University of Strathclyde

School of Psychological Sciences and Health

Person-centred therapy and pre-therapy for people who hear voices, have unusual experiences or psychotic processes: Practitioner and client perceptions of helpful and unhelpful practice and perceived client changes

Wendy Traynor

Volume 2: Appendices

A thesis submitted in fulfilment of the requirements for the degree of Doctor of Philosophy

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Signed: W. Traynor **Date: June 2019**

Appendices

A: Ethical approval Formal Documents………..……………………………….5

A.1: Ethical approval application Study 1……………………………………….6

A.2: Ethical approval Document Study 1……………………………………….10

A.3: Ethical approval application Studies 2 and 3……………………………….16

A.4: Conditional ethical approval Studies 2 and 3……………………………..29

A.5: Correspondence re S1 and S2 approval………………………………….…...32

A.6: University Sponsorship Form………………………………………….…...34

A.7: University chief investigator form………………………………………….35

A.8: NHS Sponsorship Correspondence…………………………………….…..36

A.9: Consent forms, information sheets and original process flow charts re Study 2 and Study 3…………………………………………………………………………..39

A.10 Minor amendment request letter ……………………………………………42

A.11: University form re minor amendment…………………………………...46

A.12: Correspondence re amendment re additional level………………………53

A.13: Acknowledgment of progress report……………………………………..55

B: Measures…………………………………………………………………...56

B.1: Therapeutic Relationship Scale (client form)……………………………..57

B.2: Therapeutic Relationship Scale (therapist form)…………………………58

B.3: Helpful Aspects of Therapy (HAT)………………………………………..61

B.4: Change interview protocol v5.5…………………………………………63

B.5: Positive And Negative Syndrome Scale (PANSS) scoring sheet……………65

B.6: Therapist Process Notes (study 3)……………………………………….....66

C: Study 2 Data Categories……………………………………………………...67

C.1: Study 2 Full Data categories………………………………………………68

C.2: Study 2 Categories and no of participant's responding…………………….78

C.3: Study 2 Rated Changes…………………………………………………….83

D: Study 3 HSCED documents………………………………………………….91

D.1: Rich Case Record……………………………………………………………..92

D.2: Affirmative brief……………………………………………………………..109

D.3: Sceptic brief…………………………………………………………………117

D.4: Affirmative rebuttal of Sceptic Case………………………………………..123

D.5: Sceptic rebuttal………………………………………………………………133

D.6: Affirmative and sceptic summary narrative………………………………136

D.7: HSCED Instructions for judges pro form…………………………………..137

D.8: Completed Combined Judges proforma ………………………………….…...142

A. Ethical approval Formal Documents

A.1 Ethical approval application Study 1

UNIVERSITY OF STRATHCLYDE

APPLICATION FORM FOR UNIVERSITY ETHICS COMMITTEE

This form applies to research with human participants undertaken by staff or students of the University of Strathclyde which falls within the remit of the University Ethics Committee (see Code of Practice, para 5.1). Other research can be dealt with by Departmental Ethics Committees (see Code of Practice, para 5.2).

However, this form should NOT be used for any research involving clinical trials (see Code of Practice, para 2(vii)) or medicinal products, nor for research involving staff, patients, facilities, data, tissue, blood or organ samples from the National Health Service. Applications for ethical approval for research involving the National Health Service in any way must be made under the governance arrangements for National Health Service Research Ethics Committees (see Code of Practice, para 3.2(d)) using the form issued by COREC (see Code of Practice, para 6.1).

The application will be judged entirely on the information provided in this form and full grant proposals to funding bodies should not be attached.

1. Strathclyde Investigator(s)

Name(s): WENDY TRAYNOR
Status (e.g. staff, post/undergraduate): POST GRADUATE
Department(s): EDUCATIONAL AND PROFESSIONAL STUDIES
If student(s), name of supervisor: MICK COOPER
Contact details: Telephone:
E-mail:

Please provide details for all researchers involved in the study

2. Non-Strathclyde collaborating investigator(s)

Name(s): ……………………………………
Status: ……………………………………
Department/Institution: ……………………………………
If student(s), name of supervisor: ……………………………………
Contact details: Telephone: ……………………………………
E-mail: ……………………………………

Please provide details for all researchers involved in the study

3. Title of the research:
FIRST STAGE OF PhD IN EARLY PSYCHOTIC PROCESS AND PERSON-CENTRED COUN
INITIAL QUALITATIVE INQUIRY IN LINE WITH MEDICAL RESEARCH COUNCIL GUID
ON COMPLEX INTERVENTIONS, INTERVIEWING PRACTITIONERS.

4. Where will the research be conducted? (Note that the Committee reserves the right to visit testing sites and facilities)
BY TELEPHONE

5. Duration of the research (years/months):
(Expected) start date: MAY 2005 - MAY 2006

(Expected) completion date: ....

6. **Funding body (if applicable):**
N/A

Sponsor (if applicable):
N/A

Status of proposal (Please tick as appropriate):
i) **in preparation** ....
ii) **submitted** ....
iii) **proposal accepted by funding body** ......

Date of submission of proposal ....

Date of commencement of funding ....

7. **Research objectives:**

Brief outline of the background, purpose and possible benefits of the research.
- TO EVALUATE THE EFFECTIVENESS OF PERSON-CENTRED THERAPY, (INCORPORATING PRE-THERAPY) IN EARLY "PSYCHOTIC PROCESS"
- TO CARRY OUT INITIAL QUALITATIVE ENQUIRY IN LINE WITH MRC COMPLEX INTERVENTIONS GUIDELINES THE TREATMENT IS "ADDITIONAL TREATMENT"
- NO COMPLETED RCTS ARE KNOWN TO EXIST IN THIS SPECIFIC AREA SO THE RESEARCH IS URGENTLY NEEDED.
- THE INITIAL "PRACTITIONER INTERVIEWS" WILL ESTABLISH TRENDS. QUESTIONS AND DIRECTION. THEY WILL EXAMINE METHODS AND OUTCOME IN PERSON-CENTRED THERAPY IN THIS SPECIFIC AREA. ISSUES RAISED WILL HELP TO INFORM DETAILS OF LATER QUANTITATIVE STUDIES. AND GIVE A DEEPER UNDERSTANDING OF THE AREA OF ENQUIRY.

8. **Nature of the participants:**

Number: 20-50
Age (range): ADULTS, OVER 18.
Gender of volunteers: M + F
Recruitment method(s): ADVERTISING + NETWORKING

Inclusion/exclusion criteria (if appropriate) ALL THEORETICAL MODELS OTHER THAN PERSON-CENTRED PRACTITIONERS, EXCLUDE DRUG/ALCOHOL INDUCED PSYCHOSIS
Screening procedure (if appropriate)

Any special skills, attributes, medical conditions?: N/A

Any vulnerable participants (see Code of Practice, annex 3)?: NO

Justifications for sample size (e.g. power calculations)?: 20-50 TO ALLOW FOR VARIATIONS IN PRACTISE.

9. What consents will be sought and how?

(Consent forms and participator information sheets should be appended to this application or forwarded to the secretary of the University Ethics Committee when they are prepared and before the research begins.)

SEE ATTACHED

10. Methodology

Design: -- what kind of design is to be used in the research (e.g. interview, experimental, observation, randomised control trial, etc..)?:
INITIAL INTERVIEWS WILL BE CARRIED OUT TO GATHER EVIDENCE AND INFORM LATER QUANTITATIVE ENQUIRY.

Techniques: -- what methods will be employed and what exactly is required of participants?
TELEPHONE INTERVIEWS WITH QUESTIONS/PROMPTS.
A FOCUSED DISCUSSION ON THE INTERVIEWEES EXPERIENCES OF PCT AND EARLY PSYCHOTIC PROCESS, ISSUES, MEASURES, EFFECTIVENESS, METHODS, OUTCOME.

Reference should be made to any of the following to be used in the research:

Invasive techniques
Use of drugs, foods, liquids
Any deception
Physical exertion
Manipulation of stress/anxiety
Intimate and/or confidential information being sought (see Code of Practice, para 5.1).
Acquisition of bodily fluids or tissue
Access to confidential data (e.g. medical reports)

N/A

The duration of the study for participants and frequency of testing (if repeat testing is necessary)

11. Potential risks or hazards:

Full details should be given of any potential risks or discomfort for participants, any burdens imposed and any preparatory requirements (e.g. special diet, exercise), as well as any steps/procedures taken to minimize these risks and/or discomforts.

N/A

12. Any payment to be made: NO

Include reference to reimbursements for time or expenses incurred, plus any additional fee/incentive for participation.

13. What **debriefing**, if any, will be given to volunteers?
NO STANDARD DEBRIEFING BUT DEBRIEFING AVAILABLE IF NEEDED I AM ABLE TO OFFER SUPPORT / FOLLOW UP IF REQUIRED.

14. What are the **expected outcomes** of the research? How will these be disseminated? Will you seek to publish the results?
TO ESTABLISH TRENDS, METHODS AND QUESTIONS FOR FURTHER ENQUIRY. PUBLICATION OPPORTUNITIES TO BE EXPLORED.

15. Nominated person (and contact details) to whom participants' concerns/questions should be directed before, during or after the research.
WENDY TRAYNOR

16. Previous experience of the researcher(s) with the procedures involved (if appropriate).
I HAVE PREVIOUSLY CONDUCTED UNSTRUCTURED INTERVIEWS IN A MENTAL HEALTH SETTING, AS PART OF AN M.A STUDY.

17. **Generic approval**: if approval is sought for several separate pieces of research, all employing the same basic methodology and serving the same overall objective, then generic approval can be sought for a 2-year period. Give, on a separate sheet, further details about additional studies to be covered by this approval application, using the relevant headings (1-14 above), and drawing attention to any variations in methodology, participants, risks, etc.

18. **Declaration**
I have read the University's Code of Practice on Investigations on Human Beings and have completed this application accordingly.

* *

Notes

1. If there is any variation to any aspect of the research (location, investigators, methodology, risks, etc.) then the Secretary to the University Ethics Committee should be notified in writing immediately.
2. Should anything occur during the project which may prompt ethical questions for any similar projects the lead investigator should notify the University Ethics Committee.
3. Insurance and other approval requirements from appropriate external bodies must also be in place **before** the project can commence.

* *

This completed form should be sent (electronically or hard copy) to the Secretary of the University Ethics Committee: Mrs Gwen McArthur, Secretariat, McCance Building: email: g.mcarthur@mis.strath.ac.uk

A.2 Ethical approval Documents Study 1

FACULTY OF EDUCATION
Jordanhill Campus

Notice of Departmental Ethics Committee Decision

Date:	**29th June 2005**
Applicant:	**Wendy Traynor**
Project Title:	**First stage of PhD in Early Psychotic Process and Person-centred counselling, initial qualitative inquiry with medical Research Council guidelines on complex interventions, interviewing practitioners.**

Approval Of Investigation

The Departmental Ethics Committee confirm ethics approval for the above investigation strictly within the terms as advised on the application.

When your investigation is completed we would welcome a short note indicating completion and advising of any ethical matters that may have arisen but which were not anticipated within your application.

The committee wish you success in your investigation.

For the Departmental Ethics Committee

pp [signature]

David Wallace (Chair)

THE PLACE OF USEFUL LEARNING

ʼARTMENT OF EDUCATIONAL AND
ƆFESSIONAL STUDIES
Henry Wood Building
Southbrae Drive
sgow G13 1PP
0141 950 3365/3368

Mr Clive Rc
Head of Dep

Wendy.traynor@strath.ac.uk

Ms W Traynor

15.6.06

To Whom this may concern

Re application for ethical approval.

I enclose a revised application for your consideration. I would like to particularly draw your attention to the fact that this is simply an initial scoping enquiry involving interviewing adult professional practitioners in non-medical settings. I will have no contact with clients and will be discussing "treatment" which is already occurring or has already occurred as part of the practitioner's usual work.
The degree of risk to any individuals is therefore extremely minimal and I am able to offer full de-briefing to any adult practitioners in the unlikely event that this might be requested
Yours sincerely

WL Traynor

Appendix A

ADVERT (for the person-centred newsletter, notice boards and e mail groups.)

Are you a person- centred counsellor working with clients who experience "psychotic process"? (using person-centred therapy and/or pre-therapy). I am a PhD student at the University of Strathclyde seeking practitioners who are willing to be interviewed by phone or in person about their practice and experience in this area.

Please contact Wendy Traynor on-wendy.traynor@strath.ac.uk
Or tel [redacted]

Appendix B

Date

Study of person-centred counselling and psychotic process (psychosis).

Dear

You expressed initial interest in participating in my study of person-centred counselling and psychotic process. As part of my PhD study at Strathclyde University Counselling Unit, I am conducting initial interviews with practitioners who work in this area.

I am looking for person-centred practitioners who are using person-centred counselling and/or pre-therapy with clients who present with psychotic process and are willing to take part in an interview,(telephone or face to face if feasible)

All interviews are confidential and all information will be treated in strictest confidence in line with the data protection act. You will not be personally identifiable in any report produced as part of this study

Best wishes

WL Traynor

Appendix C

Re :Study of person-centred counselling and psychotic process (psychosis).

Dear

Thank you for agreeing to participate in this study.

The aim of the study is to develop a deeper understanding of person-centred counselling and pre-therapy with individuals presenting with "psychotic process"(Warner) also more widely called psychosis (medical model).

The research is the first stage of a longer term study using mixed methods of enquiry.

"Psychotic process" is described and explored by Warner, Prouty,Van Werde and others.

I am particularly interested in developing a deeper understanding of therapist experiences, areas considered of importance and discovering how individuals practice. I am also interested in the contexts of practice, perceived outcomes and evaluations of client change or progress and what appears to have triggered any positive changes.
You will not be asked set questions but prompted to fully explore the topic and may refrain from discussing any areas as you choose.

The interview at a pre-arranged date and time, will last around half an hour to an hour. It will be relatively informal through focused discussion and involve absolutely no deception or manipulation. You will be asked to describe your experiences of counselling clients in psychotic process.

Interviews will be documented or recorded and with your permission a copy will be sent to you for your verification and comments.

All information will be treated confidentially and interview notes will be kept separately from identities which will be coded. Identity details will be destroyed after 5 years. Any material used will be anonymised as much as possible.

Any queries may be directed to W Traynor-e mail, wendy.traynor@strath.ac.uk
Phone no:

Best wishes

Wendy Traynor

Appendix D

A study of Person centred-counselling and psychotic process

I agree to take part in this research which is to explore person-centred counselling and psychotic process.

I have read the details about the interview and am aware that I will be invited to answer interview questions and engage in discussion

I am aware that I am free to withdraw from the study at any time, for any reason and that I can request that any information I have given is destroyed.

I understand that the interview will be documented and a copy will be kept in a secure location without any of my personal details

I understand that all material will be kept in a secure location and will not include any of my personal details

I understand that the researcher will take every effort to ensure that any material used for publication will be made as anonymous as possible.

Name-please print

Signed

Date

A.3 Ethical approval application Studies 2 and 3

<u>Person-centred therapy for clients who experience psychotic process</u>

<u>Research Protocol (20.07.10) 5.0</u>

University of Strathclyde

Principal investigator; Wendy Traynor, PhD student

Supervisor; Professor Robert Elliott

C/o Robert Elliott, University of Strathclyde76 South Brae Drive, Glasgow,G13 1PP

Tel [redacted]

Wendy.Traynor@strath.ac.uk

Purpose and significance: The main purpose of this research is to evaluate and improve person-centred approaches to psychosis. There is a lack of research in this area.

Theory: Clients experiencing psychosis often experience difficulties in being with and relating to others. This can be exacerbated by stigma. Some clients find it difficult to hold psychological contact with others.

Theory of Change : Person centred approaches can counteract stigma and within the context of a multi-disciplinary approach provide an environment where the client can connect with the therapist and increase in sense of self and ability to relate to both the therapist and others. Pre-therapy and contact work which is a subset of the person-centred approach can sometimes enable out of contact clients to be more in contact and benefit from therapy.

The study will consist of an open clinical trial.45 clients will be recruited in order to aim for 15 to 20 completed clients (three or more sessions) and additionally several of these 15 to 20 clients will be involved in the embedded case study. These pragmatic case studies (interpretative case study research) would provide additional more detailed rich data. This mixed methodology is necessary to ensure sufficient overall results.

The project will commence with an initial trial site and phasing in additional sites as the study progresses. Up to three years of data collection and analysis will take place allowing for multiple sites and short term and long term therapy relationships. There needs to be the opportunity of collecting long term data where feasible as therapy may be more effective with subsets

of this client group over a longer period. Treatment lengths will vary according to client need and individual service policies.

Context: The Study will be based in the UK in NHS and non-NHS service settings including the private and voluntary sector. No lone working counsellors will be included in the study.

The research team will be actively involved in supporting practitioners and assisting in administering measures. Selected measures will be used prior to therapy, every week and post stages, as agreed. (see flow chart)
The study will focus on “existing treatment.” which may be part of a multi-disciplinary package of support for some clients. The person-centred therapy will be supplemented by other treatments such as group support or psychiatric care as appropriate but the person-centred therapy and its possible impact on clients would be the focus of this study.

Practitioners and participants would be supported at all stages as needed in addition to their management and clinical supervision provided by the service setting. De-briefings will be offered by the research team to participants as needed and referrals made as appropriate.

Process and User consultation: Clients and practitioner representatives in participating service centres were consulted throughout the process of research design. Service user groups and clients and practitioners have been fully consulted regarding ethics, language process and measures and their views applied where feasible.

Criteria for therapist or practitioner inclusion: Practitioners will be person-centred counsellors or practitioners with a person-centred diploma or equivalent who practise person-centred therapy (and/or pre-therapy) and have experience with at least one client who experiences psychotic process. Therapists will ensure that all practice is consistent with the BACP Ethical Framework (code of ethics)

Participating practitioners will participate in a one hour induction by phone face to face. Therapists will be given a resource document based on phase one findings and references to inform practice as needed.

The criteria for client inclusion: Clients will be age 18 or above and will appear to present with hearing voices, hallucinating, having unusual experiences or thinking and may be experiencing psychotic process or psychosis (with or without diagnosis).Clients will be excluded where there is alcohol or substance dependency or predominantly organic factors influencing the psychosis.

