the individual's active attempts to regulate and minimise the effects of experiencing psychosis on everyday life.

Study	Sample	Methodology	Findings
5. Dilks, S., Tasker, F., & Wren, B. (2012). Conceptualizing the therapist's role in therapy in psychosis.	Dilks et al., (2008) data set extended through the collection of three further interviews with psychoanalytically aware psychologists.	Qualitative, semi-structured interviews. Grounded Theory analysis.	A grounded theory model of therapy processes in psychosis was developed that conceptualised 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.
6. Karatza, H., & Avdi, E. (2011). Shifts in subjectivity during the therapy for psychosis.	Two families engaged in family therapy, with a member of the family having a diagnosis of psychosis.	Qualitative, tape recorded sessions. Seven sessions were analysed, drawn from the beginning, middle, and end phases of two therapeutic interventions. Discourse analysis.	Therapy is required to be truly collaborative to maintain benefits, especially in the early phases of therapy when an initial formulation is being jointly constructed. They also highlighted the therapist's role in de-centring the psychiatric discourse and introducing different interpretations regarding experiences, and specifically the client's identity.

Study	Sample	Methodology	Findings
7. Allen, J., Burbach, F., & Reibstein, J. (2013). 'A Different World' Individuals' experience of an integrated family intervention for psychosis and its contribution to recovery.	Seven clients who had attended a family intervention for psychosis.	Qualitative, semi-structured interviews. Interpretative Phenomenological Analysis.	Three central themes highlighted the participants' experience: (1) They welcomed the shared experience with their families and felt contained and valued by the therapists; (2) They felt the sessions contributed to changed patterns of relating within the family and the creation of new meaning through the validation of multiple perspectives; and (3) They described how the family sessions supported a new positioning in the world, a sense of their own empowerment and personal responsibility, greater self-acceptance, an increased ability to manage emotions, and hope for the future.
8. Braehler, C., Gumley, A., Harper, J., Wallace, S., Norrie, J., & Gilbert, P. (2013). Exploring change processes in compassion focused therapy in psychosis: Results of a feasibility randomized controlled trial.	Forty participants from a larger randomised controlled trial (RCT), whereby participants were either assigned to a compassion focused therapy plus treatment as usual group, or a treatment as usual group.	Quantitative, randomised controlled trial design. Semi-structured interviews and self-report measures. Clinical Global Impression Scale, with interview narratives coded using the Narrative Recovery Style Scale.	Group CFT was associated with no adverse events, low attrition (18%), and high acceptability. Relative to TAU, CFT was associated with greater observed clinical improvement ($p < 0.001$) and significant increases in compassion ($p = 0.015$) of large magnitude. Relative to TAU, increases in compassion in the CFT group were significantly associated with reductions in depression ($p = 0.001$) and in perceived social marginalization ($p = 0.002$).

Study	Sample	Methodology	Findings
9. Wood, L., Price, J., Morrison, A., & Haddock, G. (2012). Exploring service user's perceptions of recovery from psychosis: A Q-methodological approach.	Eight clients involved in therapy were used for the establishment of the Q-concourse. 40 clients involved in therapy were administered the Q-set.	Mixed, Q-methodological approach. Semi-structured interviews. Interpretative Phenomenological Analysis. Q-set consisted of fifty two statement cards which were rated by the participants.	Analysis revealed four distinct perspectives in relation to recovery from psychosis. The first placed importance on collaborative support and understanding, the second on emotional change through social and medical support, the third group emphasized regaining functional and occupational goals, and the last group identified self-focused recovery as being important factors.
10. Wittorf, A., Jakobi-Malterre, U.E., Beulen, S., Bechdolf, A., Müller, B.W., Sartory, G., Wagner, M., Wiedemann, G., Wölwer, W., Herrlich, J., & Klingberg, S. (2013). Associations between therapy skills and patient experiences of change processes in cognitive behavioural therapy for psychosis.	Recruited participants from a larger RCT: 79 out of 166 assigned to a CBT for psychosis group.	Quantitative, each participant had one therapy tape randomly selected for analysis at one time point, with valid measures used to assess process changes throughout therapy.	General skills, such as feedback and understanding, explained 23% of the variance of patients' self-esteem experience, but up to 10% of the variance of mastery, clarification, and contentment experiences. The technical skill of guided discovery consistently showed negative associations with patients' alliance, contentment, and control experiences. The study points to the importance of general therapy skills for patient experiences of change processes in CBTp. Some technical skills, however, could detrimentally affect the therapeutic relationship.

Study	Sample	Methodology	Findings
11. Grant, P. M., Reisweber, J., Luther, L., Brinen, A. P., & Beck, A. T. (2013). Successfully breaking a 20-year cycle of hospitalizations with recovery-oriented cognitive therapy for schizophrenia.	One 57-year-old Irish American woman, who had received treatment for 25 years, attended a total of 70 individual, 50-minute recovery-oriented cognitive therapy (CT-R) sessions that occurred weekly during the first year and fortnightly during the following 6 months.	Mixed method, single case study. Clinical interview including quantitative measures (Global Assessment Scale; Scales for the Assessment of Negative & Positive Symptoms; UCSD Performance Skills Assessment; and Computerized Neurocognitive Battery). Additional qualitative treatment description.	The present case study suggests that individuals with a diagnosis of schizophrenia have untapped potential that can be brought out by providers who use CT-R as a systematic roadmap to successfully help them move along their unique recovery path. Thus, there is promise that CT-R, or similar psychotherapeutic efforts, can improve outcomes, reduce treatment costs, and most importantly promote recovery for individuals with schizophrenia.
12. Messari, S., & Hallam, R. (2003). CBT for psychosis: A qualitative analysis of clients' experiences.	Five therapists and five clients; four inpatient and one outpatient, who were involved in CBT for psychosis.	Qualitative, semi-structured interviews. Discourse analysis.	The discourses of 'This is truly happening', 'I am ill', 'CBT as an educational process', 'CBT as a respectful relationship between equals', 'CBT as a healing process' and 'CBT participation as compliance with the powerful medical establishment', are described. The study throws light on the experience of receiving CBT for psychosis and points to some of the therapeutic process variables worthy of consideration in clinical practice and future research.

Study	Sample	Methodology	Findings
13. Lysaker, P. H., & Lysaker, J. T. (2006). A typology of narrative impoverishment in schizophrenia: Implications for understanding the processes of establishing and sustaining dialogue in individual psychotherapy.	Three clients who attended psychotherapy weekly, voluntarily, provided under routine conditions in an outpatient clinic and integrative in orientation (cognitive, behavioural, psychodynamic, humanistic and constructivist).	Qualitative: Impoverished personal narratives are discussed and subsequently illustrated qualitatively with case examples that highlight the ways in which each form of narrative impoverishment differently affects the relationship in therapy.	The authors suggest several paths by which psychotherapists can help clients repair their impoverished narratives and develop healthier narratives that could set the stage for more satisfying living. Although this model has been demonstrated with individuals exhibiting psychoses, it seems to have potential for application in psychotherapy with those not showing these severe symptoms.
14. Gonzalez deChavez, M., Gutierrez, M., Ducajú, M., & Fraile, J. C. (2000). Comparative study of the therapeutic factors of group therapy in schizophrenic inpatients and outpatients.	Two psychotherapy groups; one inpatient, one outpatient. 21 inpatient and 11 outpatient participants.	Mixed, Q-methodological approach. 60 cards in the Q-set, each with a sentence relating to a therapeutic factor, were administered to participants to sort into seven categories graded by usefulness (from 'most useful' to 'least useful'. Data analysis performed with statistical procedures (Sigma program).	The three therapeutic factors considered to be most useful by inpatient group of participants were 'instillation of hope', 'cohesiveness' and 'altruism', in that order. For the outpatient group of participants, the three factors selected as most important were 'instillation of hope', 'self-understanding' and 'universality'. Both the inpatient and outpatient groups rated 'family re-enactment', 'interpersonal learning input' and identification' as the least useful therapeutic factors.

Study	Sample	Methodology	Findings
15. Morrison, A. P., & Barratt, S. (2010). What are the components of CBT for psychosis? A Delphi study.	A panel of 7 experts in the field of CBT for psychosis (authors of existing treatment manuals and therapists/supervisors on a RCT of CBTp) and 28 professionals (a mixture of clinical psychologists, cognitive therapists, psychiatrists and mental health professionals).	A quantitative 'Delphi method', a systematic, interactive method relying on a panel of independent experts answering questionnaires, was employed. The establishment of statements and collection of questionnaire responses spanned three stages.	A sum total 77 items from the three stages were rated as essential or important by >80% of the panel members. The responses were grouped together by the authors and comprised; Engagement, Structure and principles, Formulation, Assessment and model, Homework, Change strategies and Therapist assumptions.
16. Garety, P., Fowler, D., Kuipers, E., Freeman, D., Dunn, G., Bebbington, P., ... & Jones, S. (1997). London-East Anglia randomised controlled trial of cognitive-behavioural therapy for psychosis. II: Predictors of outcome.	60 participants recruited from clinical teams, were randomly assigned to either the 'CBT plus standard treatment' group (28) or a 'standard treatment only' group (32), where standard treatment consisted of case management and medication.	Quantitative, RCT of CBTp. Validated measures used, with the main outcome measure being the Brief Psychiatric Rating Scale (BPRS).	A number of baseline variables were identified as predictors of good outcome in the CBT group. Key predictors were a response indicating cognitive flexibility concerning delusions and the number of recent submissions. The authors conclude that a response to the 'mistaken' question which admits the possibility of an alternative view of a delusion would predict a good response to CBT, and therefore, that a certain cognitive flexibility, a readiness to consider alternatives, is a factor in effective CBT for delusions.