The PANSS will help to establish the severity of “presenting symptoms”.

At any stage of the research where clients present with severe or acute needs they will be referred to clinical services where possible, with their consent and confidentiality will be breeched as per contract if there may be significant risks to self or others. Such situations will be managed according

to the individual service protocols, professional body ethical guidelines and with clinical and managerial supervisors and the research team as needed. (More detail regarding these matters is within the NRES document.)

Recruitment and screening: Following ethical approval from the NHS and then the University of Strathclyde sites and therapists in service contexts will be recruited by flyers, advertisements in journals and magazines, notice boards, mental health user groups and charities. One identified site will be the counselling team in a mental health charity in Liverpool.

Interested parties will receive verbal and written information prior to screening, adapted to their needs or any disabilities. Practitioners will be inducted by the research team

Suitable clients will then be contacted by a researcher and receive basic information. Researchers will ask each potentially participating client if they are interested in taking part in the study and invite interested clients for a screening interview prior to the commencement of therapy. If clients do not wish to participate in the study they will commence therapy (as usual).

Clients will have been referred to or self referred to specific participating services and are about to receive person-centred counselling (and/or pre-therapy). Screening will consist of telephone or face to face contact by a researcher (depending on client need) followed by face to face screening by researcher or trained staff.

The main trial has two levels and participating clients will choose to take part in either level 1 or level 2. Level 1 is an open clinical trial and level 2 is an embedded case study. Minimum participation for data is three weeks (three sessions). Any data consisting of less than three sessions will be excluded.

Level 3 is an additional level where only one post therapy interview is conducted with clients who have competed treatment and only volunteer for a very minimal level of participation

Client’s travel costs for research meetings will be reimbursed where appropriate

Measures chosen and application

The Selected measures which take account of social functioning, general functioning, recovery, relationship and psychotic symptoms as defined by the medical model.
Practitioners will not usually see completed measures (except CORE which is designed for discussion with therapist).Completed measures will be placed in a sealed envelope for the researcher and stored in a locked cabinet for the research team.

What the therapists will be asked to do

Sign therapist consent form

Participate in an induction session with Wendy Traynor or a co-researcher. (induction/training session).They will receive a therapist resource paper to support practice and be able to consult the research team for support.

During the course of therapy with participating clients the therapist will administer specific measures and complete process notes according to the research protocol. (Some measures are therapist administered and some are researcher administered, as indicated on the flow chart.

The psychological contact scale will be attached to therapist process notes to be used where applicable (if clients out of psychological contact for part of the session.) This is an observational measure where clients in contact can fill the measure out themselves.

Client Screening by researcher (prior to level 1 or 2)

Client consent forms (see appendices)

Telephone screening interview

Structural initial clinical interview prior to therapy which includes:

PANSS (positive and negative syndromes scale) (audio recorded)

CORE-OM

Level 1 (All Clients/therapists)

Before every session- CORE-10-(except where full CORE-OM used)

CORE-OM given with PANSS weeks 5, 10, 15, 20, 30

Therapist and clients independently rate therapeutic alliance using Therapeutic Relationship Scale (TRS). (There are two versions of the form which will both be used in this study: a therapist version and a client version.)

Client TRS will be completed on weeks 3, 5, 10, 15, 20, 30, and 40

The therapist TRS form will be completed weekly from week 3.

At week 3 the client TRS will be administered by the therapist and for weeks 5, 10, 15 etc it will be administered by the researcher with the PANSS and CORE-OM
(The Therapist TRS also acts as adherence measure).

PANSS-pre and sessions 5, 10, 15, 20, 30

Client change interview, audio recorded (post)

Contact scale (where appropriate)

CORE and CORE-10 may be taken by the client into the therapy session and discussed or shown to the counsellor if desired and forms are then submitted to the researcher at the end of the session.
The client completes all other therapist administered measures and seals up and posts to the researcher. The client can discuss any issues in therapy relationship but the scale is private during the therapy relationship.
The therapist only sees the scale with the client's permission at end of the entire therapy relationship.

<u>Level 2 (Embedded Case Study Clients)</u>

All level 1 procedures will be followed and additionally:

Strathclyde Inventory

Client completes Helpful Aspects of Therapy (HAT

Audio recording of sessions (optional)

<u>What therapists will be asked to do</u>

Process notes with contact scale where appropriate

Give measures to clients where appropriate (according to project induction) in addition to researcher administered measures

Deliver sealed measures to secure storage for research team.

<u>Level 3</u>

<u>What the therapist will be asked to do</u>
No therapist administered measures

<u>What the client will be asked to do</u>
Complete the change interview with a researcher after end therapy relationship or complete phase of therapy

(Researcher adheres to all Professional body agency, legal and research protocols as with levels 1 and 2)

Clients who have received the information re the study and signed the consent form for level 3 and the recording form will simply be asked to give up around one hour in total
They will be given the change interview by an approved researcher for the study as previously agreed
Analysed data will be processed as in the levels already approved.

Dates to commence – April 2009
The study will commence in April 2009 if NHS ethical approval is granted or as soon as approval is complete. Data will be collected and analysed from April 09 up to April 012.

Data analysis
Data will be analysed using SPSS
Data will be aggregated across the whole.

Outcome and dissemination
Data will build on implications for a suggested treatment manual and could influence practitioner training and improved client outcomes. Results will be submitted to mental health and counselling journals such as "Person-Centred and Experiential Psychotherapies" and "Therapy Today"

Research Protocol Flow Chart

Advert

Sites and counsellors express interest and are selected if possibly suitable

↓

Check ethical approval is adequate for this site/counsellor

↓

Counsellor induction by researcher – 1 hour (face to face or by telephone). Practitioner resource doc given.

↓

Counsellor contract suitable clients identified from the waiting list or by the counsellor prior to the commencement of counselling

↓

Researcher contacts clients to provide information about the study and interested clients invited for initial screening with researcher

↓

Researcher screens client, client contract/PANNS/CORE-OM/ client change interview

↓

Researcher splits into 2 levels of participation

Level 1

Weekly Pre session counsellor administers CORE-10 (except where CORE-OM used)

Post session counsellor completes process notes (with PCS) and post in research box. (after every session)

Therapist TRS (from wk 3)

↓

Week 3, Therapist administers client TRS

↓

Week 5, 10, 15, 20, 30, 40

Researcher administers PANSS, CORE-OM, Client TRS,

↓

Final session

Refer to week 1

IN addition to scheduled measures

Counsellor completes CORE end of therapy form

↓

Researcher administers PANSS (if appropriate)

Researcher administers Change Interview

Level 2

(In addition to level 1)

Every session – all level 1 measures schedule

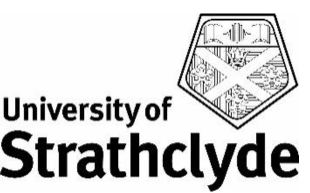
And session's audio recorded (optional)

And HAT given by counsellor after each session

↓

Pre, week 5, 10, 15, 20, 30, 40

(in addition to above) Strath Inventory given by researcher (with PANSS and CORE-OM)



(20.06.10) 2.0

Advert.

Are you are person-centred counsellor working in the UK with clients who may be hearing voices, experiencing hallucinations, experiencing psychotic process or other unusual experiences?

I am seeking adults aged 18 or over who have experienced person-centred or non-directive/experiential counselling or therapy who may be open to taking part in my doctoral research study at the University of Strathclyde. This research is intended to help build evidence base on person-centred therapy and what is useful or not useful to try to inform practitioners of general outcomes to try to build on good practice.

The study requires clients to be interviewed after therapy about their experiences of therapy. Confidentiality will be maintained and overall results will be presented with full consent and be anonymised.

For more information contact Wendy Traynor

E- Mail address wendy.traynor@strath.ac.uk

Tel

Level 3 Client information sheet (20.6.10) 4.0

Dear _____________ (*client)*

You expressed initial interest in participating in my study of person-centred counselling as part of my PhD study at Strathclyde University.

The study looks at how person-centred therapy may help people who may be hearing voices, hallucinating, have unusual experiences or are described as experiencing psychosis or psychotic process

The interview at a pre-arranged date and time, will last up to an hour. You will be asked about what was useful and less useful about your therapy experience. You can refuse to answer any question, withdraw or leave at any stage of the study if you change your mind.

How your participation will help

It is hoped that the findings of this study will improve practice by enabling a better understanding of how person centred therapy works to help people with complex issues.

Confidentiality

Data will be coded and will not be stored with details of your identity. In writing up case studies we will disguise the identity of participants and personal information. Only the research team will have access to the data. Data will be stored in encrypted files on secure computers.

You may withdraw from the study at any time without giving a reason

Any concerns or questions can be addressed to the research team listed below or to the secretary of the University Ethics Committee Gwen Mc Arthur (g.mcarthur@mis.strath.ac.uk)

You will be able to contact the researchers for de-briefing or support during and after the study, if required.

The research team includes;

Wendy Traynor Wendy.Traynor@strath.ac.uk

Robert Elliott Robert.Elliott@strath.ac.uk 0141 950 3727

(20.6.10) 2.0

Level 3 Client Consent

I agree to take part in this research whose purpose is to explore person-centred counselling and how it may help people who hear voices or have unusual experiences that may sometimes be seen as psychosis or psychotic process._The research is part of a doctoral research study based in the Counselling Unit at the University of Strathclyde.

I am aware that I will be invited to take part in interviews with a researcher and to fill in questions and measures throughout the therapy and at the end of therapy. I
understand that I will be asked to give consent for audio recording of therapy on a separate form.

I understand that I am free to withdraw from the study at any time, for any reason, without my therapy or rights being affected and for any data to be destroyed at my request.

I understand that any data will be kept in a secure location separate from personal details. I understand that the researcher will ensure that any material used for publication will be made anonymous.

Practitioners or researchers in this study may need to disclose information to others if there are serious risks that could affect the safety of the person or others or in the case of certain criminal activities. Only necessary information would be disclosed and this would be discussed with you wherever possible.

I confirm that I am at least 18 years old and that I am aware of what my participation involves and any potential risks

I understand that I will be asked separately about the use of recordings of sessions or interviews as detailed in the Release of Recordings form.

I agree to take part in this study.

--- ------------------- -------------------------
Name (please print) Date Signature

----------------------------------- ----------------------------- --------------------------
Name of researcher/witness Date Signature

Recording contract for clients (20.02.09) 2.0

I am willing for the research team to record the research interviews. I am willing for the research team to analyse the recordings for the purpose of developing and understanding person-centred therapies. Recordings will only be listened to by the University of Strathclyde research team and destroyed after 5 years after data analysis is completed.

I understand that, by responding to the above items and signing below, I have given my permission for the audio recording and other data from my sessions to be used in the manner I have specified.

Please provide us with a permanent address and phone number or email address at which you may be contacted:

Name of participant Date Signature

Name of researcher/witness Date Signature

A.4 Conditional ethical approval Studies 2 and 3

Cheshire Research Ethics Committee
Research Ethics Office
Victoria Building
Bishop Goss Complex
Rose Place
Liverpool
L3 3AN

Telephone: 0151 330 2070
Facsimile: 0151 330 2075

20 May 2009

Ms Wendy Traynor
PhD student
University of Strathclyde
c/o Professor Robert Elliott, Counselling Unit,
76 Southbrae Drive
Glasgow
United Kingdom
G13 1PP

Dear Ms Traynor

Full title of study: **Person-Centred Therapy for Clients who Experience Psychosis**
REC reference number: **09/H1017/69**

The Research Ethics Committee reviewed the above application at the meeting held on 6 May 2009. Thank you for attending to discuss the study.

Documents reviewed

The documents reviewed at the meeting were:

Document	*Version*	*Date*
cv Robert Elliot		
Practitioner resource doc	3	20 February 2009
Participant Consent Form: Client	2	20 February 2009
Participant Consent Form: Client Level 2	2	20 February 2009
Participant Consent Form: Client Level 1	2	20 February 2009
Participant Consent Form: Practitioner	2	20 February 2009
Participant Information Sheet: Client	2	20 February 2009
Participant Information Sheet: Practitioner	2	20 February 2009
Advertisement	1	28 February 2009
Questionnaire: Helpful Aspects	3.2	01 May 2008
Questionnaire: PANS, CORE-OM, CORE-10, CORE END OF THERAPY, STRATHCYLDE INVENTORY, PSYCHO CONTACT		
Interview Schedules/Topic Guides	6	20 February 2009

Compensation Arrangements		01 January 2008
Letter from Sponsor		27 March 2008
Summary/Synopsis		20 February 2009
Covering Letter		07 April 2009
Protocol	3	20 February 2009
Investigator CV		
Application		15 April 2009
Questionnaire: Therapeutic Process Notes	2	20 February 2009
Questionnaire: Therapeutic Relationship Scale	8	04 January 2008
Questionnaire: Therapeutic Relationship Scale	8	04 January 2008
Questionnaire: Therapy Form	3.2	01 May 2008

Provisional opinion

The Committee would be content to give a favourable ethical opinion of the research, subject to receiving a complete response to the request for further information set out below.

The Committee delegated authority to confirm its final opinion on the application to the Chair.

Further information or clarification required

- **As agreed, please make the BACP code of ethics regarding confidentiality more explicit in the Protocol and the Participant Information Sheet.**
- **As agreed, please confirm with the University of Strathclyde what is meant by 'case by case' with regard to indemnity.**
- **The Consent Form should include a section that refers to the researcher's responsibilities with regard to breaching confidentiality should any criminal activities be disclosed.**

When submitting your response to the Committee, please send revised documentation where appropriate underlining or otherwise highlighting the changes you have made and giving revised version numbers and dates.

The Committee will confirm the final ethical opinion within a maximum of 60 days from the date of initial receipt of the application, excluding the time taken by you to respond fully to the above points. A response should be submitted by no later than 17 September 2009.

Membership of the Committee

The members of the Committee who were present at the meeting are listed on the attached sheet.

Statement of compliance

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

09/H1017/69	**Please quote this number on all correspondence**

Yours sincerely

Mr Jonathan Deans
Chair Cheshire REC

Email: rob.emmett@liverpoolpct.nhs.uk

Enclosures: *List of names and professions of members who were present at the meeting and those who submitted written comments.*

Copy to: *Mrs Anne Muir*
[R&D Department for NHS care organisation at lead site]

Cheshire Research Ethics Committee

Attendance at Committee meeting on 6 May 2009

Committee Members:

Name	*Profession*	*Present*	*Notes*
Mrs Maureen Benbow	Senior Lecturer	No	
Dr Nick Bronnert	GP	Yes	
Rev'd Steve Burmester	Lay Member	Yes	
Mr Jonathan Deans	Consultant ENT Surgeon	Yes	
Dr Adrian Farrell	Consultant Rheumatologist	No	
Dr Sue Kaney	Consultant Psychologist	Yes	
Mr Ezzat Kozman	Consultant Member	Yes	
Dr Noel Murphy	Consultant Paediatrician	No	
Mrs Janet Petty	Nurse Member	Yes	
Dr Jane Richardson	University Lecturer	No	
Mrs Pam Rushworth	Pharmacist Member	Yes	
Dr Lenny Thornton	Consultant Member	No	
Mr Peter Ward	Lay member	Yes	
Mrs Jean Welch	Lay Member	No	
Mrs Ann Williams	Lay Member	Yes	
Dr Jill McCarthy	Lay Member	Yes	Co-opted Member

A.5 Correspondence re S1 and S2 approval

Cheshire Research Ethics Committee
Research Ethics Office
Victoria Building
Bishop Goss Complex
Rose place
Liverpool L3 3AN

Ms W Traynor
PhD student
University of Strathclyde
c/o Professor R Elliott
Counselling Unit
76 Southbrae Drive
Glasgow
United Kingdom
G13 1PP

3 June 2009

To Rob Emmett and Jonathon Deans

Re : Full title of study: Person-Centred therapy for Clients who experience Psychosis

REC reference number 09/H1017/69

Thankyou for your letter of 20.05.09 requesting that I provide responses to the chair further to your provisional opinion.

Clarifications and information as requested;

1. **Protocol and participant are now altered to** specify practitioner compliance with BACP Ethical Framework (Code of Ethics),including confidentiality limitations.

2. You have received an e mail from Ms A Muir regarding clarification of case by case wording in the insurance document

3. The client consent forms (level1 and level 2) now both include reference to the researcher's responsibilities regarding breaching confidentiality should any criminal activities be disclosed.

<u>Enclosed New Versions of documents</u>

Participant Consent Form: Practitioner version 3, 5.06.09

Participant Consent Form: Client Level 2, version 3, 5.06.09

Participant Consent Form: Client Level 1, version 3, 5.6.09

Participant Information Sheet: Client, version 3, 5.6.09

Participant Information Sheet: Practitioner, version 3, 5.6.09

Protocol, version 4, 5.06.09

Yours sincerely

Ms Wendy Traynor

Doctoral Research Student

A.6 University Sponsorship Form

090215

01 April 2009

Professor Robert Elliot
Educational and Professional Studies

University Sponsorship of Proposed Investigation Involving Human Subjects
Person-Centred Therapy for Clients who experience Psychosis

On behalf of the University I advise that pursuant to the University's Code of Practice on Investigations on Human Subjects, and based on the information contained in the ethics application, the University agrees to act as sponsor of the project entitled "Person-Centred Therapy for Clients who experience Psychosis" subject to the following conditions;

1. That the University Ethics Committee gives ethical approval of the project.

2. That the project is carried out according to the project protocol.

3. That the project continues to be covered by the University's insurance cover.

4. That the Director of Research and Innovation is immediately notified of any change to the project protocol or circumstances which may affect the University's risk assessment of the project.

5. That the project starts within 12 months of the date of this letter.

As sponsor of the project the University has responsibilities under the Scottish Executive's Research Governance Framework for Health and Community Care. You should ensure you are aware of those responsibilities and that the project is carried out according to the Research Governance Framework.

If you have any queries regarding sponsorship please contact Louise McKean at Research and Innovation.

Yours faithfully

Peter W A West

The place of useful learning

McCance Building
16 Richmond Street
Glasgow G1 1XQ
Direct line: 0141 548 2001
Facsimile: 0141 553 1521

INVESTOR IN PEOPLE

Secretary to the University:
Peter W A West, OBE
DL MA DUniv DPhil
Email: p.west@strath.ac.uk
Website: www.strath.ac.uk

The University of Strathclyde is a charitable body, registered in Scotland, number SC015263

A.7 University chief investigator form

UNIVERSITY OF STRATHCLYDE

RESEARCH & INNOVATION FORM TO BE COMPLETED FOR NHS ETHICS APPLICATIONS INVOLVING DOCTORAL STUDENTS AS CHIEF INVESTIGATOR

Doctoral students are required to be the Chief Investigator on NHS ethics applications. This is inconsistent with the University's Code of Practice which requires the academic supervisor be the Chief Investigator.

To comply with NHS guidance doctoral students should be named as the Chief Investigator on NHS ethics applications but the doctoral student's academic supervisor must complete this form and submit it to Research & Innovation with the NHS ethics application and associated paperwork before the NHS ethics application has been submitted to the NHS ethics committee.

Title of the research: Person-Centred Therapy for Psychosis

NHS Chief Investigator: Wendy Traynor

University of Strathclyde Academic Supervisor: Robert Elliott
(Must be Ordinance 16 member of staff)

I am the academic supervisor of the abovementioned project.

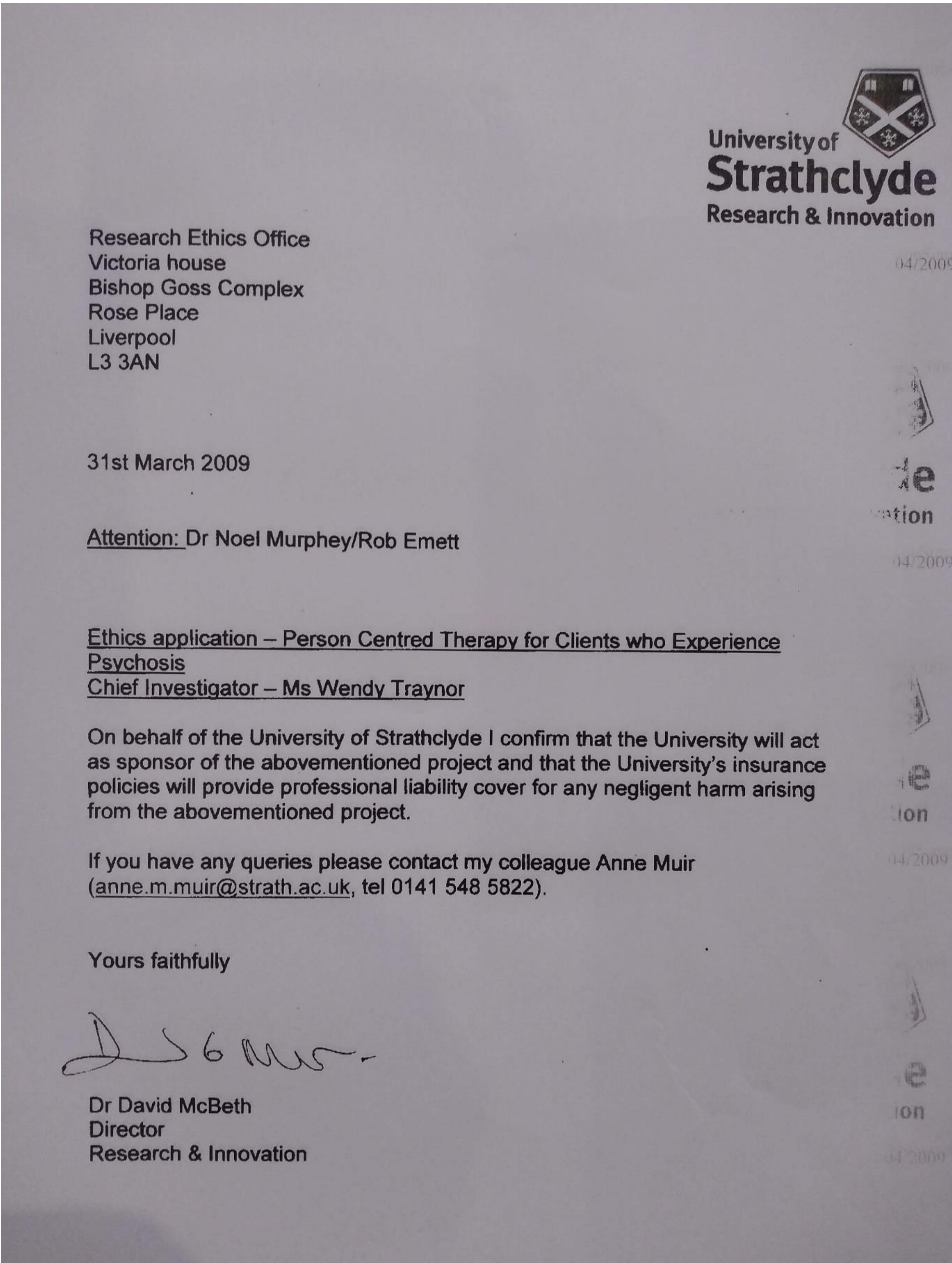
For University purposes I will be the main point of contact for the project and will ensure compliance with the University's Code of Practice on Investigations involving Human Beings, including Annex 4 (Key Responsibilities of Chief Investigator).

I have reviewed the NHS ethics application for the project and understand all points in the Declaration by Chief Investigator. I have signed the Declaration of educational supervisor.

Signed: Robert K Elliott jr

Date: 11 March 2009

A.8 NHS Sponsorship Correspondence



University of Strathclyde
Research & Innovation

Research Ethics Office
Victoria house
Bishop Goss Complex
Rose Place
Liverpool
L3 3AN

31st March 2009

Attention: Dr Noel Murphey/Rob Emett

Ethics application – Person Centred Therapy for Clients who Experience Psychosis
Chief Investigator – Ms Wendy Traynor

On behalf of the University of Strathclyde I confirm that the University will act as sponsor of the abovementioned project and that the University's insurance policies will provide professional liability cover for any negligent harm arising from the abovementioned project.

If you have any queries please contact my colleague Anne Muir (anne.m.muir@strath.ac.uk, tel 0141 548 5822).

Yours faithfully

Dr David McBeth
Director
Research & Innovation

Reference: **TO ADD** Online Form

Date: 25/03/2009 (dd/mm/yyyy)

Declaration by the sponsor's representative

If there is more than one sponsor, this declaration should be signed on behalf of the co-sponsors by a representative of the sponsor nominated to take the lead for the REC application.

I confirm that:

1. This research proposal has been discussed with the Chief Investigator and agreement in principle to sponsor the research is in place.
2. An appropriate process of scientific critique has demonstrated that this research proposal is worthwhile and of high scientific quality.*
3. Any necessary indemnity or insurance arrangements, as described in question A35, will be in place before this research starts.
4. Arrangements will be in place before the study starts for the research team to access resources and support to deliver the research as proposed.
5. Arrangements to allocate responsibilities for the management, monitoring and reporting of the research will be in place before the research starts.
6. The duties of sponsors set out in the NHS Research Governance Framework for Health and Social Care will be undertaken in relation to this research.**
7. I understand that the lay summary of this study will be published on the website of the National Research Ethics Service (NRES) as it appears in this application. Publication will take place no earlier than 3 months after issue of the ethics committee's final opinion or the withdrawal of the application.

* Not applicable to student research (except doctoral research).
** Not applicable to research outside the scope of the Research Governance Framework.

Signature: [signature]

Print Name: Dr Daid Mc Beth,

Post: Director, Research & Innovation

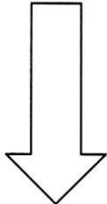
Organisation: University of Strathclyde,50 George St,Glasgow G1 1QE

Date: (dd/mm/yyyy)
02/04/2009

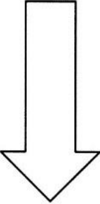
A.9 Consent forms, information sheets and original process flow charts re Study 2 and Study 3

LEVEL 3 FLOW CHART version 1 22.8.10

Client who is completing therapy or therapy phase, fitting the criteria responds to level 3 advert or word of mouth from researcher or counsellor. Researcher contacts client and supplies information.

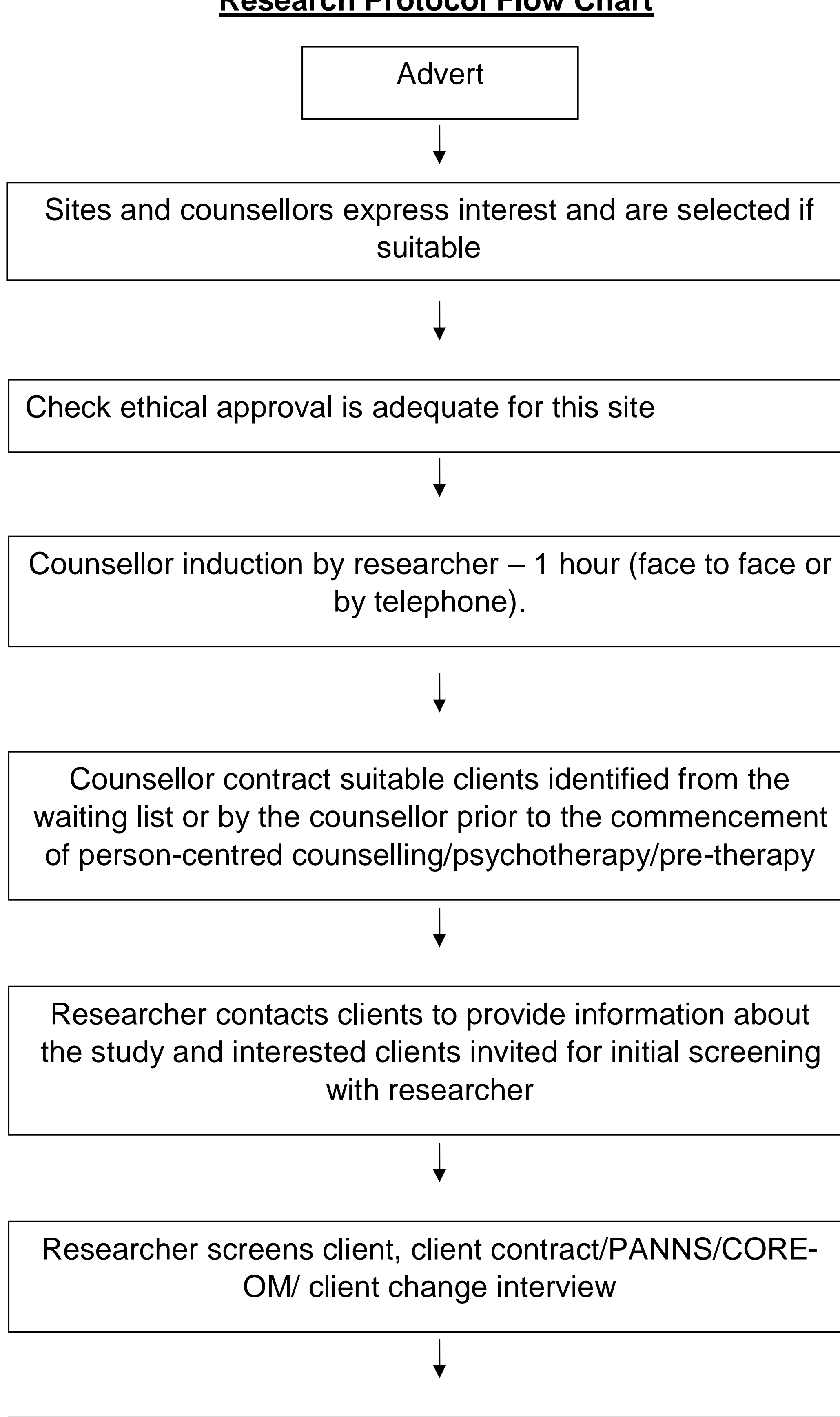


Researcher contracts with client and carries out change interview face to face or by phone which takes one hour



Client is offered de-briefing or signposting if needed

Research Protocol Flow Chart



Level 1

Weekly Pre-session counsellor administers CORE-10 (except where CORE-OM used)

Post session counsellor completes process notes (with PCS) and post in research box. (after every session)

Therapist TRS (from wk 3)

↓

Week 3, Therapist administers client TRS

↓

Week 5, 10, 15, 20, 30, 40

Researcher administers PANSS, CORE-OM, Client TRS,

↓

Final session

Refer to week 1

IN addition to scheduled measures

↓

Researcher administers PANSS (if appropriate)

Researcher administers Change Interview

Level 2

(In addition to level 1)

Every session – all level 1 measures schedule

And session's audio recorded (optional)

And HAT given by counsellor after each session

↓

Week 5, 10, 15, 20, 30, 40

(in addition to above) Strath Inventory given by researcher (with PANSS and CORE-OM)

A.10 Minor amendment request letter

Shehnaz Ishaq and Jonathan Deans From Wendy Traynor
North West Centre of Research Ethics Committees
3rd Floor
Barlow House
4 Minshull street
Manchester
M1 3MD

20 July 2010

To Shehnaz Ishaq and Jonathon Deans

Re: Full title of study: Person-Centred therapy for Clients who experience Psychosis

REC reference number 09/H1017/69

Re:Request for modification to protocol

Please could all mail be sent to my home address (which is at the bottom of this letter)

My current approved study has two levels of participation for clients

I propose to add a third level (level 3) of participation where instead of receiving measures throughout the therapy the client is only given one post therapy measure, the client change interview. This measure is currently being used in the trial in levels 1 and 2 and has been approved by your committee and has been widely used.

I am already collecting data according to the original protocol and there are no problems but request this modification to enable a significant data set to be gathered in the time frame needed.

The researcher would follow all protocols regarding any ethical concerns as already present in levels 1 and 2 and follow BACP, legal and organisational protocols regarding any arising matters as stated in consent forms.

Enclosed Original versions of documents

Change Interview Client Change Interview Schedule (v5 1/02/2008)
(remains the same)

Advert (20.02.09) 1.0

Protocol, version 4, 5.06.09 (see changed version in list of amended docs)

Participant Information Sheet: Practitioner, version 3, 5.6.09 (remains the same for levels 1 and 2)

Participant Information Sheet: Client, version 3, 5.6.09 (remains the same for level 1 and 2 but a new version for level 3 has been designed**)**

Participant Consent Form: Practitioner version 3, 5.06.09 (remains the same for levels 1 and 2 but level 3 form designed as in list of new docs)

Participant Consent Form: Client Level 2, version 3, 5.06.09 (remains the same for level 1 and 2, new doc for level 3)

Participant Consent Form: Client Level 1, version 3, 5.6.09

All other forms and systems remain unchanged

Enclosed Amended Versions of documents

Advert version 2, 20.06.10 (with just level 3 for specific level 3 recruitment)

Protocol, including flow chart (with proposed modification in bold) **version 6, 20.06.10**

Participant Consent Form: Client Level 3, version 2, 20.06.10

Participant Information Sheet: Client, version 4, 20.6.10

Participant Information Sheet: Practitioner, version 4, 20.6.10

Yours sincerely

Ms Wendy Traynor (Chief Investigator)

Professor Robert Elliott (Supervisor)

University of Strathclyde

Participant Information Sheet: Level 3 Client Information Sheet	3.0	22 August 2010
Investigator CV	Andrew Ford	23 December 2009
Protocol	7.0	09 October 2010
Notice of Substantial Amendment (non-CTIMPs)	1	25 October 2010
Covering Letter		16 October 2010

Membership of the Committee

The members of the Committee who took part in the review are listed on the attached sheet.

R&D approval

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

Statement of compliance

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

09/H1017/69:	**Please quote this number on all correspondence**

Yours sincerely

Miss Shehnaz Ishaq
Committee Co-ordinator

E-mail: Shehnaz.ishaq@northwest.nhs.uk

Enclosures: List of names and professions of members who took part in the review

Copy to:

Mrs Anne Muir
Business Development Manager
Research & Innovation
50 George Street
Glasgow
G1 1QE

Professor Robert Elliot
University of Strathclyde
Counselling Unit
76 Southbrae Drive
Glasgow
G13 1PP

A.11 University form re minor amendment

Substantial Amendment Notification Form (Cf. Section 3.7.b of the *Detailed guidance on the request to the competent authorities for authorisation of a clinical trial on a medicinal product for human use, the notification of substantial amendments and the declaration of the end of the trial*[1])

NOTIFICATION OF A SUBSTANTIAL AMENDMENT TO A CLINICAL TRIAL ON A MEDICINAL PRODUCT FOR HUMAN USE TO THE COMPETENT AUTHORITIES AND FOR OPINION OF THE ETHICS COMMITTEES IN THE EUROPEAN UNION

For official use:

Date of receiving the request :	Grounds for non acceptance/ negative opinion **:** ☐ Date :
Date of start of procedure:	Authorisation/ positive opinion **:** ☐ Date :
Competent authority registration number of the trial: Ethics committee registration number of the trial :	Withdrawal of amendment application ☐ Date :

To be filled in by the applicant:

This form is to be used both for a request to the Competent Authority for authorisation of a **substantial** amendment and to an Ethics Committee for its opinion on a **substantial** amendment. Please indicate the relevant purpose in Section A.

A TYPE OF NOTIFICATION

A.1 Member State in which the substantial amendment is being submitted:
A.2Notification for authorisation to the competent authority: ■
A.3Notification for an opinion to the ethics committee: ☐

B TRIAL IDENTIFICATION *(When the amendment concerns more than one trial, repeat this form as necessary.)*

B.1 Does the substantial amendment concern several trials involving the same IMP?[2]
yes ☐ no ■
B.1.1 If yes repeat this section as necessary.

B.2 Eudract number:
B.3 Full title of the trial : Person−Centred Therapy for Clients who Experience Psychosis
B.4 Sponsor's protocol code number, version, and date: 09/H1017/69

C IDENTIFICATION OF THE SPONSOR RESPONSIBLE FOR THE REQUEST

C.1	**Sponsor**
C.1.1	Organisation:`University of Strathclyde

[1] OJ, C82, 30.3.2010, p. 1; hereinafter referred to as 'detailed guidance CT-1'.

[2] Cf. Section 3.7. of the detailed guidance CT-1.