Study	Sample	Methodology	Findings
17. Newton, E., Larkin, M., Melhuish, R., & Wykes, T. (2007). More than just a place to talk: Young people's experiences of group psychological therapy as an early intervention for auditory hallucinations.	Eight participants who had completed a CBTp group intervention.	Qualitative, semi-structured interviews were conducted and analysed using Interpretive Phenomenological Analysis (IPA).	Two main themes emerged from the analysis. The first 'A place to explore shared experiences' had four subthemes; A safe place to talk, Normalising and destigmatising, Learning from and helping others and The role of the facilitators. The second 'An inductive account of coping with auditory hallucinations' explored a cyclical relationship between four aspects of the participants' experiences of hearing voices; The content of the voices, the participants' explanations for the voices, emotional responses to the voices and their ability to cope with the voices.
18. Smerud, P. E., & Rosenfarb, I. S. (2008). The therapeutic alliance and family psychoeducation in the treatment of schizophrenia: An exploratory prospective change process study.	A total of 28 families were randomly assigned to one of two psychosocial treatments: a less intensive supportive family management (SFM) or a more intensive applied family management (AFM) which included behavioural family management (BFM).	Quantitative, observer ratings. One audio recorded session from each participating family was listened to and coded using the System for Observing Family Therapy Alliances (SOFTA), in addition to validated outcome measures.	The therapists' relationship and alliance with the clients' families was shown to benefit the client through an increase in the supportive structure and family environment. When clients developed good therapeutic alliances with their therapist it was shown to lower family rejection of the client and lower the feeling of the client as a burden on their family. It was concluded that it would appear to be important for the therapist to engage the client's family early, to prevent subsequent increases in client symptoms and to decrease negative family interactions.

Study	Sample	Methodology	Findings
19. Larsen, J. A. (2007). Understanding a complex intervention: Person-centred ethnography in early psychosis.	15 young people involved with an early intervention in psychosis service.	A mixed method, person-centred, ethnographic study involving two years participant observation and repeated interviews.	The study discusses in detail the impact of the intervention on the processes of social negotiation and self-transformation observed from the data. The effects of different group approaches and staff perspectives are discussed in relation to how the intervention helped the young people to understand themselves and their difficulties, and what to expect for their future lives.
20. Lecomte, T., Leclerc, C., Wykes, T., Nicole, L., & Abdel Baki, A. (2014). Understanding process in group cognitive behaviour therapy for psychosis.	66 individuals with early psychosis took part in a study of group CBTp.	An uncontrolled, longitudinal study involving client and relationship process variable measures at baseline, post-therapy and follow-up assessment.	The clients' evaluation of their alliance with their therapist and an overall feeling of cohesion from both clients and therapists were linked to improved outcome, as measured by the outcome measure scales. The results also suggested that in a group context it is important for the participants to feel safe and to relate to other participants and to therapists throughout the therapy in order to improve their overall symptoms. This also appeared to have implications for the feeling of personal compatibility which clients felt towards their therapist and also the therapists' perception on alliance and shared tasks, which were linked to improved outcomes.

Appendix 4
Literature Review Quality Guidelines

A. Publishability guidelines shared by both qualitative and quantitative approaches
Although qualitative researchers often design their studies from a different philosophy of science than that followed by experimentalists, they generally share the following traditional guidelines for publishability of their research:

1. Explicit scientific context and purpose. The manuscript specifies where the study fits within relevant literature and states the intended purposes or questions of the study.

2. Appropriate methods. The methods and procedures used are appropriate or responsive to the intended purposes or questions of the study.

3. Respect for participants. Informed consent, confidentiality, welfare of the participants, social responsibility, and other ethical principles are fulfilled. Researchers creatively adapt their procedures and reports to respect both their participants' lives, and the complexity and ambiguity of the subject matter.

4. Specification of methods. Authors report all procedures for gathering data, including specific questions posed to participants. Ways of organizing the data and methods of analysis are also specified. This allows readers to see how to conduct a similar study themselves, and to judge for themselves how well the reported study was carried out.

5. Appropriate discussion. The research data and the understandings derived from them are discussed in terms of their contribution to theory, content, method, and/or practical domains, and are presented in appropriately tentative and contextualized terms, with limitations acknowledged.

6. Clarity of presentation. The manuscript is well-organized and clearly written, with technical terms defined.

7. Contribution to knowledge. The manuscript contributes to an elaboration of a discipline's body of description and understanding.

B. Publishability guidelines especially pertinent to qualitative research
The following guidelines are either specific to qualitative research, or are specifications of how more general principles apply to qualitative research. These guidelines are not intended to be all-inclusive or definitive. Authors should be able to address how they meet the intentions of these guidelines for reporting qualitative research, or their rationales for meeting alternative standards.

1. Owning one's perspective. Authors specify their theoretical orientations and personal anticipations, both as known in advance and as they became apparent during the research. In developing and communicating their understanding of the phenomenon under study, authors attempt to recognize their values, interests and assumptions and the role these play in the understanding. This disclosure of values

and assumptions helps readers to interpret the researchers' data and understanding of them, and to consider possible alternatives.

2. Situating the sample. Authors describe the research participants and their life circumstances to aid the reader in judging the range of people and situations to which the findings might be relevant.

3. Grounding in examples. Authors provide examples of the data to illustrate both the analytic procedures used in the study and the understanding developed in the light of them. The examples allow appraisal of the fit between the data and the authors' understanding of them; they also allow readers to conceptualize possible alternative meanings and understandings.

4. Providing credibility checks. Researchers may use any one of several methods for checking the credibility of their categories, themes or accounts. Where relevant, these may include (a) checking these understandings with the original informants or others similar to them; (b) using multiple qualitative analysts, an additional analytic `auditor', or the original analyst for a ` verification step' of reviewing the data for discrepancies, overstatements or errors; (c) comparing two or more varied qualitative perspectives, or (d) where appropriate, ` triangulation' with external factors (e.g. outcome or recovery) or quantitative data.

5. Coherence. The understanding is represented in a way that achieves coherence and integration while preserving nuances in the data. The understanding fits together to form a data-based story/narrative, `map', framework, or underlying structure for the phenomenon or domain.

6. Accomplishing general vs. specific research tasks. Where a general understanding of a phenomenon is intended, it is based on an appropriate range of instances (informants or situations). Limitations of extending the findings to other contexts and informants are specified. Where understanding a specific instance or case is the goal, it has been studied and described systematically and comprehensively enough to provide the reader a basis for attaining that understanding. Such case studies also address limitations of extending the findings to other instances.

7. Resonating with readers. The manuscript stimulates resonance in readers/reviewers, meaning that the material is presented in such a way that readers/ reviewers, taking all other guidelines into account, judge it to have represented accurately the subject matter or to have clarified or expanded their appreciation and understanding of it.

Appendix 5
Example of Author's Quality Coding System

A. Publishability guidelines shared by both qualitative and quantitative approaches

	8	9	10	11	14	15	16	18	19	20
1. Explicit scientific context and purpose.	p200 & 201. Clear context and aim of clinical trial	p246 & 247. Clear context and aim of the	p703. Clear context, aims and method and	p125 & 126. Clear context, aims and	p252, 253 & 255. Clear context and	p136 & 137. Clear context, area to be	p420. Clear context, but more brief than	p505. Clear context and aim: to examine	p333-336 & 338. Clear context and	p3. Clear context and objectives: to
2. Appropriate methods.	p201 & 202. Following clinical trial	p247. Justification for the use of O-	p703. Respect measures used were relevant to	p125. Clear explanation as to why a case	p257. Q-methodology justified as	p137. Q-methodology justified as	p420. RCT design grounded in	p506. method and measures used were	p337. Justification for the use of the	p3. Clear objectives: to
3. Respect for participants.	p202. Participants had to meet	p247. Creation of interview schedule	p703. Respect for participants was reflected in	p132. There is no mention of any formal	p256 & 257. Consideration was shown in	p137. Participants chose to	p420. Full participant details	p506. No specific mention of the	p337, 338 & 339. Informed consent	p3. method and measures used were relevant to
4. Specification of methods.	p202 to 205. explicit descriptions of	p247, 248 & 249. explicit descriptions of	p704 & 705. Detailed descriptions of validated	p126. Detailed descriptions of	p257 & 258. Detailed description of	p137. Detailed desciption of the procedure	p420 & 421. Detailed descriptions of	p506 & 507. Detailed descriptions of	p338 & 339. Detailed descriptions of	p4, 5 & 6. Detailed descriptions of
5. Appropriate discussion.	p209, 210 & 211. Appropriate	Discussion. References to previous	p707 & 708. Discussion. References to	Extremely clear and logical progression	p260, 261 & 262. Comprehensive	p138 & 141. Discussion identified the	p424. Detailed discussion of cognitive	p509. Results section provided a comprehensive	p339 to 343 provide comprehensive	p10. Situatin the discussion of processes
6. Clarity of presentation.	Very clear and logical structure and	Very clear and logical structure and	Very clear and logical structure and	Very clear and logical structure and	Very clear and logical structure and	Very clear and logical structure and	Very clear and logical structure and	Very clear and logical structure and	Very clear and logical structure and	Very clear and logical structure and
7. Contribution to knowledge.	Contributions justified and specific	Contributions justified and specific	Contributions justified and specific	Contributions justified and specific	findings discussed in relation to	p138. limitations acknowledged	p425. Presentation of 2 possible	p509. Although the authors claim the	Very clear contribution, but would have	Very clear contribution, but would have

B. Publishability guidelines especially pertinent to qualitative research

	1	2	3	4	5	6	7	12	13	17
1. Owning one's perspective.	p295 state aim of the paper, but limited in	p514 clear aim and what they want to be	p212. we took an exploratory position	p89. we took a critical realist position, adopt	p317 & 330. We took a critical realist position	p217. draws from social constructionis	p215. justification of IPA and its	p175. The questions were informed by the	p59. Establishing their outlook on	p131 & 132. IPA draws upon the phenomenologi
2. Situating the sample.	p290. Very detailed case study	p515. very detailed	p213. clear description of participants'	p90, 91 & 93. clear explanation of	p319 & 320. clear explanation of	p218. clear explanation of the two families	p215. clear explanation of the participants	p173. clear explanation of the participants	p61, 62 & 63. Detailed descriptions of	p131. Detailed description of participants
3. Grounding in examples.	While a case study format is presented, and	Throughout for each category	multiple, clear examples throughout	multiple, clear examples throughout	multiple, clear examples throughout	multiple, clear excamples throughout	multiple, clear excamples throughout	multiple, clear examples throughout	p61, 62 & 63. Detailed descriptions of	multiple, clear examples throughout
4. Providing credibility checks.	p292. 4 additional transcripts	p518. comprehensive reliability and	p215. clear data checks through memo	p93. followed good practice, published	p321. followed good practice, published	p219. in line with discourse analytic	p215 & 224. Followed IPA procedure	p185. Informal presentation of findings to	p66. Purely case study examples of	p132. The second author reviewed the
5. Coherence.	Understandable but the level of abstract/theore	Very coherent presentation of categories and	Logical structure and flow	Logical structure and flow	Logical structure and flow	Logical structure and flow	Logical structure and flow	Logical structure and flow	Logical structure and flow	Logical structure and flow
6. Accomplishing general vs. specific research tasks.	p295-296. Acknowledging the specific	Accomplishing general task of expanding	p225. accomplishing general task	p102. Importance of diverse	p329 & 330. Importance of recognising	p226. providing main findings but	p224. provision of main findings and	p185. Providing main findings and also	p66 & 67. Summary of the three proposed	p144. Providing main findings and linking to
7. Resonating with readers.										