C.1.2	Name of person to contact:Wendy Traynor(chief investigator,(Prof Robert Elliott,supervisor)
[redacted]	Address : [redacted]
C.1.4	Telephone number : [redacted]
C.1.5	Fax number :
C.1.6	e-mail:wendy.traynor@strath.ac.uk

C.2	**Legal representative[3] of the sponsor in the European Union for the purpose of this trial (if different from the sponsor)**
C.2.1	Organisation:
C.2.2	Name of person to contact:
C.2.3	Address :
C.2.4	Telephone number :
C.2.5	Fax number :
C.2.6	e-mail:

D APPLICANT IDENTIFICATION (please tick the appropriate box)

D.1	**Request for the competent authority**
D.1.1	Sponsor ☐
D.1.2	Legal representative of the sponsor ☐
D.1.3	Person or organisation authorised by the sponsor to make the application. ☐
D.1.4	Complete below:
D.1.4.1	Organisation :
D.1.4.2	Name of person to contact :
D.1.4.3	Address :
D.1.4.4	Telephone number :
D.1.4.5	Fax number :
D.1.4.6	E-mail

3 As stated in Article 19 of Directive 2001/20/EC.

D.2	Request for the Ethics Committee
D.2.1	Sponsor ☐
D.2.2	Legal representative of the sponsor ☐
D.2.3	Person or organisation authorised by the sponsor to make the application. ☐
D.2.4	Investigator in charge of the application if applicable[4]:
•	Co-ordinating investigator (for multicentre trial) ☐
•	Principal investigator (for single centre trial): ☐
D.2.5	Complete below
D.2.5.1	Organisation :
D.2.5.2	Name :
D.2.5.3	Address :
D.2.5.4	Telephone number :
D.2.5.5	Fax number :
D.2.6	E-mail :

E SUBSTANTIAL AMENDMENT IDENTIFICATION

E.1	**Sponsor's substantial amendment code number, version, date for the clinical trial concerned:** ( )

E.2	Type of substantial amendment
E.2.1	**Amendment to information in the CT application form** yes ☐ no ☐
E.2.2	**Amendment to the protocol** yes ■ no ☐
E.2.3	**Amendment to other documents appended to the initial application form** yes ■ no ☐
E.2.3.1	If yes specify:
E.2.4	**Amendment to other documents or information:** yes ☐ no ■
E.2.4.1	If yes specify:
E.2.5	**This amendment concerns mainly urgent safety measures already implemented[5]** yes ☐ no ■
E.2.6	**This amendment is to notify a temporary halt of the trial[6]** yes ☐ no ■
E.2.7	**This amendment is to request the restart of the trial[7]** yes ☐ no ■

4 According to national legislation.

5 Cf. Section 3.9. of the detailed guidance CT-1.

6 Cf. Section 3.10. of the detailed guidance CT-1.

7 Cf. Section 3.10. of the detailed guidance CT-1.

E.3	Reasons for the substantial amendment:
E.3.1	**Changes in safety or integrity of trial subjects** **yes** ☐ **no** ■
E.3.2	**Changes in interpretation of scientific documents/value of the trial** **yes** ☐ **no** ■
E.3.3	**Changes in quality of IMP(s)** **yes** ☐ **no** ■
E.3.4	**Changes in conduct or management of the trial** **yes** ☐ **no** ■
E.3.5	**Change or addition of principal investigator(s), co-ordinating investigator** **yes** ☐ **no** ■
E.3.6	**Change/addition of site(s)** **yes** ☐ **no** ■
E.3.7	**Other change** **yes** ■ **no** ☐
E.3.7.1	**If yes, specify:additional optional level of participation with less measures(measure previouslyapproved)**
E.3.8	**Other case** **yes** ☐ **no** ☐
E.3.8.1	**If yes, specify**

E.4	Information on temporary halt of trial[8]
E.4.1	**Date of temporary halt** (YYYY/MM/DD)
E.4.2	**Recruitment has been stopped** yes ☐ no ☐
E.4.3	**Treatment has been stopped** yes ☐ no ☐
E.4.4	Number of patients still receiving treatment at time of the temporary halt in the MS concerned by the amendment ( )
E.4.5	**Briefly describe (free text)**: • Justification for a temporary halt of the trial • The proposed management of patients receiving treatment at time of the halt *(free text).* The consequences of the temporary halt for the evaluation of the results and for overall risk benefit assessment of the investigational medicinal product *(free text).*

F DESCRIPTION OF EACH SUBSTANTIAL AMENDMENT[9] *(free text)*:

Previous and new wording in track change modus	New wording	Comments/explanation/reasons for substantial amendment
1. Protocol: I propose to add a third level (level 3) of participation		1. This measure is currently being used in the trial in levels 1 and 2 and has been approved

8 Cf. Section 3.10. of the detailed guidance CT-1.

9 Cf. Section 3.7.c. of the detailed guidance CT-1. The sponsor may submit this documentation on a separate sheet.

where instead of receiving measures throughout the therapy the client is only given one post therapy measure, the client change interview. **Advert**		by your committee and has been widely used. I am already collecting data according to the original protocol and there are no problems but request this modification to enable a significant data set to be gathered in the time frame needed.

G CHANGE OF CLINICAL TRIAL SITE(S)/INVESTIGATOR(S) IN THE MEMBER STATE CONCERNED BY THIS AMENDMENT

G.1 Type of change
G.1.1 **Addition of a new site**
G.1.1.1 **Principal investigator** (provide details below)
G.1.1.1.1 Given name
G.1.1.1.2 Middle name (if applicable)
G.1.1.1.3 Family name
G.1.1.1.4 Qualifications (MD……..)
G.1.1.1.5 Professional address
G.1.2 **Removal of an existing site**
G.1.2.1 **Principal investigator** (provide details below)
G.1.2.1.1 Given name
G.1.2.1.2 Middle name (if applicable)
G.1.2.1.3 Family name
G.1.2.1.4 Qualifications (MD……..)
G.1.2.1.5 Professional address
G.1.3 **Change of co-ordinating investigator** (provide details below of the new coordinating investigator)
G.1.3.1 Given name
G.1.3.2 Middle name
G.1.3.3 Family name
G.1.3.4 Qualification (MD……….)
G.1.3.5 Professional address
G.1.3.6 Indicate the name of the previous co-ordinating investigator:
G.1.4 **Change of principal investigator at an existing site** (provide details below of the new principal investigator)
G.1.4.1 Given name
G.1.4.2 Middle name
G.1.4.3 Family name
G.1.4.4 Qualifications (MD……..)
G.1.4.5 Professional address
G.1.4.6 Indicate the name of the previous principal investigator:

H CHANGE OF INSTRUCTIONS TO CA FOR FEEDBACK TO SPONSOR

H.1 Change of e-mail contact for feedback on application*
H.2 Change to request to receive an .xml copy of CTA data ☐ yes ☐ no H.2.1 Do you want a .xml file copy of the CTA form data saved on EudraCT? ☐ yes ☐ no

H.2.1.1 If yes provide the e-mail address(es) to which it should be sent (up to 5 addresses):
H.2.2 Do you want to receive this via password protected link(s)[10]?
☐ yes ☐ no

If you answer no to question H.2.2 the .xml file will be transmitted by less secure e-mail link(s)

H.2.3 Do you want to stop messages to an email for which they were previously requested? ☐ yes ☐ no
H.2.3.1 If yes provide the e-mail address(es) to which feedback should no longer be sent:

(*This will only come into effect from the time at which the request is processed in EudraCT).

I LIST OF THE DOCUMENTS APPENDED TO THE NOTIFICATION FORM (cf. Section 3.7 of detailed guidance CT-1)

Please submit only relevant documents and/or when applicable make clear references to the ones already submitted. Make clear references to any changes of separate pages and submit old and new texts. Tick the appropriate box(es).

I.1 Cover letter
■

I.2 Extract from the amended document in accordance with Section 3.7.c. of detailed guidance CT-1 (if not contained in Part F of this form)
☐

I.3 Entire new version of the document[11]
☐

I.4 Supporting information
■

I.5 Revised .xml file and copy of initial application form with amended data highlighted
☐

I.6 Comments on any novel aspect of the amendment if any :

J SIGNATURE OF THE APPLICANT IN THE MEMBER STATE

J.1 I hereby confirm that/ confirm on behalf of the sponsor that (delete which is not applicable)

- The above information given on this request is correct;
- The trial will be conducted according to the protocol, national regulation and the principles of good clinical practice; and
- It is reasonable for the proposed amendment to be undertaken.

J.2 APPLICANT OF THE REQUEST FOR THE COMPETENT AUTHORITY (as stated in section D.1):☐

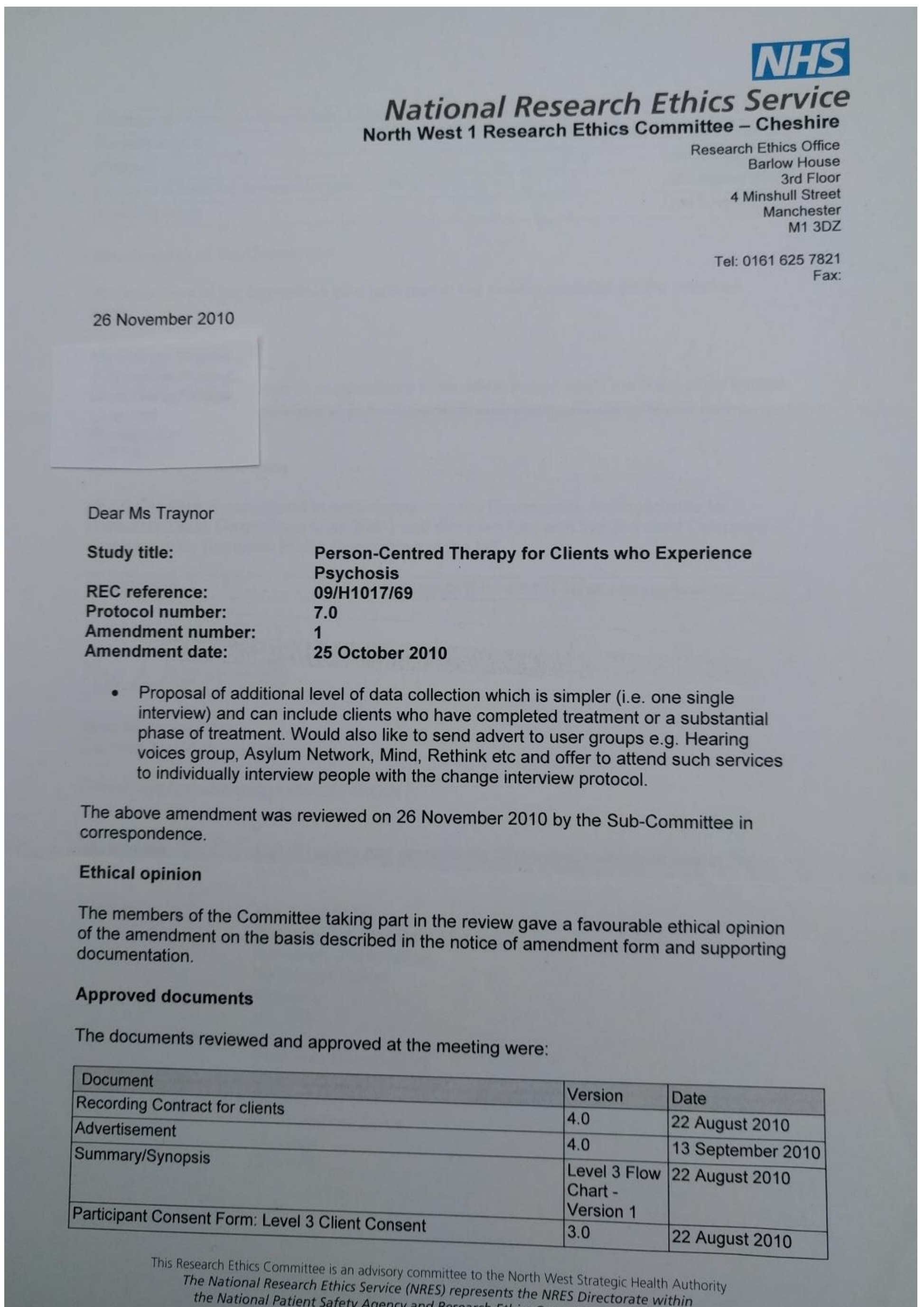
J.2.1 Signature [12]:
J.2.2 Print name :
J.2.3 Date :

[10] This requires a EudraLink account. (See https://eudract.ema.europa.eu/ for details)
[11] Cf. Section 3.7.c. of the detailed guidance CT-1.
[12] On an application to the Competent Authority only, the applicant to the Competent Authority needs to sign.

J.3 APPLICANT OF THE REQUEST FOR THE ETHICS COMMITTEE (as stated in section D.2): ☐
J.3.1 Signature [13]: J.3.2 Print name: Wendy Traynor J.3.3 Date :20 July 2009

[13] On an application to the Ethics Committee only, the applicant to the Ethics Committee needs to sign.

A.12 Correspondence re amendment re additional level



NHS

National Research Ethics Service

North West 1 Research Ethics Committee – Cheshire

Research Ethics Office
Barlow House
3rd Floor
4 Minshull Street
Manchester
M1 3DZ

Tel: 0161 625 7821
Fax:

26 November 2010

Dear Ms Traynor

Study title:	**Person-Centred Therapy for Clients who Experience Psychosis**
REC reference:	**09/H1017/69**
Protocol number:	**7.0**
Amendment number:	**1**
Amendment date:	**25 October 2010**

- Proposal of additional level of data collection which is simpler (i.e. one single interview) and can include clients who have completed treatment or a substantial phase of treatment. Would also like to send advert to user groups e.g. Hearing voices group, Asylum Network, Mind, Rethink etc and offer to attend such services to individually interview people with the change interview protocol.

The above amendment was reviewed on 26 November 2010 by the Sub-Committee in correspondence.

Ethical opinion

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

Approved documents

The documents reviewed and approved at the meeting were:

Document	Version	Date
Recording Contract for clients	4.0	22 August 2010
Advertisement	4.0	13 September 2010
Summary/Synopsis	Level 3 Flow Chart - Version 1	22 August 2010
Participant Consent Form: Level 3 Client Consent	3.0	22 August 2010

This Research Ethics Committee is an advisory committee to the North West Strategic Health Authority
The National Research Ethics Service (NRES) represents the NRES Directorate within the National Patient Safety Agency and Research Ethics Committees in England

Participant Information Sheet: Level 3 Client Information Sheet	3.0	22 August 2010
Investigator CV	Andrew Ford	23 December 2009
Protocol	7.0	09 October 2010
Notice of Substantial Amendment (non-CTIMPs)	1	25 October 2010
Covering Letter		16 October 2010

Membership of the Committee

The members of the Committee who took part in the review are listed on the attached sheet.

R&D approval

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

Statement of compliance

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

09/H1017/69:	Please quote this number on all correspondence

Yours sincerely

Miss Shehnaz Ishaq
Committee Co-ordinator

E-mail: Shehnaz.ishaq@northwest.nhs.uk

Enclosures: List of names and professions of members who took part in the review

Copy to:

Mrs Anne Muir
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Professor Robert Elliot
University of Strathclyde
Counselling Unit
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G13 1PP

A.13 Acknowledgment of progress report

NHS

National Research Ethics Service

NRES Committee North West - Cheshire

Research Ethics Office
Barlow House
3rd Floor
4 Minshull Street
Manchester
M1 3DZ

Tel: 0161 625 7815

01 August 2011

Dear Ms Traynor

Study title:	**Person-Centred Therapy for Clients who Experience Psychosis**
REC reference:	**09/H1017/69**

Thank you for sending the progress report for the above study dated 26 July 2011. The report will be reviewed by the Chair of the Research Ethics Committee, and I will let you know if any further information is requested.

The favourable ethical opinion for the study continues to apply for the duration of the research.

09/H1017/69:	**Please quote this number on all correspondence**

Yours sincerely

PP. A. Totenhofer

Miss Shehnaz Ishaq
Committee Co-ordinator

E-mail: shehnaz.ishaq@northwest.nhs.uk

Copy to: Mrs Anne Muir
Business Development Manager
Research and Innovation
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B. Measures

B.1 Therapeutic Relationship Scale (client form)

THERAPEUTIC RELATIONSHIP SCALE – Client form (Version 8.0; 4/01/08)

Client ID ____________________ Date ____________ Session____________

Please read each statement below and think **to what extent** you have felt in that way with your therapist **in this session**. Then mark the box that is closest to this. There are no right or wrong answers – it is only important what is true for you individually.

	Not at all	A little	Quite a lot	A great deal
1. I felt understood by my therapist	☐ 0	☐ 1	☐ 2	☐ 3
2. I felt it was ok for me to say everything that was in my mind	☐ 0	☐ 1	☐ 2	☐ 3
3. My therapist responded warmly to me	☐ 0	☐ 1	☐ 2	☐ 3
4. My therapist interrupted my train of thought	☐ 3	☐ 2	☐ 1	☐ 0
5. I felt hurt by my therapist	☐ 3	☐ 2	☐ 1	☐ 0
6. I felt my therapist was sensitive to my mood and my feelings	☐ 0	☐ 1	☐ 2	☐ 3
7. I felt I needed to please my therapist	☐ 3	☐ 2	☐ 1	☐ 0
8. My therapist took no notice of some things that were important to me	☐ 3	☐ 2	☐ 1	☐ 0
9. I felt my therapist's outward response to me was different to how they felt underneath	☐ 3	☐ 2	☐ 1	☐ 0
10. My therapist took the lead in the session	☐ 3	☐ 2	☐ 1	☐ 0
11. My therapist realised what I meant even when I had difficulty expressing myself	☐ 0	☐ 1	☐ 2	☐ 3
12. I felt pushed by my therapist	☐ 3	☐ 2	☐ 1	☐ 0
13. My therapist was open and honest with me	☐ 0	☐ 1	☐ 2	☐ 3
14. I felt accepted by my therapist no matter what I said	☐ 0	☐ 1	☐ 2	☐ 3
15. I felt it was ok for me to correct or disagree with my therapist	☐ 0	☐ 1	☐ 2	☐ 3
16. I felt pressurized by my therapist's expectations	☐ 3	☐ 2	☐ 1	☐ 0

	Not at all	A little	Quite a lot	A great deal
17. I hide from my therapist what I was really thinking or feeling	☐3	☐2	☐1	☐0
18. My therapist said things that showed that they did not understand me	☐3	☐2	☐1	☐0
19. I shared more than I expected with my therapist	☐0	☐1	☐2	☐3
20. I felt my therapist disapproved of me	☐3	☐2	☐1	☐0
21. My therapist has a good understanding of what I want to gain from therapy	☐0	☐1	☐2	☐3
22. I dropped what I was thinking in order to pay attention to my therapist	☐3	☐2	☐1	☐0
23. I felt my therapist trusted me	☐0	☐1	☐2	☐3
24. I am happy with the way that my therapist and I are working together	☐0	☐1	☐2	☐3
26. I felt uncomfortable with my therapist	☐3	☐2	☐1	☐0
27. My therapist revealed something personal about themselves to me	☐0	☐1	☐2	☐3
28. I felt close to my therapist	☐0	☐1	☐2	☐3

Thank you for your time in completing this questionnaire

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B.2 Therapeutic Relationship Scale (therapist form)

THERAPEUTIC RELATIONSHIP SCALE – Therapist form (Version 8; 04/01/08)

Client ID ______________________ Date ______________ Session____________

Please read each statement below and think **to what extent** you have felt in that way with your therapist **in this session**. Then mark the box that is closest to this. There are no right or wrong answers – it is only important what is true for you individually.