Key:

🟩	Green indicates the author judged that this criterion had been met fully.
🟧	Amber indicates the author judged that this criterion had been met partially.
🟥	Red indicates the author judged that this criterion had not been met.

Appendix 6
Table of Therapy Information for each Psychologist/Client Pair

Psychologist/Client Pairs	Therapeutic modality	Length of therapy (months)[1]	Completed therapy at time of interview?
Gemma & Eve	CBT	10	Yes
Gemma & Carly	CBT	5	Yes
Adam & Ted	CBT	48[2]	No
Jane & Andy	CBT	9	No
Michael & Selena	CBT	18	No
Jo & Arianna	CBT	14	No

[1]Length of therapy was calculated from the point at which the psychological intervention started up to, either the end of treatment, or the point at which the interview was conducted (which ever occurred first).

[2]Adam identified that although he had been seeing Ted over the past 4 years, there had been times during this period where they did not engage in therapy. However, during these times they remained in contact with each other.

Appendix 7
Interview Schedule

Interview Schedule

Questions will be asked of client and therapist and will be adapted to suit. As the interview is semi-structured, follow up questions will be asked if deemed necessary at the time of interviewing.

The interview schedule will include questions regarding the following areas:
- Making sense of experiences.
- Collaboration between the client and therapist.
- Relating experiences to understanding of personal therapy goals.
- Impact of individual factors.

- Making sense of experiences.

What did you think therapy would be like?
How was it different to what you expected?
How do you think therapy helped you?
How do you think your personal goals for therapy were achieved?
Could you tell me what you feel has changed in relation to moving towards your personal goals for therapy?
What was helpful in making sense of your personal experiences?
What was difficult in making sense of your personal experiences?
Did the way you understood your experiences change over time? If yes, how so?

- Collaboration between the client and therapist.

Could you tell me what you think were the positive and negative aspects of working together in your sessions? (Either with the client or with the therapist)
How important was it to have a strong relationship with the therapist/client?
Could you give me some examples of how you thought you worked well with the therapist/client?
What did it mean for you to work closely with someone while focusing on specific goals?

- Relating experiences to understanding of personal therapy goals.

What did it mean to work towards personal goals in therapy?
How were the therapy sessions used to work towards these goals?
How were the therapy sessions specific to your personal experiences/ situation?

- Impact of individual factors.

Was there anything that you found particularly hard to understand throughout the therapy? (Client only).
Were there particular individual factors that made therapy easier/harder?
How did people's ideas about personal agency affect the therapy? (Therapist only).
Could you tell me what you think helped, and what was difficult, when making the therapy specific to the individual client? (Therapist only).

Appendix 8
Participant Information Sheet

Robert Medcalf
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Exploring how people experiencing psychosis make use of understandings and strategies developed during the joint activity of therapy

Research Ethics Committee Reference: 13/LO/0792

YOU WILL BE GIVEN A COPY OF THIS INFORMATION SHEET AND THE CONSENT FORM

My name is Robert Medcalf 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 decide whether you want to take part, I would like to let you know why the research is being done and what your participation will involve. I would be grateful if you took a little time to read the following information carefully and discuss it with others if you wish. Please ask me if there is anything that is not clear or if you wish to know more. You should only participate if you want to; choosing not to take part will not disadvantage you in any way.

What is the purpose of the study?

The purpose of this study is to find out more information about therapy activities that occur during therapy for psychosis.

When people are involved in therapy it is possible that the therapist and client may work together to make sense of experiences and to then use this understanding to help the client manage their difficulties in a more effective way. This process can help people to work towards their own understanding of personal recovery. Some people find that they can do this more easily than other people, and that after a while they find they do not need as much guidance from their therapist, and therefore could be said to take more 'ownership' of their experiences.

I am interested in finding out more information about how people manage the processes within therapy, whilst working towards what recovery means to them.

Who am I asking to participate?

I am asking people who are currently involved in therapy for psychosis within [NHS Trust] services, aged 18 years and older. I am also asking psychologists who work with such people to help by taking part in this study

What are the benefits for you of taking part?

- As a "thank you" I am offering every participant the chance to be entered into a prize draw for a £40 Marks & Spencer voucher.

- There are no other direct benefits, however we believe that by participating and allowing me to conduct this study, you will contribute to the greater good by providing new information regarding therapy processes in therapy for psychosis.
- We cannot promise the study will help you personally but the information we get from this study could help improve the treatment of people with psychosis.

What will I ask of you if you take part in the study?

- If you agree to participate you will be asked to complete 1 interview which will take about thirty minutes to one hour. This interview will be near the end of the therapy.
- The interview will include questions regarding the relationship between therapist and client, how you make sense of your experiences and how you view the process of increasing ownership of experiences.
- The interviews will be audio recorded, then transcribed in full for analysis.
- Interviews will take place at current service locations and you may claim up to £10 for travel expenses if required.
- If I think there is an important area that has been highlighted in my interviews with other people, that we did not talk in great detail about, I may get back in contact with you to see if a second interview would be possible, to hear your thoughts about this important area. However, you are under no obligation to consent to this second interview.

What are the risks?

- There are no major risks involved – all we want to do is ask you questions about you and your experiences in therapy. Some of these questions may touch on sensitive areas. 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?

I take confidentiality very seriously. All personal information about you is regarded as strictly confidential. Only I will be able to trace the information you have given to your personal details, for the purposes of data collection and organisation. Your therapist will not see any of the information you provide. All the information about you will be coded; you will not be identifiable in any of the study data. This ensures that suitable standards of security and confidentiality are applied. The audio recording of the interviews will be securely held on an encrypted memory stick and then deleted once fully transcribed. The anonymised data collected will be held for up to twelve months from the time of the interview to allow the project to be completed, allowing for any unforeseen delays.

The only time I would consider breaching confidentiality would be if you tell me something which may place you or someone else at severe risk (such as suicidal plans or plans to harm someone). In those cases you might be contacted by your GP or psychologist.

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

You are free to withdraw from this study within a month after the interview without giving a reason by contacting myself using the details at the top of this letter. Withdrawal will not affect any of the care and treatment you receive from the NHS. If you withdraw from the study after a month from your interview, I would like to use the data collected up to your withdrawal, and of course the same confidentiality regulations will apply.

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 make comments if they would like to, to help me complete the research.

Who is organising and funding the research?
- Canterbury Christ Church University.
- [NHS 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 myself directly using the details at the top of this information sheet. Alternatively you can either contact my academic supervisor at Canterbury Christ Church University, [Name], either at the above address or by telephone on [Telephone number], OR contact the NHS Patient Advice and Liaison Services [Trust branch] on **[Telephone number].**

Thank you very much for your time and once again please ask for more information on the project if you wish.

Kind regards,

Robert Medcalf

Appendix 9
Example Transcript with Focused Coding

This has been removed from the electronic copy.

Appendix 10
Example Research Memos Utilised in Theoretical Coding

1. Establishing a "deeper understanding"

I'm noticing that when I ask participants about understanding of experiences that the response is that there was a sense of confusion and avoidance. A strong impression I'm getting is that when people, especially clients, think about what they were experiencing is that it is distressing or frustrating, which a lot of the time appears to lead to avoidance. However when participants speak about how they made use of therapy, often one of the first tasks was to gain some understanding of and to make links between past experiences, how they reacted to them and how they affect them now; conveyed through how they are presenting. Focused codes seem to be linked in how there is a search for a better or deeper understanding of their experiences, seeing things in a new way, as Carly-[C] (L217-218) explained.

2. Having a space to talk

Both psychologists and clients have spoken a lot about the early stages of therapy as 'having a space to talk' with someone about what is going on for them. There have been a few references to clients not having anyone else currently, or ever, to talk to and share their experiences with. The psychologists refer to providing a safe and contained space to allow clients to simply talk, without imposing any strict structure to the session at that point in time, as CBT would suggest.

3. Committing to therapy

A lot of the dialogue from clients and psychologists make reference to the need for commitment, from both sides. On speaking about expectations, a common reference has been made around participants underestimating how hard therapy would be and how much perseverance is needed to get to a place where both the client and psychologist feel happy with the outcomes. Clients especially have made reference to having to 'wait a long time' to start therapy, or they have friends who have attended therapy but not committed 100% and therefore not seen the results they were after; giving the client a sense of if they want this to work, they need to be 100% committed to see results. This outlook is shared by the psychologists also, who have touched on the importance of showing their clients their own commitment to the therapy as a psychologist and the effort they are putting into the sessions and the therapy as a whole so the client sees that they are 'sharing' the level of commitment and effort going into the sessions.

4. Increasing sense of empowerment

Clients have spoken a lot about the psychologist as performing as a 'motivating guide' role, rather than an authoritative or dictating role. They see the psychologist as suggesting different ideas and collaboratively negotiating a plan of action with the client, testing out different approaches and methods and going with those that the client feels more at ease with. In doing this the clients identified that they were

realising solutions for themselves, in turn boosting their confidence in their abilities to self-manage their care and their development, with the support of the psychologist. The psychologists also talked about how they actively attempted to facilitate an increase in the clients' confidence and sense of worth, with the aim of supporting a sense of empowerment for the client; enabling the client to demonstrate they are in control and hold the responsibility of their life and experiences.

5. "Working it out together"

A high number of the interviews have focused around how the clients and psychologists decided the direction in which to take the therapy or how to go about deciding and setting goals or session plans. There is a strong sense of collaboration emerging, with psychologists speaking about 'being led by the client' and 'working alongside the client' in sharing their perspective, current thinking or even distress and confusion. There is also mention from clients around a sense of 'working together' with their psychologist to make decisions, and that the experience of therapy was one of a 'shared journey'.

6. Creating a new perspective

There appears to be a consensus with most if not all of the participants that one of the main changes or outcomes, throughout therapy, was that clients are now able to create a new perspective to view themselves and their lives. Psychologists spoke about 'shifting' the clients' perspective through testing out different ways of looking at things and by reframing experiences. Clients equally spoke a lot about this notion of 'adopting a new perspective on life' and 'reconstructing your life'. This appeared to bring with it quite a significant change in the client's life, the way they understand themselves and their experiences. This also appeared to have a bearing on the client's sense of control over their life and how the introduction of a more balanced and realistic viewpoint had allowed some form of personal growth and enable them to feel more confident in their ability to cope with future difficulties.

7. Managing the evolving relationship

When describing how they view their role, psychologists have spoken quite a lot about the need to monitor both the progress of the client and the way in which their relationship is developing or changing. There seemed to be an acknowledgement of the relationship going through different 'phases' as the therapy progressed, and that the psychologists felt a need to acknowledge, react to and manage the relationship as it evolved. The need to find a balance was referred to on several occasions, and this made me think about the impact that this may have on the clients' development of a new perspective which is more balanced and realistic. In addition, the psychologists spoke about how they were continually thinking about how to relate to the client, and that this was influenced by the clients' interactions with them, so something about the joint interaction or shared experience creating this back-and-forth between working together and 'managing' the relationship.

8. "Make friends with the hole"

Carly-[C] told me a story during their interview and as she was telling me it felt like she kept repeating this one phrase "make friends with the hole". It was four times that she repeated this, which might not sound like many, but the way in which she was saying it really emphasised some sort of realisation for her that this act of facing up to your fears and not avoiding your problems was key to getting some form of progress in therapy. I've extracted the story as it is too long for a quote:

> ...when I first started working in mental health, I was volunteering, and part of the volunteering training was, erm, taken by [name] from the [service], and he said, there was once a woman and she got up in the morning, got dressed, got herself together, went out of the house, she could have gone right or left at the end of her road, but she went left, she'd walk down that road then she'd fall down this hole and, erm, everyday this would happen. But one day she thought, well I'm not going to walk that way I'm going to walk down the other road, right? So she chose the other road and she made that change. Now when we went to, I was also volunteering with another mental health programme and they went to county hall, and there were loads of speakers and all that, there was presentations and stuff, so I was upstairs talking to an American woman, she was one of the speakers, she said, erm, I was talking to someone and telling them that story and the woman said, well why didn't she make friends with the hole? And I said to [psychologist], I understand where she's coming from now, I thought she was an idiot, complete idiot, I said is anyone listening to her? She's an idiot, 'course you'd walk the other way. But when I sat there with [psychologist] I told her the story and I said I can understand where she was coming from now, finally... (Carly-[C], L 219-235)

Other clients also spoke about this idea of acknowledging or identifying a need to change or improve, and also this need to "confront your fears". This links in with the idea that clients need a high degree of commitment to therapy, so by facing up to your problems you can then fully commit to improving your situation and being able to cope better.

9. Holding the psychologist in high regard

Across all clients there appeared to be an appreciation and admiration of the psychologist. There were common accounts of appreciating the time that the psychologist had for the client and that not all professionals that they had contact with would always have time for them in the same way. This appreciation appeared to be linked in some way with trust of the psychologist and that this would then impact upon their ability to work together effectively. As typically clients had not spoken about their difficulties with anyone prior to therapy this act of using the therapy to talk to somebody appeared to also elevate the psychologist into a position of high regard, as the clients were not able to engage in this with anyone else in their lives. This seems to then add to the idea regarding 'seeing the psychologist as special' and 'being grateful to psychologist', and appears to point towards a client experience of 'holding the psychologist in high regard'.

Appendix 11
Research Diary

February 2012: Been looking through the folders with the suggestions of MRPs, there is a lot to choose from, but my initial thought is to do something involving psychosis, because of my previous job and it's an area of interest of mine.

April 2012: I have made contact with a potential external supervisor on the phone. I have read her research and spoken to her around a few ideas I have that could be built on for an MRP project. She seemed interested and gave advice on different literature to read when thinking about making a proposal.

May 2012: Emailed draft proposals to same potential external supervisor. She has responded to say she is happy to be my external supervisor. Given more information around literature and happy to discuss the project further. Now working out a time to meet. She has also found an interesting looking article by McCabe & Priebe (2004) on relationships between health locus of control, quality of life, explanatory models of psychosis and ethnicity. This might conceptually link up with my study. Also attached a PDF of her 2010 paper and an early view copy of a paper on therapist activities in psychosis.

June 2012: Attended the Salomon's ethics review panel meeting with two members of Salomon's research staff. This was a good opportunity to talk over my proposal. However there seemed to be a few concerns regarding the use of pre-existing construct like locus of control when using grounded theory. I need to think a bit more around my positioning in relation to grounded theory analysis.

I have received the outcome of the ethics panel meeting. They have requested clarification of certain aspects of the proposal, most notably using grounded theory analysis as a means of generating theory emerging from the data, as opposed to using a pre-existing construct, therefore I have removed the focus on locus of control from my initial proposal and have addressed their bullet points, amending the research to propose an exploration of processes within therapy for psychosis.

July 2012 – Oct 2012: I have received full ethics approval from the Salomons review panel. I can now start thinking about submitting my full application form to IRAS. I have sent revised proposals back and forth with internal and external supervisors to reach a final aim.

October 2012: Registered with IRAS. Currently trying to find out about the application process – seems very confusing! There appears to be many different sections and forms so I will have to seek advice regarding this.

December 2012: Following a month of consulting with research staff at Salmons I am clearer on the IRAS process and am now completing the application. Christmas break much needed!

Very sad family news, my girlfriend's Nan has been very sick and passed away over the Christmas break. Have had to spend time supporting her through this very difficult time.

February 2013: On further discussions with my external supervisor and research staff after the Christmas break, we have decided that the nature of my project is more suited to a proportionate review panel application. So I have now submitted a proportionate review panel request to IRAS and fingers crossed they come back with an approval!

March 2013: Sad times – my application for proportionate review has been declined due to IRAS deeming the project to be in line with criteria for a full panel review. Feeling frustrated and slightly confused as I have spent a lot of time with various people discussing the nature of my project and its suitability for proportionate review. Oh well, on to a full review application now….

April 2013: OK – so I have just submitted my full review application to IRAS – fingers crossed this one is approved. I should hear back within the month. While I wait I am going to read up on literature for my literate review.

June 2013: Attended full panel review meeting, this was a slightly odd experience. Today has been a roasting hot day and I was the last to be seen. I walked into a room of seemingly hot and frustrated people from different walks of life and was only in the room for around eight minutes. I expected it to be a lot longer! They asked me questions and told me I will be sent a decision in the near future. Back to my literature review reading.

Good news, today I have received a provisional favourable opinion decision from the panel. I now have to clarify a few points and will send back this week.
Have also been in contact with the specific NHS Trust 'research area' team [specific name removed] to introduce my project and apply for approval to conduct my project within their Trust, before applying to R&D as stated on the Trust website.

July 2013: Favourable opinion granted! Relief! Have also got straight back in touch with NHS Trust contact. They have also approved approval – good week all round and means I can now apply to the NHS Trust R&D department.

August – September 2013: Have been liaising with the NHS Trust R&D department as they have requested further information in addition to the supporting evidence requested on their application form. I will liaise with liaise with my NRES committee contact to obtain the relevant information required.

Now have the relevant information – I have sent it back to the NHS Trust R&D department. Now awaiting yet another decision!

I have liaised with my external supervisor who has informed me that she will start speaking with psychologists at the service where I am recruiting to gauge interest and provide possible leads for participants. I have also begun my formal literature search and starting my section A.

October 2013: NHS Trust R&D approval granted. I am a GO for recruitment!!
I am currently emailing psychologists in the service to inform them about the study and to follow up on interested leads provided by my external supervisor. I have about

three leads at the moment and hoping some interviews will come out of these imminently. My section A is progressing nicely.

November 2013: First interview has been confirmed! The process of recruiting through the psychologist appears to be working well. The client was happy for me to contact them directly so I have organised a time to meet and discuss the project further and sign the consent forms.

Have met with the participant and they wanted to do the interview then and there, however I had to explain that due to ethics, I have to leave one week between completing the application and doing the interview to give time should they have any further questions. Luckily they are OK with this.

It is a week later and I have done my first two interviews with the psychologist and the client. It was really interesting to hear about the same therapy, but from two different perspectives and now that I'm up and running with the interviews I'm looking forward to getting into the data. There already appears to be a lot of similarities in their accounts, mainly about the way in which they made decisions as being made together, and thinking about the different therapeutic strategies used. Last week of November and I have transcribed the first pair of interviews. It took more time than first anticipated but I have heard Salomon's lend out a transcribing peddle – must look into that for the rest of my transcriptions. The actual process of writing out the interviews myself was a good decision, despite the length of time taken over it, because by transcribing them myself I am really starting to feel more familiar with the data. Even hearing the participants' voices again reminds me of how they were in the interviews. However, I need to keep track of this when I start line-by-line coding to ensure it is the data emerging and not my experience of the person coming through.