	Not at all	A little	Quite a lot	A great deal
1. I understood my client	☐0	☐1	☐2	☐3
2. My client felt it was ok for them to say everything that was in their mind	☐0	☐1	☐2	☐3
3. I responded warmly to my client	☐0	☐1	☐2	☐3
4. I interrupted the train of thought of my client	☐3	☐2	☐1	☐0
5. My client felt hurt by me	☐3	☐2	☐1	☐0
6. I was sensitive to my client's mood and feelings	☐0	☐1	☐2	☐3
7. My client felt they needed to please me	☐3	☐2	☐1	☐0
8. I missed some things that were important to my client	☐3	☐2	☐1	☐0
9. My outward response to my client was different to how I felt underneath	☐3	☐2	☐1	☐0
10. I took the lead in the session	☐3	☐2	☐1	☐0
11. I could understand what my client meant even when they had difficulty expressing themselves	☐0	☐1	☐2	☐3
12. I pushed my client	☐3	☐2	☐1	☐0
13. I was open and honest with my client	☐0	☐1	☐2	☐3
14. I accepted my client no matter what they said	☐0	☐1	☐2	☐3
15. My client felt it was ok for them to correct me or disagree with me	☐0	☐1	☐2	☐3
16. I had expectations of my client	☐3	☐2	☐1	☐0

	Not at all	A little	Quite a lot	A great deal
17. I think my client was open with me about what they were thinking or feeling	☐0	☐1	☐2	☐3
18. I said things that showed I did not understand my client	☐3	☐2	☐1	☐0
19. I think my client shared more than they expected with me	☐0	☐1	☐2	☐3
20. I felt disapproving of my client	☐3	☐2	☐1	☐0
21. I have a good understanding of what my client want to gain from therapy	☐0	☐1	☐2	☐3
22. My client dropped what they were thinking in order to pay attention to me	☐3	☐2	☐1	☐0
23. I trusted my client	☐0	☐1	☐2	☐3
25. I believe my client is happy with the way we are working together	☐0	☐1	☐2	☐3
26. My client felt uncomfortable with me	☐3	☐2	☐1	☐0
27. I revealed something personal about myself to my client	☐0	☐1	☐2	☐3
28. I felt close to my client	☐0	☐1	☐2	☐3

Thank you for your time in completing this questionnaire

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B.3 Helpful Aspects of Therapy (HAT)

HELPFUL ASPECTS OF THERAPY FORM (H.A.T.)
(Version 3.2; 05/2008)

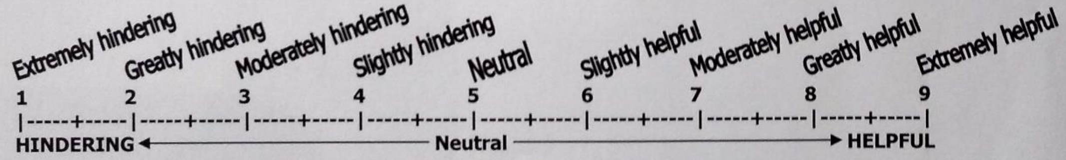
Therapist ______ Client ID __________

Date ____________ Session _______

1. Of the events which occurred in this session, which one do you feel was the most **important** or **helpful** for you personally? (By "event" we mean something that happened in the session. It might be something you said or did, or something your therapist or counsellor said or did.)

2. Please describe what made this event important/helpful and what you got out of it.

3. How **helpful or hindering** was this particular **event**? Rate it on the following scale. (Put an "X" at the appropriate point; half-point ratings are OK; e.g., 7.5.)



4. About where in the session did this event occur?

5. About how long did the event last?

Please turn over

6. Did anything else particularly **helpful** happen during this session? **YES NO**

(a. If yes, please rate how **helpful** this event was:

Slighty ☐6 Moderately ☐7 Greatly ☐8 Extremely ☐9

(b. Please describe the event briefly:

7. Did anything happen during the session which might have been **hindering**? **YES NO**

(a. If yes, please rate how **hindering** the event was:

Slightly ☐4 Moderately ☐3 Greatly ☐2 Extremely ☐1

(b. Please describe this event briefly:

B.4 Change interview protocol v5.5

Client Change Interview Schedule (v5; 1/02/2008)

After each phase of counselling, clients are asked to come in for an hour-long semi-structured interview. The major topics of this interview are any changes you have noticed since therapy began, what you believe may have brought about these changes, and helpful and unhelpful aspects of the therapy. The main purpose of this interview is to allow you to tell us about the therapy and the research in your own words. This information will help us to understand better how the therapy works; it will also help us to improve the therapy. Your therapist will not be shown this information until you have finished counselling with them, and only then if you give us permission to do so. This interview is recorded for later transcription. Please provide as much detail as possible.

1. General Questions: [about 5 min]
1a. How are you doing now in general?
1b. What has therapy been like for you so far? How has it felt to be in therapy?
1c. What medications are you currently on? *(interviewer: record on form, including dose, how long, last adjustment, herbal remedies)*

2. Changes: [about 10 min]
2a. What changes, if any, have you noticed in yourself since therapy started?
(Interviewer: Reflect back change to client and write down brief versions of the changes for later. If it is helpful, you can use some of these follow-up questions: For example, Are you doing, feeling, or thinking differently from the way you did before? What specific ideas, if any, have you gotten from therapy so far, including ideas about yourself or other people? Have any changes been brought to your attention by other people?)
2b. Has anything changed for the worse for you since therapy started?
2c. Is there anything that you wanted to change that hasn't since therapy started?

3. Change Ratings: [about 10 min] *(Go through each change and rate it on the following three scales:)*
3a. For each change, please rate how much you expected it vs. were surprised by it? (Use this rating scale:)
(1) Very much expected it
(2) Somewhat expected it
(3) Neither expected nor surprised by the change
(4) Somewhat surprised by it
(5) Very much surprised by it

3b. For each change, please rate how likely you think it would have been if you hadn't been in therapy? (Use this rating scale:)
(1) Very unlikely without therapy (clearly would not have happened)
(2) Somewhat unlikely without therapy (probably would not have happened)
(3) Neither likely nor unlikely (no way of telling)
(4) Somewhat likely without therapy (probably would have happened)

(5) Very likely without therapy (clearly would have happened anyway)

3c. How important or significant to you personally do you consider this change to be? (Use this rating scale:)
(1) Not at all important
(2) Slightly important
(3) Moderately important
(4) Very important
(5) Extremely important

4. Attributions: [about 5 min] **In general, what do you think has caused the various changes you described? In other words, what do you think might have brought them about?** (Including things both outside of therapy and in therapy)

5. Resources: [about 5 min]
5a. What personal strengths do you think have helped you make use of therapy to deal with your problems? (what you're good at, personal qualities)
5b. What things in your current life situation have helped you make use of therapy to deal with your problems? (family, job, relationships, living arrangements)

6. Limitations: [about 5 min]
6a. What things about you do you think have made it harder for you to use therapy to deal with your problems? (things about you as a person)
6b. What things in your life situation have made it harder for you to use therapy to deal with your problems? (family, job, relationships, living arrangements)

7. Helpful Aspects: [about 10 min] **Can you sum up what has been helpful about your therapy so far? Please give examples.** (For example, general aspects, specific events)

8. Problematic Aspects: [about 5 min]
8a. What kinds of things about the therapy have been hindering, unhelpful, negative or disappointing for you? (For example, general aspects. specific events)
8b. Were there things in the therapy which were difficult or painful but still OK or perhaps helpful? What were they?
8c. Has anything been missing from your treatment? (What would make/have made your therapy more effective or helpful?)

9. The Research:. [about 10 min]
9a. What has it been like to be involved in this research? (Initial screening, research interviews, completing questionnaires etc)
9b. Can you sum up what has been helpful about the research so far? Please give examples.
9c. What kinds of things about the research have been hindering, unhelpful, negative or have got in the way of therapy? Please give examples.

10. Suggestions: [about 5 min] **Do you have any suggestions for us, regarding the research or the therapy? Do you have anything else that you want to tell me?**

B5 Positive And Negative Syndrome Scale (PANSS) scoring sheet

PANSS RATING FORM
absent minimal mild moderate moderate severe
severe extreme
P1 Delusions 1 2 3 4 5 6 7
P2 Conceptual disorganisation 1 2 3 4 5 6 7
P3 Hallucinatory behaviour 1 2 3 4 5 6 7
P4 Excitement 1 2 3 4 5 6 7
P5 Grandiosity 1 2 3 4 5 6 7
P6 Suspiciousness/persecution 1 2 3 4 5 6 7
P7 Hostility 1 2 3 4 5 6 7
N1 Blunted affect 1 2 3 4 5 6 7
N2 Emotional withdrawal 1 2 3 4 5 6 7
N3 Poor rapport 1 2 3 4 5 6 7
N4 Passive/apathetic social withdrawal
1 2 3 4 5 6 7
N5 Difficulty in abstract thinking 1 2 3 4 5 6 7
N6 Lack of spontaneity & flow of conversation
1 2 3 4 5 6 7
N7 Stereotyped thinking 1 2 3 4 5 6 7
G1 Somatic concern 1 2 3 4 5 6 7
G2 Anxiety 1 2 3 4 5 6 7
G3 Guilt feelings 1 2 3 4 5 6 7
G4 Tension 1 2 3 4 5 6 7
G5 Mannerisms & posturing 1 2 3 4 5 6 7
G6 Depression 1 2 3 4 5 6 7
G7 Motor retardation 1 2 3 4 5 6 7
G8 Uncooperativeness 1 2 3 4 5 6 7
G9 Unusual thought content 1 2 3 4 5 6 7
G10 Disorientation 1 2 3 4 5 6 7
G11 Poor attention 1 2 3 4 5 6 7
G12 Lack of judgement & insight 1 2 3 4 5 6 7
G13 Disturbance of volition 1 2 3 4 5 6 7
G14 Poor impulse control 1 2 3 4 5 6 7
G15 Preoccupation 1 2 3 4 5 6 7
G16 Active social avoidance 1 2 3 4 5 6 7

Ptot = ________ Ntot = ________ Ptot - Ntot = ________
Gtot = _______

B.6 Therapist Process Notes (study 3)

THERAPIST PROCESS NOTES (Wendy Traynor /Robert Elliott, version 2 25/3/09)

CLIENT CODE________ SESSION ______DATE__________ THERAPIST ______

Process Notes

1. Brief summary of main episodes and events of session.

2. Unusual within therapy events (e.g. late, interruptions, challenges, out-of mode).

3. Important extra-therapy events (e.g. relationships, work, injury/illness, changes in medication, self help efforts

4. What theoretical approach was used in the session? Indicate:

Person-centred Integrative CBT Gestalt Other: please specify:

5. Ideas for next time (from self and supervision)

6. Please rate how helpful or hindering to your client you think this session was overall	7. How do you feel about the session you have just completed with your client?
___1.Extremely hindering	___1.Perfect
___2.Greatly hindering	___2.Excellent
___3.Moderately hindering	___3.Very good
___4.Slightly hindering	___4.Pretty good
___5.Neither helpful nor hindering; neutral	___5.Fair
___6.Slightly helpful	___6.Pretty poor
___7.Moderately helpful	___7.Very poor
___8.Greatly helpful	
___9.Extremely helpful	

1

C Study 2 Data Categories

C.1 Study 2 Full Data categories

Study 2 (Chapter 3) Full domains/categories with detail

Domain 1.0: Changes (Mid and Post-therapy)

1.1 Positive Changes (improvements, getting better)

1.1.1 Positive Global Change

1.1.1.1 Positive global change noted by client

1.1.1.2 Positive global change noted by others/being more visible

1.1.2. Internal/self-related changes

1.1.2.1 Reduction in specific problematic internal experiences (other than self-harm related experiences)

1.1.2.1.1 Reduction/improvement in unusual experiences

1.1.2.1.1.1 Hearing voices less/less hallucinations

1.1.2.1.1.2 Less frequent OCD issues/less problem re unusual/distressing thoughts

1.1.2.1.1.3 Feeling things are less unreal

1.1.2.1.2 Feeling less "mad"/weird/decreased self-stigma about unusual experiences

1.1.2.1.3 Improved problematic mood/emotion states

1.1.2.1.3.1. Less depressed

1.1.2.1.3.2. Less anxiety or panic/improved coping with anxiety/more relaxed

1.1.2.1.3.3 Feeling less shame

1.1.2.1.3.4 Better coping with/reduction in anger or agitation

1.1.2.2 Improvements in general experience of self

1.1.2.2.1 Improvements in evaluation of self

1.1.2.2.1.1 Increased self -confidence

1.1.2.2.1.2 Higher goals for self

1.1.2.2.1.3 More self-respect

1.1.2.2.1.4 More self-value/self- acceptance

1.1.2.2.2 Increased self-awareness/Extra depth

1.1.2.2.2.1 More mature

1.1.2.2.2.2 More connection with self

1.1.2.2.2.3 More connection with feeling

1.1.2.2.2.4 More visible to self

1.1.2.2.3 More in control of self

1.1.2.2.4 More patient with self

1.1.2.2.5 More solid/less fragile/less vulnerable/more self- depth/grew stronger, more resilient

1.1.2.2.6 Gaining hope/positivity

1.1.2.2.7 Increase in perspective

1.1.2.2.8 More able to deal with loss/trauma/issues

1.1.3 Increased positive external connection

1.1.3.1 Increased positive connection to External World (other than harmful actions toward self/others

1.1.3.1.1 Increase in coping abilities

1.1.3.1.1.1 Improved global coping

1.1.3.1.1.2 Improved self -care

1.1.3.1.1.2.1 Improved global self-care

1.1.3.1.1.2.2 Improved personal hygiene

1.1.3.1.1.3 Improvement in lifestyle (healthier emotionally/overall)

1.1.3.1.1.4 Getting out more/more able to travel

1.1.3.1.1.5 Better coping with voices/hallucinations

1.1.3.1.2 Improved ability to access to resources/services for support

1.1.3.1.3 Educational achievement

1.1.3.1.4 More able to work

1.1.3.2 Improvement in Interpersonal connections

1.1.3.2.1 General /global improvement in interpersonal connections/ Better quality of relationships/Different attitude to those other than therapist [outside of therapy]

1.1.3.2.2 Less difficulties or conflict with others/Treating others with more respect/less judgement re others/more able to apologise

1.1.3.2.3 Interpersonal improvement with specific groups

1.1.3.2.3.1 Improvement in Interpersonal connections with friends

1.1.3.2.3.2 Improvement in Interpersonal connections with family

1.1.3.2.3.3 Improvement in Interpersonal connections with intimate others

1.1.3.2.4 More social connections (quantity)

1.1.3.2.5 More able to test self (in being in company of feared gender)

1.1.3.3 Improvement in interpersonal abilities

1.1.3.3.1 Greater ability to be with/connect/trust others

1.1.3.3.2 Greater ability to set appropriate boundaries with others

1.1.3.3.3 More able to complain/be assertive

1.1.3.3.4 Better able to talk/express and share oneself

1.1.3.3.5 More able to ask for help/depend on others

1.1.4 Reduction in Risky Experiences/Behaviours

1.1.4.1 Reduction in Internal sources of risky behaviours

1.1.4.1.1 Fewer/less intense suicidal ideas (thoughts/of harming others (thoughts)

1.1.4.1.2 Increased reflection on potentially risky lifestyle

1.1.4.1.2.1 Got out of toxic relationship

1.1.4.2 Reduction in external risky behaviours

1.1.4.2.1 Less harm to self or others(behaviour)

1.1.4.2.2 Reduction in risky life-style/behaviours/actions

1.1.5 Physiological improvement

1.1.5.1 More energy

1.2 Negative (post-therapy), deterioration, getting worse

1.2.1 Negative Global Change: Things got worse/felt worse

1.2.2 Negative Specific Change

1.2.2.1 Temporarily lost faith in PCT approach

1.2.2.2 Less close to intimate partner

1.2.2.3 More suspicious

1.2.2.4 Increased ruminations

1.3. No change/missing changes

1.3.1 Client wanted to be one hundred percent better

1.3.2. Client wanted change to be faster

Domain 2.0. Helpful Aspects

2.1 Helpful client contributions (outside of therapy or brought into therapy)

2.1.1 Helpful client personal attributes

2.1.1.1 Laid back attitude/flexible

2.1.1.2 Being self-reflective/ Self- aware/self -processing

2.1.1.3 Helpful Beliefs and philosophies

2.1.1.4 Taking responsibility and being real/open/mature

2.1.1.5 Perseverance/determination

2.1.1.6 Fear helped client to use therapy

2.1.1.7 Client stable/ready for therapy/change

2.1.1.8 Client able to transform negatives into positives

2.1.2 Helpful self-initiated self-help/coping activities or strategies

2.1.3 Helpful client circumstances/situation (situational resources)

2.1.3.1 Helpful others (friends)

2.1.3.2 Helpful others (family)

2.1.3.3 Helpful others (intimates)

2.1.3.4 Increased links to wider community including people/work/support networks

2.1.3.5 Awareness of /or access to resources/finances/housing

2.2. Helpful Therapy contributions

2.2.1 Contextual therapeutic parameters

2.2.1.1 (General) Therapist perceived as similar cultural origin/age as client

2.2.1.1.1 Therapist had perceived similarities with client

2.2.1.1.2 Therapist disclosed personal experience of voices/hallucinations/delusions etc

2.2.1.2 Holding professional boundaries

2.2.1.3 Helpful use of space, room, setting

2.2.1.4 Helpful use of time, organisation of session

2.2.2 In-session/Therapy Processes

2.2.2.1 Therapy Global helpfulness/helpful relational atmosphere/global quality of relationship

2.2.2.2 Helpful Relational Aspects

2.2.2.2.1 Strong therapeutic alliance perceived by client

2.2.2.2.2 Therapist warm

2.2.2.2.3 Therapist sympathetic

2.2.2.2.4 Therapist non- judgemental/accepting

2.2.2.2.4.1 Therapist accepting client

2.2.2.2.4.2 Therapist not labelling or pathologizing client

2.2.2.2.4.3 Therapist not interpretative

2.2.2.5. Therapist in-session qualities

2.2.2.5.1. Therapist caring/valued me

2.2.2.5.2 Therapist attentive/very present/sensitive

2.2.2.5.3 Therapist real/authentic/genuine

2.2.2.5.4 Therapist commitment/positive attitude

2.2.2.5.5 Therapist empathic

2.2.2.6 Helpful therapist Actions

[nonverbal]

2.2.2.6.1. Helpful physical contact

2.2.2.6.2 Therapist flow/rhythm helpful

2.2.2.6.3 Therapist helpfully challenges client

[allowing]

2.2.2.6.4 Strong patience of therapist

2.2.2.6.5 Therapist not pressurising

[Tracking client]

2.2.2.6.6 Reflections helpful

2.2.2.6.7 Being listened to helpful

[Motivating action]

2.2.2.6.8 Motivated me/ positive insisting of therapist

2.2.2.6.9. Helpful therapist referral of client to other resources

2.2.2.7 Therapist open to creative, symbolic process

2.2.2.7.1 Therapist uses/echoes analogies, metaphors

2.2.2.7.2 Therapist creative

2.2.2.8 Positive client in-session actions

2.2.2.8.1 Able to talk /talk about stuff that client couldn't discuss with friends.

2.2.2.8.2. Able to talk about traumatic/difficult experiences

2.2.3. Positive Immediate Within-therapy Effects

2.2.3.1 Feeling understood/being taken seriously

2.2.3.1 Feeling understood /being taken seriously

2.2.3.2 Stress or anxiety relief/able to vent/ better coping with stress

2.3 Other helpful treatments/other helpful therapy (non PCE)

2.3.1 Helpful CBT

2.3.2 Helpful dream work

2.3.3 Helpful groupwork

2.4 Difficult/painful but ok/helpful aspects of therapy

Domain 3. Unhelpful Aspects

3.1. Client Negative Contributions (interfering factors)

3.1.1 Client personal attributes with negative effect

3.1.1.1 Worry/fear

3.1.1.2 Client lacks perspective/overthinking/thinking issues

3.1.1.3 Client is over- confident

3.1.1.4 Client finds it hard to trust/achieve safety with others

3.1.1.5 Guilt

3.1.1.6 Suicidal feeling as barrier

3.1.1.7 Seeking unnecessary resources

3.1.1.8 Self harm-physical and emotional

3.1.2 Unhelpful Client circumstances/situation/others

3.1.2.1 Global Life stresses

3.1.2.2 Unhelpful friends/ Friends don't understand/Pressure from friends

3.1.2.3 Not getting on with family/unsupportive family

3.1.2.4 Unsupportive others/lack of supportive others

3.1.2.5 Stressful job

3.1.2.6 Poor standard of housing/accommodation

3.1.2.7 Finances and inflation

3.2 Unwanted/unhelpful Therapist contributions

3.2.1 Unhelpful Contextual therapeutic parameters (e.g. room, spacing, timing, service)

3.2.2 Unhelpful In-session/Therapy Processes

3.2.2.1 Global unhelpfulness

3.2.2.2 Negative Relational atmosphere (global quality of relationship)

3.2.2.2.1 Deteriorating relationship

3.2.2.3 Unhelpful therapist in-session Qualities

3.2.2.4 Unhelpful/unwanted therapist Actions

3.2.2.4.1 Therapist negative actions

3.2.2.4.1.1 Therapist Judged client

3.2.2.4.1.2 Therapist verbally attacked/criticized client

3.2.2.4.2 Unwanted therapist directivity

3.2.2.4.2.1 Therapist focused on and overemphasised emotions

3.2.2.4.2.2 Therapist pushing client to access feelings that client did not want to connect with

3.2.2.4.2.3 Pressure from therapist for client to conform to expected therapy outcomes

3.2.2.4.2.4 Therapist stated the obvious

3.2.2.4.2.5 Therapist initiated unwanted directive technique

3.2.2.4.2.6 Therapist exerts power

3.2.2.5 Client in session unhelpful actions

3.2.2.5.1 Therapist initiated unhelpful "stonework"

3.2.3 Unhelpful Immediate Within-therapy Negative Effects

3.3 Missing aspects/processes of Therapy

3.3.1[Missing information about therapy]

3.3.1.1 Wanting to be informed of therapist modality (without asking)

3.3.1.2 Wanting therapy qualifications/credentials and teamwork with therapist

3.3.1.3 Wanted signposting re resources

3.3.1.4 Wanted card/details to contact therapist directly post therapy with option of further sessions

3.3.2 Wanted structure/goals/progress tracking

3.3.2.1Wanted structure or plan

3.3.2.2 Wanted format to disclose progress/deterioration or therapist to check progress

3.3.3. [missing relational qualities]

3.3.3.1 Therapy not relational enough

3.3.3.2 Wanted therapist to be more in tune

3.3.3.3 More Challenge wanted

3.3.3.4 Would have liked therapist perspective

3.3.3.5 Wanted more interaction

3.3.4 Wanting other additional treatment/links

3.3.4.1 Wanted to be nursed/rest in ward/" asylum"

3.4. Other unhelpful treatments

3.4.1 Other unhelpful therapy (non PCE)

3.4.1.1Unhelpful C.B.T

3.4.1.2 Unhelpful Psychodynamic Therapy

3.4.1.3 Unhelpful psychiatric treatment/consultation

3.4.2 Unhelpful medication

3.4.2.1 Reporting that medication led to suicidal feelings/risk

3.4.2.2 Withdrawal signs from anti-depressants

3.4.2.3 pressure to take meds from other professionals (not therapist)

C.2 Study 2 Categories and no of participant's responding

DOMAIN 1 CHANGES-MID/POST THERAPY	
Category	**No Reponses**
1.1.1 Positive Global Change	**16**
1.1.1.1 Positive global change noted by client	**16**
1.1.1.2 Positive global change noted by others/being more visible	**2**
1.1.2. Positive Internal/self-related changes	**16**
1.1.2.1 Reduction in specific problematic or unusual internal experiences (other than self-harm related experiences)	**15**
1.1.2.1.1 Reduction/improvement in unusual experiences	**9**
1.1.2.1.1.1 Hearing voices less/less hallucinations	**3**
1.1.2.1.1.2 Less frequent OCD issues/less problem re unusual/distressing thoughts	**4**
1.1.2.1.1.3 Feeling things are less unreal	**3**
1.1.2.1.2 Feeling less "mad"/weird/decreased self-stigma about unusual experiences-	**5**
1.1.2.1.3 Improved problematic mood/emotion states	**13**
1.1.2.1.3.1. Less depressed/happier	**4**
1.1.2.1.3.2. Less anxiety or stress/improved coping with anxiety/more relaxed	**4**
1.1.2.1.3.3 Feeling less shame	**1**
1.1.2.1.3.4 Better coping with/reduction in anger or agitation	**5**
1.1.2.2 Improvements in general experience of self	**16**
1.1.2.2.1 Improvements in evaluation of self	**8**
1.1.2.2.1.1 Increased self –confidence	**5**
1.1.2.2.1.2 Higher goals for self	**1**
1.1.2.2.1.3 More self-respect	**1**
1.1.2.2.1.4 More self-value/self- acceptance	**5**
1.1.2.2.2 Increased self-awareness/Extra depth	**10**
1.1.2.2.2.1 More mature	**1**
1.1.2.2.2.2 More connection with self	**9**
1.1.2.2.2.3 More connection with feeling	**2**
1.1.2.2.2.4 More visible to self	**1**
1.1.2.2.3 More in control of self	**2**
1.1.2.2.4 More patient with self	**1**
1.1.2.2.5 More solid/less fragile/Less vulnerable	**5**
1.1.2.2.6 Gaining hope/positivity	**2**
1.1.2.2.7 Increase in perspective	**6**
1.1.2.2.8 More able to deal with loss/trauma/issues	**2**
1.1.3 Increased positive external connection	**16**
1.1.3.1 Increased positive connection to External World (excluding harmful action to self/others	**16**
1.1.3.1.1 Increase in coping abilities	**7**
1.1.3.1.1.1 Improved global coping	**4**
1.1.3.1.1.2 Improved self-care	**4**
1.1.3.1.1.2.1 Improved personal hygiene	**1**
1.1.3.1.1.3 Improvement in lifestyle (healthier emotionally/overall)	**1**
1.1.3.1.1.4 Getting out more/more able to travel	**2**
1.1.3.1.1.5 Better coping with voices/hallucinations	**2**
1.1.3.1.2 Improved ability to access to resources/services for support	**1**
1.1.3.1.3 Educational achievement	**4**
1.1.3.1.4 More able to work	**1**
1.1.3.2 Improvement in Interpersonal connections	**11**
1.1.3.2.1 Less difficulties/conflict with others/Treating others with more respect/judge others less	**3**

1.1.3.2.2 Interpersonal improvement with specific groups	**9**
1.1.3.2.2.1 Improvement in Interpersonal connections with friends	**1**
1.1.3.2.2.2 Improvement in Interpersonal connections with family	**4**
1.1.3.2.2.3 Improvement in Interpersonal connections with intimate others	**4**
1.1.3.2.3 More social connections (quantity)	**2**
1.1.3.2.4 More able to test self (in being in company of feared gender)	**1**
1.1.3.3 Improvement in interpersonal abilities	**7**
1.1.3.3.1 Greater ability to be with/connect/trust others	**6**
1.1.3.3.2 Greater ability to set appropriate boundaries with others	**1**
1.1.3.3.3 More able to complain/be assertive	**5**
1.1.3.3.4 Better able to talk/express and share oneself	**2**
1.1.3.3.5 More able to ask for help/depend on others	**2**
1.1.4 Reduction in Risky Experiences/Behaviours	**8**
1.1.4.1 Reduction in Internal sources of risky behaviours	**5**
1.1.4.1.1 Fewer/less intense suicidal ideas, self -harm (thoughts)/ideas of harming others	**3**
1.1.4.1.3 Increased reflection on potentially risky lifestyle	**3**
1.1.4.1.3.1 Got out of toxic relationship	**2**
1.1.4.2 Reduction in external risky behaviours	**4**
1.1.4.2.1 Less harm to self or others (behaviour)	2+
1.1.4.2.2 Reduction in risky life-style/behaviours/actions	**2**
1.1.5 Physiological improvement	**3**
1.1.5.1 More energy	**3**
1.2 Negative (post-therapy), deterioration, getting worse	**5**
1.2.1 Negative Global Change: Things got worse/felt worse	**3**
1.2.2 Negative Specific Change	**4**
1.2.2.1 Temporarily lost faith in PCT approach	**1**
1.2.2.2 Less close to intimate partner	**1**
1.2.2.3 More suspicious	**1**
1.2.2.4 Increased ruminations	**1**
1.3. No change/missing changes	**4**
1.3.1 Client wanted to be one hundred percent better	**2**
1.3.2. Client wanted change to be faster	**2**

DOMAIN 2.0. HELPFUL ASPECTS	
Category	**No Reponses**
2.1 Helpful client contributions (outside of therapy or brought into therapy)	**17**
2.1.1 Helpful client personal attributes	**12**
2.1.1.1 Laid back attitude/flexible	**2**
2.1.1.2 Being self-reflective/ Self- aware/self -processing	**3**
2.1.1.3 Helpful Beliefs and philosophies	**1**
2.1.1.4 Taking responsibility and being real/open/mature	**2**
2.1.1.5 Perseverance/determination	**6**
2.1.1.6 Fear helped client to use therapy	**1**
2.1.1.7 Client stable/ready for therapy/change	**2**
2.1.1.8 Client able to transform negatives into positives	**1**
2.1.2 Helpful self-initiated self-help/coping activities or strategies	**8**
2.1.3 Helpful client circumstances/situation (situational resources)	**8**
2.1.3.1 Helpful others (friends)	**1**
2.1.3.2 Helpful others (family)	**3**
2.1.3.3 Helpful others (intimates)	**1**
2.1.3.4 Increased links to wider community including people/work/support networks	**3**
2.1.3.5 Awareness of /or access to resources/finances/housing	**2**
2.2. Helpful Therapy contributions	**15**
2.2.1 Helpful contextual therapeutic parameters	**7**

2.2.1.1 (General) Therapist perceived as similar cultural origin/age as client	2
2.2.1.1.1 Therapist had perceived similarities with client	1
2.2.1.1.2 Therapist disclosed personal experience of voices/hallucinations/delusions etc	1
2.2.1.2 Holding professional boundaries	1
2.2.1.3 Helpful use of space, room, setting	1
2.2.1.4 Helpful use of time, organisation of sessions	3
2.2.2 Helpful In-session/Therapy Processes	15
2.2.2.1 Therapy Global helpfulness/helpful relational atmosphere/global quality of relationship	4
2.2.2.2 Positive Relational Aspects	9
2.2.2.2.1 Strong therapeutic alliance perceived by client	1
2.2.2.2.2 Therapist warm	1
2.2.2.2.3 Therapist sympathetic	7
2.2.2.2.4 Therapist non- judgemental/accepting	4
2.2.2.2.4.1 Therapist accepting client	4
2.2.2.2.4.2 Therapist not labelling or pathologising client	2
2.2.2.2.4.3 Therapist not interpretative	1
2.2.2.5. Positive Therapist in-session qualities	7
2.2.2.5.1. Therapist caring/valued me	3
2.2.2.5.2 Therapist attentive/very present/sensitive	2
2.2.2.5.3 Therapist real/authentic/genuine	3
2.2.2.5.4 Therapist commitment/positive attitude	3
2.2.2.5.5 Therapist empathic	1
2.2.2.6 Helpful therapist Actions {non-verbal}	10
2.2.2.6.1. Helpful physical contact	1
2.2.2.6.2 Therapist flow/rhythm helpful	1
2.2.2.6.3 Therapist helpfully challenges client [allowing]	1
2.2.2.6.4 Strong patience of therapist	1
2.2.2.6.5 Therapist not pressurising {Tracking client]	4
2.2.2.6.6 Reflections helpful	1
2.2.2.6.7 Being listened to helpful	1
[Motivating action]	
2.2.2.6.8 Motivated me/ positive insisting of therapist	2
2.2.2.6.9. Helpful therapist referral of client to other resources	1
2.2.2.7 Therapist open to creative, symbolic process	3
2.2.2.7.1 Therapist uses/echoes analogies, metaphors	1
2.2.2.7.2 Therapist creative	1
2.2.2.8 Positive client in-session actions	2
2.2.2.8.1 Able to talk /talk about stuff that client couldn't discuss with friends	1
2.2.2.8.2. Able to talk about traumatic/difficult experiences	1
2.2.3. Positive Immediate Within-therapy Effects	8
2.2.3.1 Feeling understood /being taken seriously	2
2.2.3.2 Stress or anxiety relief/able to vent/ better coping with stress	4
2.3 Other helpful treatments/other helpful therapy (non PCE)	3
2.3.1 Helpful CBT	2
2.3.2 Helpful dream work	1
2.3.3 Helpful groupwork	1
2.4 Difficult/painful but ok/helpful aspects of therapy	10

DOMAIN 3. UNHELPFUL ASPECTS	
Category	No Reponses
3.1. Client Negative Contributions (interfering factors)	12
3.1.1 Client personal attributes with negative effect	8
3.1.1.1 Worry/fear	2

3.1.1.2 Client lacks perspective/overthinking/thinking issues	2
3.1.1.3 Client is over- confident	1
3.1.1.4 Client finds it hard to trust/achieve safety with others	1
3.1.1.5 Guilt	2
3.1.1.6 Suicidal feeling as barrier	1
3.1.1.7 Seeking unnecessary resources	1
3.1.1.8 Self harm-physical and emotional	2
3.1.2 Unhelpful Client circumstances/situation/others	7
3.1.2.1 Global Life stresses	1
3.1.2.2 Unhelpful friends/ Friends don't understand/Pressure from friends	3
3.1.2.3 Not getting on with family/unsupportive family	2
3.1.2.4 Unsupportive others/lack of supportive others (generally)	3
3.1.2.5 Stressful job	1
3.1.2.6 Poor standard of housing/accommodation	1
3.1.2.7 Finances and inflation	1
3.2 Unwanted/unhelpful Therapist contributions	7
3.2.1 Unhelpful Contextual therapeutic parameters (e.g. room, spacing, timing, service)	2
3.2.2 Unhelpful In-session/Therapy Processes	5
3.2.2.1 Global unhelpfulness	1
3.2.2.2 Negative Relational atmosphere (global quality of relationship)	1
3.2.2.2.1 Deteriorating relationship	1
3.2.2.3 Unhelpful therapist in-session Qualities	1
3.2.2.4 Unhelpful/unwanted therapist Actions	4
3.2.2.4.1 Therapist negative actions	2
3.2.2.4.1.1 Therapist Judged client	1
3.2.2.4.1.2 Therapist verbally attacked/criticized client	1
3.2.2.4.2 Unwanted therapist directivity	4
3.2.2.4.2.1 Therapist focused on and overemphasised emotions	1
3.2.2.4.2.2 Therapist pushing client to access feelings that client did not want to connect with	1
3.2.2.4.2.3 Pressure from therapist for client to conform to expected therapy outcomes	2
3.2.2.4.2.4 Therapist stated the obvious	1
3.2.2.4.2.5 Therapist initiated unwanted directive technique	1
3.2.2.4.2.5.1 Therapist initiated unhelpful "stonework"	1
3.2.2.4.2.6.1 Therapist exerts power	1
3.2.3 Unhelpful Immediate Within-therapy Negative Effects	1
3.3 Missing aspects/processes of Therapy	6
3.3.1 Missing information about therapy	3
3.3.1.1 Wanting to be informed of therapist modality (without asking)	1
3.3.1.2 Wanting therapy qualifications/credentials and teamwork with therapist	1
3.3.1.3 Wanted signposting re resources	2
3.3.1.4 Wanted details to contact therapist directly after ending if needing further sessions	2
3.3.2 Wanted structure/goals/progress tracking	3
3.3.2.1 Wanted structure or plan	2
3.3.2.2 Wanted format to disclose progress/deterioration or therapist to check progress	2
3.3.3. Missing relational qualities	2
3.3.3.1 Therapy not relational enough	2
3.3.3.2 Wanted therapist to be more in tune	1
3.3.3.3 More Challenge wanted	1
3.3.3.4 Would have liked therapist perspective	1
3.3.3.5 Wanted more interaction	1
3.3.4 Wanting other additional treatment/links	1
3.3.4.1 Wanted to be nursed/rest in ward/ "asylum"	1
3.4. Other unhelpful treatments	7