December 2013: Recruitment hasn't been as good as it first appeared. Many psychologists are interested in the study but are telling me that they either don't have any clients who they are nearing the end of therapy with, or they do have clients nearing the end of therapy, but they are going through a difficult time at the moment so cannot participate at this stage. I have asked if it is OK to remain in contact for future reference in case they can participate at a later date, and they are OK with that. Have arranged for my second pair of interviews; however it is now very close to Christmas so we have arranged to meet in January, 2014.

Off to Ireland to spend Christmas with my family – can't wait.

January 2014: Have got the transcribing peddle and written up my second pair of transcripts. Made transcribing so much easier, however still taking me around six hours per interview as they are around 50 minutes long each.

Sent off my section A to supervisors for an initial review.

First draft of my section A back from review – a lot of work needed. The general feel is there but I need to address their comments, mainly around continuity throughout the document.

February 2014: Recruitment is not going well. One potential client participant I was due to meet didn't show three weeks in a row, despite confirming the interview time and location twice on the day before and once on the actual day. This is the frustrating side to recruitment. I managed to speak with them again on the phone and after booking in again I once again reiterated that if they didn't want to participate then they didn't have to and that they didn't have to tell me why they didn't want to participate. They subsequently decided to not participate. I feel like I have wasted a lot of time and energy, but now need to focus on finding more participants. Going to investigate reaching out to another psychosis service within the same Trust.

Starting to do line by line coding, discussing with my external supervisor. I have found on my initial line by line codes I have been thinking too deeply and almost generating Focused codes. On noticing this I have spoken with my external supervisor about this. She has agreed but appears glad I have picked this up and noticed myself. I need to remind myself on future coding to stay within the activity on each individual line and not think too much when generating the line by line codes.

March 2014: I have successfully extended my recruitment out to a different psychosis service, still within the same NHS Trust. This is due to the majority of psychologist in the initial service having already been contacted and unfortunately not able to help. Third pair of interviews has been arranged for the same day, so very productive! However concern that it is now March and no more are lined up despite continued efforts to call, email and visit service locations which at first have seemed very engaged, but nothing has come out of my continued conversations.

Third pair of interviews went well. I am starting to notice links between the different accounts, not just between the psychologist and client pairs. But also overall conversations being had – most notably this idea of working together in a joint capacity. There also seems to be a lot of talk about increasing the clients' confidence and their ability to do and realise things for themselves, which is facilitated by the initial listening to the client by the psychologist and then working out the best therapeutic strategy to take based on client experiences and perceptions. It will be interested to see if all of the different participants come out with the same information. I have started to realise the importance of writing memos to record my thinking regarding potential links and relationships between codes emerging from the data.

Transcribed this pair of interviews – still taking me a long time and worried that with only three pairs completed so far this is not going to generate sufficient data for submission. Have also had a lot of time taken up meeting with my family around ongoing personal family circumstances. Going to call both external and internal supervisors tomorrow to discuss the possibility of an extension.

Spoken to both supervisors who have both acknowledge the difficulties in recruitment so I am currently applying to Salamons for an extension on my project to allow time to interview more pairs. In the meantime I am still following up on warm leads at the new service.

April 2014: Feel disappointed to not be handing in my MRP at the same time as the majority in my cohort. I have now spoken to all supervisors, who feel that due to my

initial leads in the first service drying up it would be beneficial to reach out to different Trusts to ensure more participants can be secured.

I have identified psychosis services in three local NHS Trusts and have made contact with these services, however many psychologists are out or on holiday so cannot gauge potential interest at this stage. Will send out emails.

I have liaised with my contact in the NRES committee regarding the procedure for extending my recruitment to different NHS Trusts. They have informed me that as my initial approval covered NHS Trust sites, my first port of call is to contact he specific R&D department directly and apply for approval through them. Once approval is received the NRES committee contact requested to be kept up to date.

I am currently applying for direct Trust R&D approval. One Trust appears to have several interested psychologists so the decision has been made to focus my attention on gaining R&D approval for this particular trust, whilst still simultaneously applying for R&D approval with the other two Trusts in case this one doesn't come through for me.

In the meantime after having line by line coded my first three pairs of interviews, I have also Focus coded them and it will be interesting to see if these will be applicable to future interviews.

May 2014: The more interested Trust has granted R&D approval and I am trying to arrange interviews as quickly as possible.

I have been back in contact with the psychologists in the new Trust to let them know I have R&D approval – great news, this has resulted in two new pairs of participants, which are booked in and will mean I have five pairs.

From contacting services in the original Trust a new opportunity has arisen to promote the project. I am attending their team meeting, with a view to having some time at the end of the meeting to speak to the whole team about my project.

Just back from a positive meeting – I am hoping it generates some more participants. Interviews four and five have been transcribed and are being coded using Focused codes generated in the first three pairs of interviews.

June 2014: Just heard back from the meeting I attended and a psychologist is interested and has a client in mind. They are speaking to their client this week and will get back to me.

Great news – they are happy to participate and I have scheduled both interviews. Both interview are now complete and I am starting to think these could be my last ones as I am seeing no new Focused codes emerging but this will be confirmed once I have Focus coded these interviews.
I have just finished the Focused coding and it appears that sufficient saturation has been achieved in recruitment. I am now beginning my analysis - it's all up to me now, no more recruitment.

July 2014: It became apparent that due the last pair being coded in June, I was not going to make the July 18th deadline. I have applied for a two week extension and this was approved. I am now working hard to document my results. I can see I am begin to get a model emerging, which is really exciting and I feel like all my hard work to date is coming together.

I have shared the model and my section B with my supervisors. I have taken on their advice and feedback and I feel confident, despite a tight timeframe, that I can make adjustments to my work and make the August 1st deadline.

September 2014: I received a mark of 'revise and resubmit' which I'm disappointed with. I agree with the feedback from examiners and I'm disappointed and frustrated with myself that I did not include certain aspects within my submission. My main priority now is to work on addressing the points raised by the examiners and bringing the project up to a higher standard. One of the main points raised regarding my literature review was the need for the systematic process to be more evident for the reader. To address this I'm going to complete another systematic literature search within psychology-based databases to see if this will yield further studies to include in the review.

One of the most important points regarding my main project was the lack of participant demographic information, to put my participants in context for the reader. To collect this information I will need to liaise with NRES and the relevant R&D Departments to ensure I can obtain approval to re-contact my participants. I included a bullet point in my Participant Information Sheet explaining that I may need to get back in contact with my participants so I hope this will ease this process.

October 2014: Great news! I have submitted and received approval for a minor project amendment from NRES and both R&D Departments! I can now re-contact my participants to collect demographic information, as long as the participants consent to providing this anonymous information.

I was really expecting this process of data collection to take longer than this but I have managed to collect all the relevant demographic information from the psychologist and client participants over the course of two days! (with a weekend in between!). This is such a huge boost to my work and means I can start to re-analyse my interview transcripts, following the same grounded theory method, to remain open to any potential relationships between this information and the activities and processes described by participants.

I've completed an exhaustive, systematic literature search and an additional 10 studies have now been included in my literature review. The original key themes have been strengthened plus additional information is starting to show more relevance which is interesting.

Since the course has finished I have devoted all of my time to working on this which has been great as I feel I am really getting into it. I've completed my literature review now and I've negotiated a new schedule with my supervisors regarding the reviewing of my work which we are all happy with. I'm going to Ireland to see my family so I'm getting a first re-draft of the whole MRP to my supervisors just before I leave, to

allow them at least two weeks to review it all, as suggested by the research staff at Salomons. I'm happy with this time scale because I know my supervisors are both very busy and it will give me time to enjoy time away after working so hard on this over the past two months.

I received some feedback a lot faster than expected so I've decided to cancel some holiday plans to continue my work. I feel like I need to keep on top of this as I want to make sure I make the 5th December deadline.

I've now received feedback from both my supervisors and I'm feeling OK at this point. Some good feedback regarding the changes I've made so far, but there are other areas that I need to focus on now before the second re-draft.

November 2014: Since receiving the first re-draft feedback I've been working through my supervisors' comments and trying to implement changes where I can. I'm starting to find it tricky finding a balance between sufficiently addressing the examiners' comments and considering and implementing other, equally valid and valued feedback from my supervisors. It is proving tougher than expected though as I need to be confident myself what I want to address and focus on because if I'm not the work will not be a clear as it could be. I'm still able to work on this full-time though which is great because it means I can give it the time and dedication it needs, as I want to make sure above all else that I'm happy with the final product- something to be proud of after all this hard work!

I've submitted a second re-draft to supervisors now. Also trying to negotiate a job after attending several interviews but it's proving difficult without HCPC registration. I'm staying motivated though and keeping going with it all.

I didn't have to wait long at all again for the first part of feedback which is great. Some mixed feedback regarding aspects I have implemented well and others where there could be potential for further development. Again, I'm feeling that pressure to find a balance between meeting the requirements set by the examiners and incorporating the equally valuable feedback from my supervisors.

I've spoken to my internal supervisor and my manager at Salomons on the phone and I'm feeling a lot more comfortable and confident in the work I have produced so far. Feedback regarding my Section B has also come back and is largely positive, with a few areas that still need to be tightened up. However, I'm feeling confident that I will make the 5th December deadline but I'm going to be working continuously on this until I am happy with the final product.

Appendix 12
Salomons Ethical Review Panel Approval

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Appendix 13
NHS Trust R&D Approvals

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Appendix 14
Participant Demographic Information Form

<u>Participant Demographic Information Form</u>

Canterbury
Christ Church
University

Participant ID: _____

Do you consent to the following demographic information being collected?   YES / NO

Date information collected: _____

<u>Psychologist</u>

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:

Which therapeutic model / approach was adopted during the therapy with your relevant 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.