3.4.1 Other unhelpful therapy (non PCEP)	**4**
3.4.1.1 Unhelpful C.B.T	**2**
3.4.1.2 Unhelpful Psychodynamic Therapy	**2**
3.4.1.3 Unhelpful psychiatric treatment/consultation	**1**
3.4.2 Unhelpful medication	**4**
3.4.2.1 Reporting that medication led to suicidal feelings/risk	**1**
3.4.2.2 Withdrawal signs from anti-depressants	**2**
3.4.2.3 Pressure to take meds from other professionals (not therapist)	**1**

C.3 Study 2 Rated changes only

<u>Changes specifically listed and rated by 17 CLIENTS</u>

Qualitative data *including* these listed changes (below) was included in the final full analysis

97 changes were named and numerically rated by 17 clients as per the standard change interview protocol.73 of these changes were rated by the participant as somewhat unlikely or very unlikely without the therapy. Therefore 75% of the specifically rated changes rated as very or somewhat without the therapy

Change	<u>Change was</u>: 1 - <u>expected</u> 3 - neither 5 - <u>surprising</u>	<u>Without therapy</u>: 1 - unlikely 3 - neither 5 - likely	<u>Importance</u>: 1-not at all 2-slightly 3-moderately 4-very 5-extremely
C1(1) Change in thinking	1 2 3 <u>4</u> 5	<u>1</u> 2 3 4 5	1 2 3 4 <u>5</u>
C1(2) Getting out more	1 <u>2</u> 3 4 5	1 <u>2</u> 3 4 5	1 2 3 4 <u>5</u>
C1(3) Feeling things were more real	1 2 3 4 <u>5</u>	<u>1</u> 2 3 4 5	1 2 3 4 <u>5</u>
C1(4) Meeting people (coping better with)	1 <u>2</u> 3 4 5	1 2 <u>3</u> 4 5	1 2 3 <u>4</u> 5
C1(5) Getting out of the city I live in	<u>1</u> 2 3 4 5	<u>1</u> 2 3 4 5	1 2 3 4 <u>5</u>
C1 (6) More in control	<u>1</u> 2 3 4 5	<u>1</u> 2 3 4 5	1 2 3 4 <u>5</u>
C2.(1)Being helped through issues	<u>1</u> 2 3 4 5	1 2 3 <u>4</u> 5	1 2 3 4 <u>5</u>
C2.(2) More objectivity/perspective	1 <u>2</u> 3 4 5	1 <u>2</u> 3 4 5	1 2 3 <u>4</u> 5

C3 (1.)Less agitated	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
C3 (2). Less depressed	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
C3 (3). New relationship	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
C4(1).Healthier relationship with partner	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
C4 (2).Finished degree	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
C4(3). OCD-less frequent occurrence of	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
C4 (4). More friends	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
C4(5).Move on quickly with conflict	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
C4(6).Loss impacting less on me	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
C4(7).Feeling more secure	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
C4(9).Less angry with difficult incidents	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
C4(10). Personal Hygiene and presentation improved. More self- awareness, perspective?	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
C5(1).Done a college course	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
C5(2). Going out with people	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5

C5(3). Got a boyfriend	1 2 3 4 **5**	**1** 2 3 4 5	1 2 3 4 **5**
C5(4). Positive relationships	1 2 3 4 **5**	1 2 **3** 4 5	1 2 3 4 **5**
C5(5). Hope	1 2 3 4 **5**	**1** 2 3 4 5	1 2 3 4 **5**
C5(6). Permission to be myself	1 2 **3** 4 5	**1** 2 3 4 5	1 2 3 **4** 5
C5(7). Other people commented	1 2 3 4 **5**	**1** 2 3 4 5	1 2 3 4 **5**
C6 (1). Less build up of anger	**1** 2 3 4 5	**1** 2 3 4 5	1 2 **3** 4 5
C6(2). More assertive	1 2 **3** 4 5	1 2 3 4 **5**	1 **2** 3 4 5
C6(3). More tolerant	1 2 3 4 **5**	1 2 **3** 4 5	1 2 3 **4** 5
C6(4). Better relationship with mum (last column not rated)	1 2 3 4 **5**	**1** 2 3 4 5	1 2 3 4 5
C6 (5).Translating therapy into life	1 2 3 4 **5**	**1** 2 3 4 5	1 2 3 4 **5**
C6 (6).Feeling less weird/less different and more self accepting	1 2 **3** 4 5	1 2 **3** 4 5	1 2 3 4 **5**
C6 (7). Being valued and self valuing	1 2 3 4 **5**	**1** 2 3 4 5	1 2 3 4 **5**
C6 (8). Easier to relax C6 (9). Focusing on what I can do/want to do instead of what's wrong	**1** 2 3 4 5 **1** 2 3 4 5	**1** 2 3 4 5 1 2 **3** 4 5	1 2 3 4 **5** 1 2 3 4 **5**

C6 (10). More able to build relationships	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
C6(11). Developing appropriate boundaries	1 2 3 4 5	1 2 3 4 5	1 2 3 4.5 5
C7 (1.) Trust in others e.g. therapist	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
C7(2). Less suicidal	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
C7 (3). Stopped washing in bleach and now feeling less contaminated/dirty	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
C8A(1.)Shift in perspective	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
C8A(2.) More able to unpick things in environment (taking things less personally)	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
C8 A(3).Feeling my problems were bigger?-listen	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
C8(4). Less unusual thoughts?-listen	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
C8B(1).Therapy kept me alive	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
C8B(2). Enhanced understanding of human experience	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
C8B(3?). Feeling wanted	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
C9B(1).Strong sense of self	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
C9B(2). Increased confidence in what I already know	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
C9B(3?). Increased reflection re voices and greater sense of reality	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
C10(1).Became a lot more aware of what I wanted	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5

C10(2). More able to express my needs	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
C10(3).Felt less depressed-(used to be so low I was off work-enormous change)	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
C10(4). Valuing myself-can spend time and money on me	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
C10(5).Very Scary Stuff in peripheral vision went away	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
C10(6). Normalizing unusual experiences	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
C10(7). Feeling less mad	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
C10(8). Became a lot les judgmental of myself and others	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
C10(9). More able to ask others for help and less need to be totally independent	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
C10(10). I express myself more	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
C10(11).I learnt to say sorry	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
C10(12). I became more humble	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
C12(1).Became more assertive in personal relationship	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
C12 (2). More in control of emotions	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5

C12(3).Able to complete an educational course	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
C12 (4). Stronger as a person in identity and more self confident	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
C12 (5).I became more fully me-I'd never been me	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
13A(1).Shifted perspective re parents/more realistic perspective	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
13A(2). I felt like I was waking up	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
13B(2.) Behaviour changed dramatically for the better/more controlled/better decisions	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
13B (3).I know myself better	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
13B(4) Looked after self and respected self more	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
C14(1.)Voices became very much less frequent/hearing less voices/voices became very rare	1 2 3 4 5	1.5 2 3 4 5	1 2 3 4 5
C14(2.) Became connected to self (expectation not rated)	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
C14(3).Ending a toxic relationship	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
C14(4). Feeling less ashamed	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
C14(5).Achieve Greater confidence	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5

C14(6). Becoming more visible	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
C14(9). Valuing own qualities	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
C17(1) Increase in confidence	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
C17(2) More able to travel locally and longer distances	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
C17(3) More able to go shopping	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
C17(4) Able to go to concert and busy places alone	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
C18(1) Counselling helped me to talk more	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
C18(2) Counselling has reassured me re the nature of my voice	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
C18(3) More confident to go out(voices can affect ability to go out)	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
C18(4) Able to go to the gym C18	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
C19(1) Easier to deal with things (when having someone to talk to)	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
C 20 (1) More energy	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5

C20 (2) Better talking	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
C20(3) Different attitude towards third (people other than therapist)	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5

D Study 3 HSCED documents

D.1 Rich Case Record

Person-Centred Therapy (PCT) for Psychotic Process: The Case of Becky

Rich Case Record

Compiled by Wendy Traynor; audited by Robert Elliott.

1. Context

The American Psychiatric Association (2013) outlines the diagnostic description of psychosis: Symptoms may involve having unusual thoughts, perceptions or experiences such as hearing voices or paranoid ideas. Such processes are not always problematic but for many people can cause distress and severe difficulties. "Psychotic process" is a description from a person-centred and experiential therapeutic perspective of a psychological condition. This can impact on all aspects of a person's functioning and in particular the ability to be in psychological contact with others or to hold narratives regarding their experiences which make sense in a cultural context (Warner, 2001, p.90-91); part of this, there may be impaired contact with "Self, World and Other" (Prouty, 1990 p 645-58).

The National Institute of Clinical Excellence (NICE) guidelines for schizophrenia (2009) were current at the time of this case study and were updated in 2014; both prescribe cognitive behavioural therapy (CBT) and psychotropic medication as the recommended, evidence based interventions for psychosis in adults. Neither recommend supportive psychotherapy unless it is a specific patient choice. The client in this case study, who was referred to person-centred psychotherapy by her family, was therefore, in accordance to such guidelines and in negotiation with the client (referred to here as "Becky") additionally referred to the early intervention in psychosis team to be potentially offered CBT as a choice. She was offered PCT prior to full engagement with the EIP team (which took several months from referral to engagement).

The researcher-interviewer (who was a colleague of the therapist) conducted the Client Change Interview (Elliott, Slatick & Urman, 2006) and administered the Positive and Negative Syndrome Scale (PANSS); Kay, Fiszbein and Opler,1987). The researcher-interviewer had been trained by the therapist-researcher to conduct the Client Change interview and by a NHS hospital based early intervention team to conduct the PANSS, according to the United Kingdom First Episode Research Network (FERN) research protocols.

The therapist-researcher author was a person-centred-experiential therapist with a Diploma in person-centred counselling who completed an advanced person-centred theory training, a one year certificate in clinical mental health focused on working with people with enduring and long term mental health issues including therapeutic, psycho-social and pharmacological treatment perspectives. She also held a Child and Adolescent Mental Health (CAMHS) Diploma and was undertaking a PhD in Counselling as well as other training. She worked within the British Association for Counselling and Psychotherapy Ethical framework (2010) and supervised by a

person-centred clinical supervisor. She had over twenty years of clinical practitioner experience. Therapy delivered was informed by training and intervention style set out by Tolan (2003)

2. Background and course of treatment

Becky (not her real name), aged nineteen, was referred to therapy at a voluntary sector agency by her parents, and received twenty-two sessions of person-centred therapy (Brodley, 2006; Tolan, 2003) from the author, who is a qualified and experienced person-centred therapist. (See Timeline for summary of main events of the client's life and care during the therapy period and afterwards.)

Becky lived with her parents. She was in employment at the start of the therapy and experienced some periods of employment and some periods of unemployment throughout the therapy. Becky had recently lost a sibling through suicide. The referral form said that Becky experienced suicidal ideas and at assessment she stated that she sometimes wished that she was dead. She had also experienced another traumatic personal loss and was experiencing panic attacks. She had used some ecstasy and cannabis when she was younger; more recently, prior to the therapy, she had used "legal highs". However, since her sibling's death, she reported no recent or current use. After her sibling's suicide Becky reported feelings of unreality, including feeling outside of herself, not feeling "in reality", that her voice was not hers, and that she was not real.

Becky presented to the PCT therapist over the first sessions with hearing voices, noises and experiencing unusual perceptions of reality. She met the criteria for psychosis according to Diagnostic Statistical Manual (DSM-IV). Becky was experiencing anxiety and sleep difficulties. She experienced unwanted thoughts and was scared of acting on these; specifically, she sometimes considered taking her own life and also reported that she was frightened that she might hurt others, although there was no evidence of risk of acting on this. She was not taking any medication at assessment.

The PCT therapist felt there were potentially gaps in her care package and supported the client in accessing other services and making choices regarding her treatment. Specifically, NICE guidelines for possible psychosis required referral to the Early Intervention in Psychosis (EIP) team. The referrals took some weeks to be processed. The therapist communicated with the client's general practitioner (GP), who referred her to primary care mental health service. On commencement of the PCT therapy and in dialogue with Becky regarding her overall treatment, the therapist referred her to the Early Intervention in Psychosis (EIP) team. The referral was for possible psychiatric consultation, family intervention, and Cognitive Behavioural Therapy (as indicated in the guidelines). The referral was acknowledged at week ten of the PCT.

Becky was eventually assessed and offered directive interventions by the EIP team, but chose to continue to use the therapy in order "to vent feelings and to explore other areas". However, she did not regularly engage with the EIP team until after twenty sessions of PCT were completed. She engaged with the EIP team during one

of her periods of unemployment when she expressed the view that engagement with the EIP team was easier for her.

Multiple measures were applied to create a rich and comprehensive body of client data. The intent was to give a full a picture of the client's situation coming to therapy, the process during therapy and the situation at the end of therapy. Quantitative and qualitative measures were used to indicate how much the client changed over the course of therapy (quantitative) and which psychological processes and factors were involved in this change (qualitative).

The data to be presented were gathered through completion of various measures by the client over the course of the 22 therapy sessions, as well as a Change Interview conducted at the end of therapy. The measures used were the positive and negative syndrome scale (PANSS) (Kay, Fiszbein and Opler ,1987), CORE-10 (weekly), CORE-34 (week 5 and then every 5th week instead of CORE-10) from the CORE system (Connoll and Barkham,2007), Therapeutic Relationship Scale (TRS) every session from week 5 (therapist and client versions) (Carrick & Elliott, 2013), Helpful Aspects of therapy (HAT; Llewelyn, 1988) every session, Change Interview (Elliott, Slatick & Urman, 2006), and Therapist Process Notes (following each session).

The PANSS established the severity of "presenting symptoms" in terms of the medical definition of psychosis (DSM IV _R at the time of the therapy). Unfortunately, it was not possible to carry out a post treatment PANSS prior to Becky moving onto directive interventions with the EIP team, because during the weeks after she commenced the EIP support she reported that focusing on herself (such as in the PANSS) could be dysregulating; the researcher therefore deemed it unethical to proceed.

3. Outcome Data

The research protocol required clients to complete a battery of measures prior to, during and post-therapy. The measures used were the Positive and Negative Syndrome Scales (PANSS), CORE-OM/CORE-10, and Change Interview. CORE outcome data are summarized in Table 1 and Figure 1. During the early stages of PCT there appeared to be no marked change in what might be regarded by the medical model as psychotic process; however, the client's ability to cope, normalise and self-accept, self soothe and other areas were noted by the client as qualitative changes during this period of contact. Her PANSS data was complete only through session 7, and showed no change, with continued presence of psychosis.

Quantitative Outcome Data

Table 1: Client Outcome Measures: CORE-34/Core-10

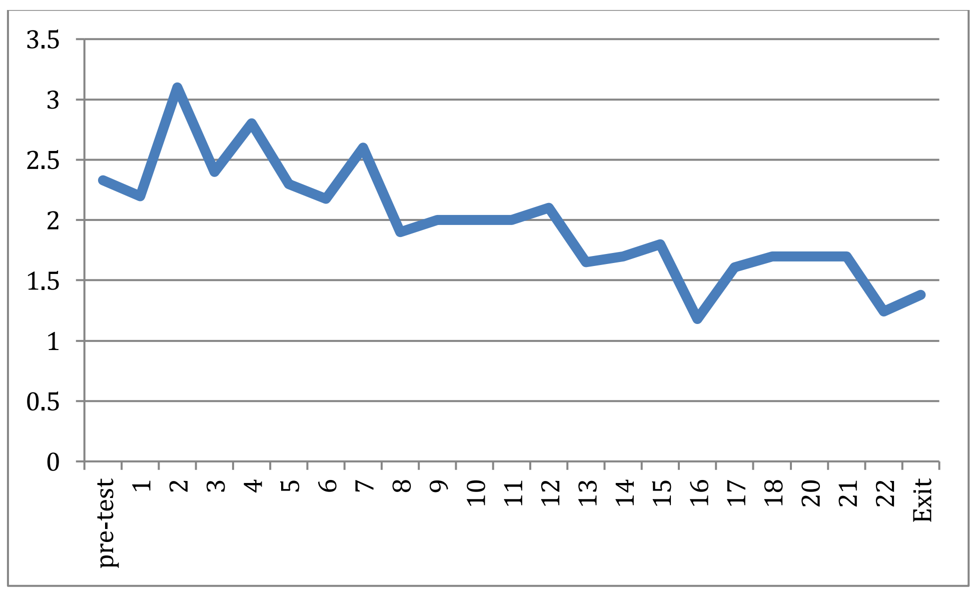
	Cut-off	RCI Mini-mum	Screen-ing	Session 7	Session 12	Session 22
CORE-34/ CORE-10	<1.00	.5 (↓)	**2.33 (mode-rate)**	**2.6 (severe)**	**2.1 (mode-rate)**	**1.24** (mild)**

*p<.2; **p<.05

Becky's combined mean CORE-34 and CORE-10 scores showed a marked decrease from 2.33 to 1.24, indicating that she showed reliable change but did not cross the clinical cut-off.