<u>Client</u>

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: _____

Duration of psychosis:

How many years have you experienced symptoms of psychosis? _____ years.

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

Guidance provided by the Office for National Statistics (ONS) was followed when considering the categories for 'Ethnicity' and the use of five-year age bands for 'Age'.

ONS (2014). Ethnic group. Retrieved from http://www.ons.gov.uk/ons/guide-method/measuring-equality/equality/ethnic-nat-identity-religion/ethnic-group/index.html#1

ONS (2012). 2011 Census: Population estimates for the United Kingdom, 27 March 2011. Retrieved from http://www.ons.gov.uk/ons/dcp171778_292378.pdf

Appendix 15
Minor Amendment Approval

The following provides information regarding the approved minor amendment to collect participant demographic information. In addition, emails provide evidence regarding the submission, acknowledgement and approval of the amendment from the National Research Ethics Service (NRES) and the relevant R&D departments:

1) Minor Amendment Form:

This has been removed from the electronic copy.

2) NRES Approval:

This has been removed from the electronic copy.

3) R&D Department 1 Approval:

This has been removed from the electronic copy.

4) R&D Department 2 Approval:

This has been removed from the electronic copy.

Appendix 16
Service User Consent Form

CONSENT FORM

Title of Project: Exploring how people experiencing psychosis make use of understandings
and strategies developed during the joint activity of therapy
Name of Researcher: **Robert Medcalf**

Please initial box

1. I confirm that I have read and understand the participant information sheet dated 08/07/2013
(version 2) 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 to my information being kept anonymously while the research is being conducted.

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

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

Name of Participant_____   Date_____

        Signature _____

Name of Person taking consent _____   Date_____

        Signature _____

Appendix 17
Psychologist Consent Form

CONSENT FORM

Title of Project: Exploring how people experiencing psychosis make use of understandings and strategies developed during the joint activity of therapy
Name of Researcher: **Robert Medcalf**

Please initial box

1. I confirm that I have read and understand the participant information sheet dated 08/07/2013 (version 2) 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 my information being kept anonymously while the research is being conducted.

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

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

Name of Participant_____   Date_____

        Signature _____

Name of Person taking consent _____   Date_____

        Signature _____

Psychologist

Appendix 18
Research Summary Sent to Participants, Ethics Board and R&D

Exploring Processes in Therapy for Psychosis

Thank you for taking the time to be interviewed as part of this study, I really appreciate your support. I am in the process of writing up and will be submitting the study in partial fulfilment of the Canterbury Christ Church University Doctorate in Clinical Psychology. This document is a summary of the study and its findings, which, as promised, I wanted to share with you for your information, so you can see how your interviews and the data it generated has been used to further inform research on therapy for psychosis. If you have any comments or would like to get in touch, please contact me at r.d.medcalf14@canterbury.ac.uk or feel free to call me on +44 (0)7930 810156.

Aim
This study aimed to explore how people experiencing psychosis made use of understandings and strategies developed during the joint activity of therapy.

Methods
Semi-structured interviews were conducted with 11 participants (six psychologist-client pairs) towards the end, or recently after finishing, therapy for psychosis. Transcribed interviews were analysed using grounded theory (GT).

Results
The model constructed presents interactions between three core categories; 'Enabling Personal Empowerment', 'Navigating a Collaborative Journey' and 'Building Belief to generate Trust'.

Core categories with comprising subcategories

Core Category	Subcategory
1. Enabling Personal Empowerment	Establishing a "deeper understanding"
	Increasing sense of empowerment
	Creating a new perspective
	"Make friends with the hole"
2. Navigating a Collaborative Journey	"Working it out together"
	Managing the evolving relationship
3. Building Belief to Generate Trust	Committing to therapy
	Having a space to talk
	Holding the psychologist in high regard

The diagram below shows how these categories interacted with each other.

Theoretical model of client and psychologist experiences within therapy for psychosis
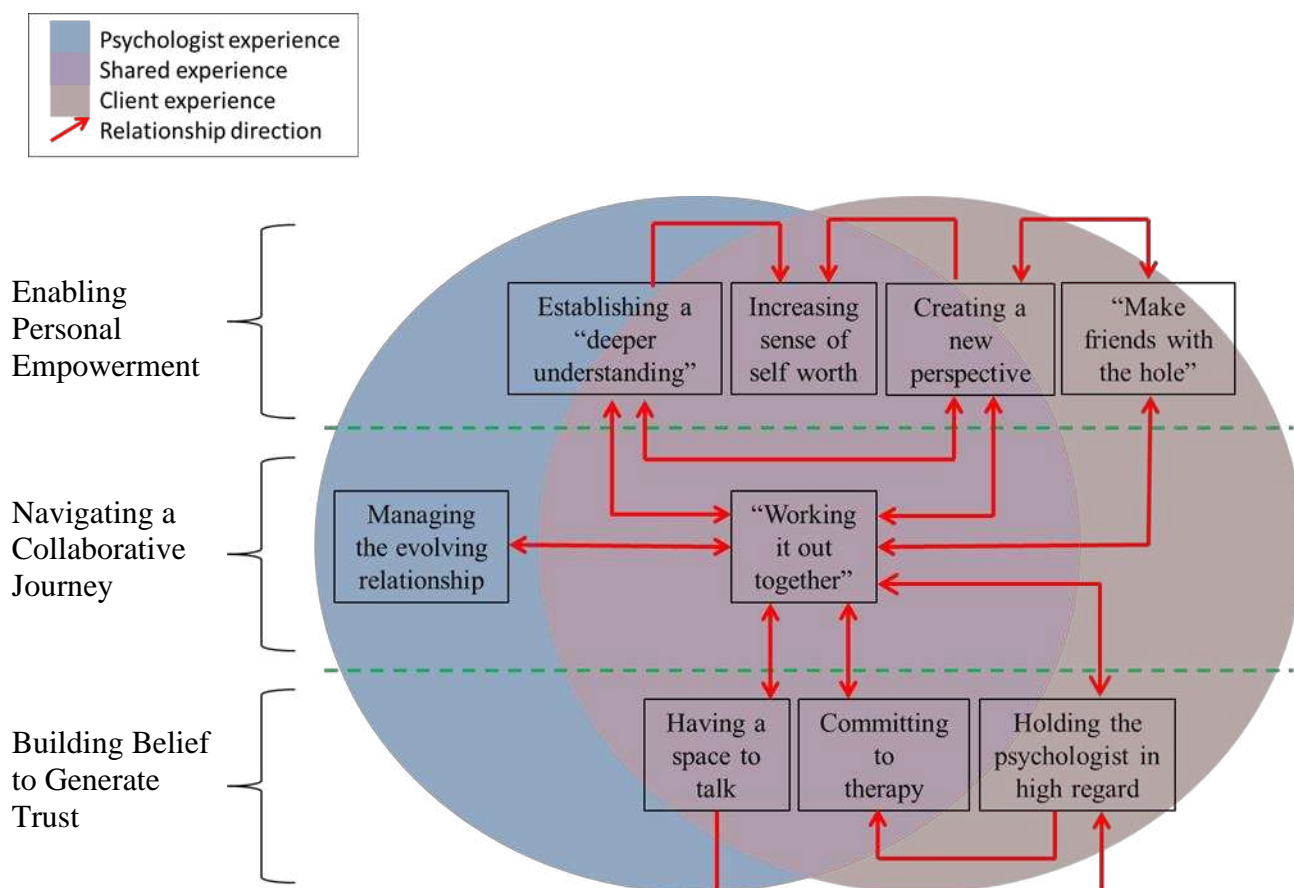
Through the interviews, processes were identified that indicated that clients developed a better understanding of themselves through therapy, including having a better idea of their thinking and the direction in which they wanted to take their psychosis therapy. This direction was developed in a joint collaborative way with the psychologist, with this relationship seemingly inspiring clients to continue to self-reflect and continue with this understanding outside of and or after their therapy had ended.

From these findings a theoretical model could be identified, which attempts to capture the core therapeutic processes in therapy for psychosis as identified by, and grounded in, participants' experiences and understandings of therapy, which ultimately led to the emergence and use of the 'most appropriate' therapeutic strategies for the client.

It transpired that there was a considerable amount of overlap between the psychologist and client accounts (shared experience), both within the psychologist-client pairs, and across the two separate groups. This suggests therapy processes are viewed in a very similar manner by psychologists and clients.

From the interviews it was clear that clients did not feel they had opportunities to talk about their difficulties before therapy initiation, with clients' reflections in therapy enabling them a sense of realisation that their previous way of life had been increasingly isolating them from social interaction. Highlighting the importance of having a space to talk about experiences and difficulties and listening to what people experiencing psychosis say about their difficulties. Through the process of listening, this study also suggested that the process of the psychologist offering different perspectives and ways of understanding for the client to test out, was important in allowing the client to let go of their 'old self' and focusing on developing their 'new self'.

Through this process of talking and listening, participants felt a sense of "working it out together", building a trusting relationship between both parties and enabling the client to establish a perspective they felt appropriate for them, which in turn appeared to increase their sense of self-worth. It appeared that in "working it out together" and generating new perspectives, from an unhelpful to a helpful perspective, it could be adapted to their view of their own lives, which allowed clients to generate a "deeper understanding" of their experiences.

The facilitation of the clients' sense of empowerment throughout therapy also appeared to be an important process within this study's findings. This brought with it an increased sense of understanding and control for clients over managing their difficulties and confidence about their ability to cope with difficulties in the future.
It was clear from the data that clients hold their psychologist in high regard, so much so that it warranted a core category of its own; however the psychologist often noted the importance of the psychologist in being in charge of managing the client-psychologist relationship, so a balance between creating a warm and accepting environment and relationship, whilst remaining professional.

This study has seemingly further supported existing research in the identification of specific client, psychologist and shared processes experienced during therapy to enable greater client understanding of therapy itself and the therapeutic strategies it entails. It has been identified that this could imply how people make use of understandings in therapy and what happens in therapy are closely linked phenomena, which have led this study to a possible defined GT model in therapy for psychosis.

Distinguished client, psychologist and shared processes of therapy for psychosis are proposed, which interrelate through dynamic, multi-directional interactions across subcategories. Interlinking shared processes seemingly allowed the client to develop a greater understanding for, trust in and implementation of, the therapeutic strategies that worked best for them.

What emerged appeared to reflect processes whereby helping clients to understand their problems as partly one of belief and interpretation can foster trust in the psychologist and resultantly enable both parties to feel comfortable to work together to make sense of client fears and experiences; enabling the creation of a new perspective and increased client empowerment.

The presence of influencing or interacting effects with other subcategories seemed to demonstrate that there may also be a multi-directional relationship across the three

core categories, leading to a theoretical model that may help to further inform the research and practice of therapy for psychosis. The proposed model could add new insight into how processes in therapy for psychosis could interrelate, through dynamic, multi-directional interactions between subcategories and subsequently core categories.

Thank you once again for your involvement in this project and please don't hesitate to contact me with any questions, comments or concerns

Kind regards,

Robert Medcalf
Trainee Clinical Psychologist
Salomons - Canterbury Christ Church University

Appendix 19
Coding Table

Core category	Subcategory	Focused code	Supporting Quote
Enabling Personal Empowerment	Establishing a "deeper understanding"	Creating a "deeper understanding"	…she's really got my thoughts and my feelings and taken them, we sort of dissected everything, because that's what you need to do...you can make sense of your problems a bit more, because it's like you have a deeper understanding… (Carly-[C], L211-218)
		Learning about yourself	...the difficult experiences are breaking my cycles of depression, so the depression brings me low, yes, but the side effects are that I think negatively so I don't think I can, I don't know, prepare a meal for myself, I don't think it's worth getting up and out of bed, erm, I just don't feel life is worth it, and that is particularly difficult with me… (Ted-[C], L182-186)
		Linking difficulties to past experiences	If I hadn't have come here I wouldn't have found that out, I would have been always stuck in my dreams and hearing the voices because it turned out that a lot of my bad dreams and voices were related to things that had actually happened to me in my life before which I had blocked out. (Andy-[C], L70-73)
		Making explicit links between client's difficulties and life experiences	…and I don't think she'd probably thought about the links between her early experiences and her beliefs about herself and the world. She knew she'd had horrible early experiences, she knew some of her treatment had been bad, she knew she didn't deserve to feel as bad about herself as she did, but I don't think she'd made those links explicitly. (Gemma-[P], L150-154)
		"Getting to grips" with client's situation	...I would say those first three or four sessions were very much me, kind of, getting to grips with what was going on for her, and it turned out it wasn't really what I thought it was going to be... (Gemma-[P], L32-34)

Core category	Subcategory	Focused code	Supporting Quote
Enabling Personal Empowerment (continued)	Establishing a "deeper understanding" (continued)	"Pulled the threads together"	I think we pulled the threads together a little bit with these different experiences, there were three main events which he talked a lot about, and we talked about what was similar about them, and in each of them they involved other people making decisions that he felt he had no control over, and we started to wonder what might be going on there really… (Adam-[P], L127-131)
		Facilitating opportunities to improve understanding	Umm, so I guess I was more trying to get him to think about and talk about how his problems had first started umm, and yeah more sort of thinking about what were the early warning signs, what were the things he noticed first, or other people noticed first, yeah what might have, sort of, what we know from his perspective that might have triggered his psychosis, umm, which he was able to do to some extent at that point I think. (Jane-[P], L63-68)
		Opening doors	All these doors that I thought were closed, were then opened one by one since we were talking together. (Selena-[C], L85-87)
	Increasing sense of worth	Realising solutions for herself	...she didn't just say to me "you've got to do this, you've got to do that", she helped me realise myself, and helped me come up with ideas myself, things I could do to help myself relax indoors, relax, erm, more so that I would be stronger and more able to cut down on the number of rituals I was doing… (Eve-[C], L216-219)
		Psychologist as a motivating guide	…so she helped me...explore these areas more, she gave me CDs and literature and I would go home and do exercises she had devised, or together we'd sort of devised... (Eve-[C], L214-216)
		Learning from the psychologist	But one of the other things [psychologist] also taught me about was mindfulness… (Carly-[C], L136-137)
		Building up confidence	...with [psychologist], one to one, gave me a chance to build my confidence in those things without feeling overwhelmed, so then I could build myself up to speaking with other people. I was so insular, I was so scared and fearful of others and inside myself, you know, but I'm not like that anymore... (Arianna-[C], L544-547)

Core category	Subcategory	Focused code	Supporting Quote
Enabling Personal Empowerment (continued)	Increasing sense of worth (continued)	Bolstering the client's sense of worth	...if something good happens he normally doesn't think it's down to him or give himself the credit he deserves, and so, just trying to challenge that thinking about what qualities he's brought to, and the positive things he's brought that make changes in his life, because otherwise he wouldn't be able to see that, so yeah reflecting and noticing with him, me commenting at times being very explicit about saying that I can see certain positive qualities in him being played out in certain situations, so reinforcing his positive thinking I guess, bolstering his sense of worth which was his major difficulty, and challenging him to be able to do more for himself. (Adam-[P], L 568-575)
		Increasing client's control	So one of the beliefs that we actually built and tried to work with at the end was "I have quite a lot of control over my life", because she felt like "I have no control", one of her negative core beliefs that she carried around was "I've got no control". (Gemma-[P], 762-765)
		Being the "captain of the ship"	...her relationship to those difficulties is fundamentally altered so that she now will think well this is an internal experience umm, or it could be something else, but either way I'm in control. I think the metaphor she uses is 'I'm the captain of the ship' (Michael-[P], L28-30)
		Shifting the hope	...maybe holding the hope a bit in a stronger way, whereas I think she holds hope herself now. But being very explicit that if you do this, umm, there is a very high likelihood its going to improve things… (Michael-[P], L278-280)
	Creating a new perspective	Re-framing experiences	...the main thing we formulated together was the reframing of past events and the impact of those on how she's feeling now, why she might be feeling that way about herself in relation to self-blame and trying to think a different way about some of those feelings and how they are affecting her (Jo-[P], L 46-50)
		Adopting a new perspective on life	...so she helped me realise that I had to learn how to be with people again, and I had to get out there, I had to socialise with people and build a social network, erm, you know, sort of, learn how to take those first steps again to building a life… (Eve-[C], L 478-480)
		Reconstructing your life	So with this, it is a lot slower than I thought I would do it but I am slowly reconstructing my life again, so, erm, I've got it in my head that I can work again, erm, I've got it in my head that I can actually master my own life, get a grip on my life, even if things take a very bad turn for the worse I can cope with it, before I would have given up. (Ted-[C], L 147-150)

Core category	Subcategory	Focused code	Supporting Quote
Enabling Personal Empowerment (continued)	Creating a new perspective (continued)	Testing out different perspectives	We started off thinking about how the way [client] was thinking about her problems was one way of thinking about things, rather than necessarily the way things are that everybody would universally accept. We considered that there might be different perspectives, I suppose by a mixture of what I would always do, of asking them and then floating possibilities, so saying something like 'some people might think...', 'I wonder if...', 'could it be that...', and seeing which perspectives were acceptable and which weren't. (Jo-[P], L 159-164)
		Shifting client's perspective	...for him the biggest issues were rumination and worry, as it is for a lot of people, and I think over the therapy he's been able to recognise how, when he is trying to problem solve or getting lost in his mental experience...he feels overwhelmed and feels a complete lack of agency, whereas when he does focus on one thing he's able to get a different perspective, he realises he can do some things, even if the bigger picture still feels quite bleak at times he has some control within that, so it helps him to move from an over generalised position of everything is hopeless to a more positive position of there are some things I can do and some steps I can take, so the testing things out was a way of proving that to himself, giving him proof that there were things he could do and they would feel helpful for him. (Adam-[P], L 396-405)
	"Make friends with the hole"	"Make friends with the hole"	…yeah, make friends with the hole. So that's exactly what I did with my anxiety, my paranoia, a lot of the things, I don't fear them because obviously I've sort of made friends with them… (Carly-[C], L 244-246)
		Acknowledging a need to change	Yeah, it was like, my life, I'd been living it back to front. I'd been doing so many rituals and it got, just before, well, when I actually started therapy, I was so ill, I was almost prepared to admit myself to hospital or a women's service because I felt like I was losing my mind, I was that ill and I'd never been like that for twenty odd years and so I, I'd been cutting myself off more and more from people thinking that was the way to get better, but therapy taught me that that was the wrong way, and that was the way to get worse. I had to do it the other way round. (Eve-[C], L 107-113)

Core category	Subcategory	Focused code	Supporting Quote
Enabling Personal Empowerment (continued)	"Make friends *with the hole"* (continued)	Identifying the need to improve	OK, erm, basically before the therapy, erm, I'd just got into a cycle. I think it's partly to do with being unemployed and partly because I allowed myself to be isolated, so basically I was at home just folding in on myself...but you've got to break these cycles because they themselves can make you ill... (Ted-[C], L 119-125)
		"Confront your fears"	Confront your fears, that's what therapy is all about, and that's what [psychologist] taught me, you confront your fears head on, you look at them in every single way you think, and every single way you can document them or acknowledge them, and then you can put your thoughts and feelings and your level of understanding in to some kind of perspective of what it is that is actually going on with you (Selena-[C], L 580-585)
Navigating a Collaborative Journey	"Working it out together"	"Working it out together"	…I think I started and then she took it over. So I had in my head four or five things I thought I'd gathered from the few sessions that I'd heard from her, so I was, kind of, priming her and saying, well one thing you've talked about is this, do you think this is something that needs to go down there, but we were working it out together…(Gemma-[P], L370-374)
		Acknowledging a shared journey	…in some respects being quite long-suffering, that sounds a bit negative but, erm, I think we've endured a lot together, you know, it's been a long journey… (Adam-[P], L 430-432)
		Being led by client	…I was able to say, right which of these are still bothering you, which one's do we want to work on, and we identified about half of them, and then I'd say we spent a session or two on each one, but more just exploring it, offering a few little tips here and there, and then moving on to the next one, that was kind of enough, that was all she said she needed each time, so instead of labouring each one we'd move on when she felt ready. (Gemma-[P], L 194-199)
		Working together	...I couldn't see my way through it, but with this therapy with [psychologist], we've gone on, like, a zig-zag path, sorting everything out slowly...it was all a mess, but working with [psychologist] helped me to slowly unravel it all. (Arianna-[C], L 118-123)
		"Coming alongside" the client	...there was a, kind of, an interested, validating, empathic curiosity, a sort of coming alongside her and normalising, trying to reframe together… (Jo-[P], L 279-280)

Core category	Subcategory	Focused code	Supporting Quote
Navigating a Collaborative Journey (continued)	Managing the evolving relationship	Reacting to client change	...that also lead to a change in her where she was connecting more to her family once again, and I guess connecting to people who were important to her. I think as that's going on in terms of trying to make sense of these experiences, she's connected to family members and friends that she hasn't connected to for quite some time, so the isolation reduced as well and I tried to demonstrate that to her and enable her to see that improvement for herself. (Michael-[P], L 89-93)
		Thinking about how to relate to client	I make the judgement about how familiar and open and warm to be based on a million factors, one of them is how long I think I might see somebody for I suppose, erm, but also there's something about her and her interactions and the way she was making use of the space and being quite talkative and moving between different topics... (Gemma-[P], L 508-514)
		Finding a balance when managing relationship	…well for me it was difficult judging when to balance the whole validating and hearing her experiences versus the whole I've heard this before I'm not learning anything new if we want to move on we need to try something different, and you're always balancing that as a therapist… (Gemma-[P], L 396-399)
		Highlighting the importance of monitoring the relationship	I think our relationship has changed a lot over time and, erm, it's sort of seen lots of different phases really...but we would use the sessions to review where we felt we were at and to constantly re-calculate, re-organise the, erm, what was needed for him to make the next step (Adam-[P], L 325-332)
		Reacting to external events	I think during the course of therapy, events overtook our initial plans, because she had some very significant life events and our goals changed around those. (Jo-[P], L 135-136)
Building Belief to Generate Trust	Committing to therapy	Committing to therapy 100%	...I said to my therapist early on I want to give it 100% and I'm in this, you know, to do my very best and I would like to have a life... (Eve-[C], L 659-661)
		Persevering through tough times	The only problem is that I thought at first it was going to be easy but it, erm, I find it pretty difficult myself, erm, erm, yes I find it very difficult, erm, I think other parts of my problems keep invading what I'm being told by the psychologist, especially when I'm more depressed, but I kept going... (Ted-[C], L 11-14)

Core category	Subcategory	Focused code	Supporting Quote
Building Belief to Generate Trust (continued)	Committing to therapy (continued)	Making the effort with therapy	I would have just given up before but now I want to give it a go, at least just to try it and see what happens, [psychologist] helped me to think that way and to do that more. (Andy-[C], L 269-271)
		Committing to enacting change	…I thought that there was something we could do about it, and it wasn't that I was just going to sit here and hear about this, that I thought this was something we could work on together, and I, I'd seen it work before and I thought it was possible. (Gemma-[P], L 268-271)
		Valuing client's commitment	She just really absorbed things, really took it on board and went with it…she was very up for the process, she was very motivated and engaged and always came... (Gemma-[P], L 211-218)
	Having a space to talk	Wanting a space to talk	...I just wanted to talk because I hadn't really done that before. I'd spoken to, when I saw [other psychologist], I did talk to her but that was about my life up to then sort of thing and I didn't tell her all of it, I don't know, it was just different with her. (Carly-[C], L 420-423)
		Providing a safe and containing space to talk	I think there's something for her about having a space to talk about her difficulties because generally she tends to help others rather than ask for help, erm, she's not so good at requesting help when she needs it, and certainly not talking help, erm, so my sense was that the first half at least of our work really, if not most of it, was about her having a safe space to kind of talk through things in a fairly, erm, not structured but, I don't know, containing way, and I actually think that, well later on it turned out that she felt she gained quite a lot of understanding into her difficulties, just by having that talking space… (Gemma-[P], L 58-66)
		Allowing clients time to tell their story	But also at the beginning we spent time thinking about her problems, because this wasn't something she'd done before, erm, so just having time for her to tell her story, to try to put it in some kind of order… (Jo-[P], L 21-23)
		Seeing the benefits of talking	...he doesn't really spend much time with anyone else, so in a way I think that it was good for him to have that opportunity to just have some conversations with someone else, but then again it's still within this mental health therapy setting so we spoke about how it might be helpful if he was doing that outside of here as well. (Jane-[P], L 512-515)

Core category	Subcategory	Focused code	Supporting Quote
Building Belief to Generate Trust (continued)	Holding the psychologist in high regard	Appreciating the psychologist	...so [psychologist] has just been there, she's been a godsend really, because she's just been there through all these things...and if I hadn't had [psychologist] I don't know how I would have coped, I thank god because I think she was a godsend... (Arianna-[C], L 190-192)
		Seeing psychologist as special	A lot of the time when you go for help somewhere you see one doctor, you have one session or two sessions, then the next time you go you have to see another doctor, and then another person, and every time you see someone new you lose a part of your life with that person. I gave them my trust in talking about my problems now I have to do the same all over again with someone new. But with [psychologist] it was always him I saw. He gave me the time to talk and to tell him in my own time, without having to worry about needing to see someone new. (Selena-[C], L 169-176)
		Admiring the psychologist	…but in regard to [psychologist] we hit it off straight away…he always seemed to have time for me, he didn't cancel any appointments, he was always positive, even when I thought I was negative he was always able to put a positive spin, turn it around... (Ted-[C], L 393-396)
		Being grateful to psychologist	The next week I said I just want to say thank you so much for walking with me, that was above and beyond the call of duty, I don't think anyone else would have done that for me, and I came in with some chocolates to give her them, and at Christmas, I went all the way from my house to [town] to hotel chocolat, bought some chocolates, and I said to her you have to accept them because I really want to give them to you because you've really helped me... (Carly-[C], L 517-512)

Appendix 20
Author Guidelines for Submission to the Journal of 'Psychology &
Psychotherapy: Theory, Research and Practice.'

Author Guidelines

Psychology and Psychotherapy: Theory Research and Practice (formerly The British Journal of Medical Psychology) is an international scientific journal with a focus on the psychological aspects of mental health difficulties and well-being; and psychological problems and their psychological treatments. We welcome submissions from mental health professionals and researchers from all relevant professional backgrounds. The Journal welcomes submissions of original high quality empirical research and rigorous theoretical papers of any theoretical provenance provided they have a bearing upon vulnerability to, adjustment to, assessment of, and recovery (assisted or otherwise) from psychological disorders. Submission of systematic reviews and other research reports which support evidence-based practice are also welcomed, as are relevant high quality analogue studies. The Journal thus aims to promote theoretical and research developments in the understanding of cognitive and emotional factors in psychological disorders, interpersonal attitudes, behaviour and relationships, and psychological therapies (including both process and outcome research) where mental health is concerned. Clinical or case studies will not normally be considered except where they illustrate particularly unusual forms of psychopathology or innovative forms of therapy and meet scientific criteria through appropriate use of single case experimental designs.

1. Circulation: The circulation of the Journal is worldwide. Papers are invited and encouraged from authors throughout the world.

2. Length: All articles submitted to PAPT must adhere to the stated word limit for the particular article type. The journal operates a policy of returning any papers that are over this word limit to the authors. The word limit does not include the abstract, reference list, figures and tables. Appendices however are included in the word limit. The Editors retain discretion to publish papers beyond this length in cases where the clear and concise expression of the scientific content requires greater length (e.g., a new theory or a new method). The authors should contact the Editors first in such a case.

Word limits for specific article types are as follows:

• Research articles: 5000 words
• Qualitative papers: 6000 words
• Review papers: 6000 words
• Special Issue papers: 5000 words

3. Brief reports: These should be limited to 1000 words and may include research studies and theoretical, critical or review comments whose essential contribution can be made briefly. A summary of not more than 50 words should be provided.

4. Submission and reviewing: All manuscripts must be submitted via http://www.editorialmanager.com/paptrap/. The Journal operates a policy of

anonymous peer review. Before submitting, please read the terms and conditions of submission and the declaration of competing interests.

5. Manuscript requirements: • Contributions must be typed in double spacing with wide margins. All sheets must be numbered.

• Manuscripts should be preceded by a title page which includes a full list of authors and their affiliations, as well as the corresponding author's contact details. A template can be downloaded here.

• Tables should be typed in double spacing, each on a separate page with a self-explanatory title. Tables should be comprehensible without reference to the text. They should be placed at the end of the manuscript with their approximate locations indicated in the text.

• Figures can be included at the end of the document or attached as separate files, carefully labelled in initial capital/lower case lettering with symbols in a form consistent with text use. Unnecessary background patterns, lines and shading should be avoided. Captions should be listed on a separate sheet. The resolution of digital images must be at least 300 dpi.

• For articles containing original scientific research, a structured abstract of up to 250 words should be included with the headings: Objectives, Design, Methods, Results, Conclusions. Review articles should use these headings: Purpose, Methods, Results, Conclusions.

• All Articles must include Practitioner Points – these are 2-4 bullet points, in addition to the abstract, with the heading 'Practitioner Points'. These should briefly and clearly outline the relevance of your research to professional practice.

• For reference citations, please use APA style. Particular care should be taken to ensure that references are accurate and complete. Give all journal titles in full and provide DOI numbers where possible for journal articles.

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