Questions common to both CORE-34 and CORE-10 (a shortened version of CORE-34) showed high scores (which diminished markedly from severe to moderate or lower) in areas including experiencing panic or terror, difficulty getting to or staying asleep, and unwanted memories or images causing distress. These were patient symptoms reported "over the last week".

Figure 1: Weekly Mean Outcome on CORE-10 and corresponding 10 questions on the CORE-34



Qualitative Outcome Data

The change interview was conducted by a practitioner researcher who was not the therapist. Changes noted are summarised in the table below where the client described their perceptions of changes and rates these according to the categories identified in the measure. The unrated changes at the lower part of the table refer to changes which were discussed in other answers in addition to the questions which asked the client to rate changes

Table 2. Becky's Post Therapy Qualitative Changes

Change	How expected/surprising change was	How unlikely change would have happened without therapy.	Importance of change
1.Feeling things are more real	Very much surprised	Very unlikely	Very important
2.Getting out more (locally)	Very much surprised	Very unlikely	Extremely important
3.Meeting people	Somewhat expected	Neither likely/unlikely	Very important
4.Getting out of the city I live in	Very much surprised	Very unlikely	Extremely important

During the process of the change interview Becky described further changes which were not rated. These changes were (in her own words): being more in control, coping better in general, coping better with anxiety, getting on with stuff more with less dwelling on the bad stuff, coping better with being around people and coping better with talking to people.

Becky described her experiences of struggling with her sense of reality as follows

(B): And before I didn't feel like stuff was real, and I do feel like stuff is a bit more real now (R: Would you say that's around things that are happening are not real?) *I thought my whole life wasn't real, that it was in my head. I still do think that a bit but it's not as strong as it was which is like good* 1.1/13

Becky described her perception of changing.

"Stuff has just changed a tiny bit.

I do think it's improving me. I think it helps." 1.1/31a

She also expanded on her increased ability to go out as the therapy progressed.

B: Getting out of the city (named)—like I never used to be able to go—I went to the caravan the other weekend 1.1/56

4. Change Process Data

Two kinds of change process data were collected, from the Change Interview and from the Helpful Aspects of Therapy (HAT) Form.

Client Change Interview Data

The data in Table 3 was obtained from Becky's responses to the questions in the Change Interview and complement the quantitative data from this measure. Becky gave ratings for changes experienced in Table 2 as well as the qualitative descriptions below. The data in Table 3 show different helpful aspects of the therapy as expressed by Becky. The main findings included Becky's perception of being able to "vent" difficult or painful feelings in an atmosphere where she felt understood as well as other factors.

Table 3. Helpful Therapy Factors

1.0. Factors within the therapy

1.1. Immediate effects:
1.1.1. Feeling very understood (even when not clear): T [Therapist] just GETS me, completely, even when I say something and I think she probably won't understand she says the same thing in the proper way—THAT really helped (1.1/31a) It feels REALLY helpful because if you ever explain to someone and they say they know what you mean and they will just say something and they've not felt like that at all but T really gets it (1.1/31b)
2. De-stressing I'm leaving the stress here, relieving it (R: and relieve –did you say stress?) Yes—stress and problems (1.1/20 to 1.1/22b)
1.2. Relational atmosphere
1.2.1. Valued opportunity to talk/vent about issues: Being able to talk about stuff that I wouldn't be able to talk about with family and friends. (1.1/2) / I just don't think they'd [family and friends] take me seriously-yeh (1.1/3) Coming here and being able to vent about stuff is good cause it's not all inside then.1.122a When I come here I can vent it, I don't have to think about it in my head and I'm getting it out sort of 1.1/26a
1.3. Processes:
1.3.1. Therapist actions:
1.3.1.1. Multi-disciplinary referral: I think like T, what's the word? –like—told the early intervention team about me and just getting help like that –that was a big change really as I realised that they can help you and stuff. 1/23b Knowing that there was support for stuff like that.1/23a
2. Personal/Situational Attributes/Resources That Have Helped Becky to Use Therapy
2.1. Laid back/not obsessed I'm sort of laid back so I don't take stuff seriously—1.1/24 Yeh like not getting too obsessed with it—trying to—I dunno I think if I'm on my own I can be like—I can use that not to get too obsessed with it on your own cos you're alive 1.1/25-1.126a
2.2. Helpful life situation changes My job was a bit stressful but I've left it now 1.126c
3. Difficult but Potentially Beneficial Processes (Within and Outwith therapy)

3.1. Talking about painful experiences Like yeh---in the beginning talking about my "sibling" and also that was horrible but it helped at the time. 1.1/33 At first it was like difficult to just open up really about all the stuff that's gone on in the past two years that's like that I've just really kept to myself and that's it really –just opening up about stuff I hadn't told anyone about 1.1/34
4. Helpful Aspects of Taking Part in Research
4.1. (Client) Being asked questions about experiences 1.1/35 (Client) I prefer just getting questions sometimes and answering them. I think in therapy normally I might forget to say certain things but if you ask me a question I'll remember it. / (So it's a bit of a –I've forgotten the word (laughs) –a reminder) / Yeh—laughs. /It's been ok 1.1/36

Table 4 shows Becky's descriptions of unhelpful factors of therapy which were associated with factors outside of the therapy such as her tendency to worry, lack of family support and the negative impact of medication.

Table 4. Unhelpful factors (re client's attributes, unhelpful others and context outside of therapy)

1. Unhelpful client attributes Being a worrier. / Worry about stuff that is physically wrong with me –like I'm dying—that's probably the main thing. / Yeh physical—yeh—like that I'm dying (client laughs) / I always think there's something wrong with me. 1.1/28a to 1.1/29d
2. Unhelpful others **2.1. Difficult responses from family/not feeling supported/ understood** My mum, not getting on with her—she doesn't want to know sort of so that's not good. / Just feeling ignored by my mum and dad really. / Yeh -they just don't get it at all—that does my head in 1.1/27a to c I just don't think they'd [family and friends] take me seriously-yeh 1.1/3
2.2. Difficult issues with friends When my friends say they wanna go to "a music festival" next year and I don't really want to go—I wanna go but I don't feel like I can go—they don't understand and they say that they want to do something and I say I can't do that and they say "don't be stupid" or are horrible and that like—makes it harder. / Cause they don't understand but they could just say "alright"—not PUSH it. / 'Cause it's like 5 days and ages ago I wouldn't be bothered but because it's 5 days I'd think –I'd be drinking and stuff—and drink because like—I want to drink to get back to normal –but the next day when I've got a hangover I convince myself that I'm going to die and I don't think I could have any fun if I thought that every

day like that’s what it’d be like really and I’d start worrying about not being able to get enough sleep—just worrying about everything and being like a nervous mess 1.129a to 1.1/30c
3. **Unhelpful treatments:** I was on Cipralax and Prozac. They made me feel worse, suicidal so I just had to stop. I had really bad withdrawal symptoms from them as well so I thought, “There’s no point in going on anything else”. 1.1/4 to 1.1/5
3. Processes client had hoped for that were absent **3.1. Incomplete improvement** Like I want---I didn’t expect. I wanted though to be a hundred percent better. / I didn’t expect it to be that quick. / (R: So you wanted things to change faster but it hasn’t but you recognise there has been a little bit of change) Yeh 1.1/15 to 1.1/18
4. Unhelpful Therapy Processes **4.1. Nothing hindering:** There’s nothing hindering about it 1.1/32

Helpful Aspects of Therapy (HAT) data

Becky completed the Helpful Aspects of Therapy Form (version 3.2, 2006) Lewellyn, 1988) each week from week 5 (Table 5) describing what aspects had been helpful or hindering. No hindering events were named. Helpful aspects described by Becky included examples such as expressing emotions such as crying (twice) and in one instance that “crying made me feel more real”, “expressing how I feel as it’s the only time I can”, “venting” and “getting it all out”, “being understood”, “getting stress out”.

Table 5. Client Post-session descriptions of helpful events

Session	Helpful Aspect/What made it helpful/describe event briefly 1/2/3	Helpfulness Rating (question 3/6)
S5	Talking about my brother/felt released some sadness. Feel a bit relieved (towards end of session)/. Just talking about things that really scare me.	7.5 Moderately to greatly helpful Greatly helpful
S7	Crying /made me feel more real / My therapist’s understanding	6 (slightly helpful) Greatly helpful
S8	Just talking and letting things out. /Just talking letting things out (repeated statement) All of it was helpful	8 Greatly helpful) Greatly helpful

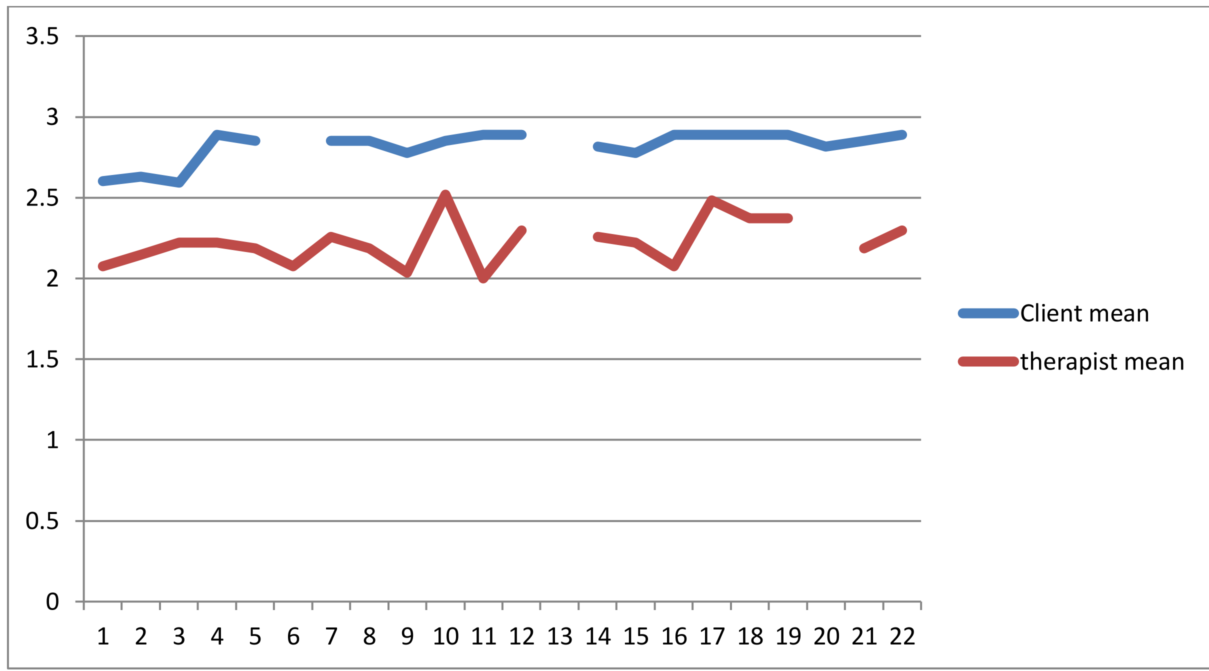
S9	Just generally talking. / Just made me feel bet	7 (moderately helpful)
S10	Talking about loss. / Crying-letting it all out Just talking in general	8(Greatly helpful) Greatly helpful
S11	Just talking. / Getting stress out	7(Moderately helpful)
S12	Talking. / Just letting it all out	7(Moderately helpful)
S13	Generally letting everything out. / Feeling some relief	8(Greatly helpful)
S14	General catch up. / Getting things out	9(extremely helpful)
S15	Generally talking about what's being going on. / Bit of release All over really	8 (greatly helpful)
S16	Expressing how I felt. / Because it's the only time I can	8 (Greatly helpful)
S17	Venting. / Relief	9 (Extremely helpful)
S18	Painting and talking. / It was relaxing	8 (Greatly helpful)
S20	Talking, my therapist "getting" me. / Just because no one really does	8 (Greatly helpful)
S21	I enjoyed painting and Listening to music. / It was nice to "chill out" Generally talking	9 (extremely helpful) Extremely helpful

Therapeutic Relationship Scale (TRS) quantitative change

Sanders and Freire (2008) developed the Therapeutic Relationship Scale (TRS). This instrument aims to capture the client's and therapist's experience of the quality of their relationship, with specific focus on the core conditions of empathy, unconditional positive regard and congruence, the client's experience of deference, and therapist's directivity. The pilot version of the TRS comprises 27 items which focus on these dimensions: Empathy, Acceptance, Warmth, Collaboration/Partnership, Trust/Feeling Safe, Genuineness, Dynamics of power, and Self-disclosure.

The client and therapist versions of the TRS data were compared. This data was gathered during most sessions with some omissions for clinical reasons. Table 6 shows how the client's estimation of alliance is consistently higher than the therapists but both the therapist and client consistently rated the elements of alliance as positive. For question 24 the client's score showed that they consistently rated their satisfaction with the way that they and the therapist were working together with the maximum score (3) on each session apart from one (2).

Table 6



Summary of therapy processes

During the period of therapy, I saw an increase in Becky's ability to cope on a day to day basis but continued psychotic material and suicidal ideas at times during the early sessions. Her ability to be with others, cope, normalise, self-accept and self-sooth as well as other areas were reported to the therapist as changes during the period of contact.

Becky's Timeline

This is a schedule and description of Becky's therapy. Following referral to the service where the therapy took place (known as "site 1") Becky was offered screening

Screening

An initial service assessment and introduction took place less than three weeks after referral. Becky had recently been on holiday then was referred to the counselling service after becoming emotionally unwell. Measures were given as per protocol with some variation if the client was less able. Becky discussed the research and therapy with the therapist and was happy to participate.

Initial themes of focus included family issues. Becky discussed a difficult romantic relationship as well as exploring multiple loss issues. Becky had experienced the traumatic loss of sibling (six months prior to the first therapy session) as well as other traumatic loss. She reported feeling out of her body and discussed what she thought was depersonalisation

Session 1

In this session, Becky raised themes of coping and conflict. We also discussed what therapy involved.

Session 2

Becky discussed her fantasies regarding her being dead but stated that she had no actual plans to kill herself. Support options, coping and emergency resources were discussed. She described feelings of grief for what she had lost in terms of her well-being. She discussed her feeling of self- hatred and not feeling herself but said that she was going through the motions and not feeling real. She wondered if she could control the future and if she was real. She talked about her sibling's death through suicide and the emotional pain of this for her. There were thoughts around "what if" things had been different and how his death could have been prevented and reflections regarding how events unfolded. She also discussed family dynamics and how hard it was to talk to family about how she really felt as they stated the fear that she also may take her own life. She regretted not speaking to her sibling more before his death. She explored how much she loved her sibling.

Session 3

During this session I confirmed with Becky that the referral from her GP to the psychiatrist was in place and discussed possible EIP referral as option in the future depending on how assessment proceeded with psychiatric services. Becky discussed Issues regarding friends, identity, reality, what is real, coping and her appearance ("can't be bothered").She discussed her need to clarify her referral status, coping**,** difficulties with friends and being with others as well as visual problems and exclaimed "How can things be real?"

Session 4

Time was spent looking at core outcome scores and Becky's low mood. Multi-disciplinary working and referral was discussed. She discussed a past relationship, traumatic losses and her lifestyle in past.

Session 5

Becky discussed issues relating to her feelings of being real or unreal as well as coping strategies and sources of support. Becky expressed fears that she could hurt someone but there was no evidence that she would act on this. She debated whether to go to her deceased sibling's grave.

HAT data showed helpful events in this session consisted of Becky talking about her brother. She described how she felt the release of some sadness, and felt a bit

relieved (towards end of session).These experiences were rated as between moderately and greatly helpful.

Session 6

This session included a discussion relating to the context of multidisciplinary support

On the way to the session Becky contacted the therapist and expressed uncertainty regarding if she could attend the session. Becky cried in the session. She expressed feelings of things being pointless, hopeless, commenting "Will I be like this all my life?" she asked questions and raised discussions regarding trust of others, hurt feelings and debated how to feel connected. She also discussed relationships.

Session 7

Becky talked about feeling the risks of going out and mixing with people as it made her feel freaked out. She was having "weird" dreams, sleep difficulties and feeling "freaked out" at times. She also spoke about recent dynamics with an ex –partner and feeling upset wanting a relationship which she felt may help her to feel things and feel intimacy.

Hat data showed that Becky found that Crying made her "feel more real" which she rated as slightly helpful. She also described her experience of her therapist's understanding as greatly helpful.

Research assessment session *2nd* PANSS

Session 8

A referral letter was discussed as well as treatment options to potentially supplement the therapy. Becky reported that she had felt very suicidal and attributed this to the effect of medications as the feelings had increased since she had commenced the medication. She reduced medication herself (antidepressant). She reported that she had tried to talk to family and that she felt alone. She said that she had started a new job and said that this was going well. She laughed and discussed others perceptions of her as happy and her inner struggle

HAT data named "Just talking and letting things out "as the most helpful event of the session and that. All of it was helpful" Becky rated these events as greatly helpful.

Session 9

Becky arrived late as she had forgotten to bring money for car parking. She informed me that she was to have an assessment the following week with the "crisis service". Some positive changes were noted in CORE outcomes and 'Becky reported that her job was going well. She had withdrawn from medication without medical supervision. We discussed her talking to her General Practitioner (GP) regarding this issue. She described anxieties, vigilance regarding her breathing and worries in case her heart stopped and she died.

HAT data showed Becky describing "Just talking and letting things out" as a helpful event and that all of it was helpful. She rated this as moderately helpful

Session 10

Becky discussed her guilt regarding her previous lifestyle. She reported that she had been assessed by the local crisis team and intended discussing medications with her GP. A large part of session was looking at sibling loss (through suicide) in depth. Becky cried and I was moved to tears at the sadness and horror of it all. She was taking antidepressant on alternate days and felt that the medication be causing her to feel worse.

HAT data showed Becky describing talking about the loss and "crying-letting it all out" and Just talking in general as the most significant helpful events of the session which she rated as greatly helpful.

Session 11

We discussed medication and the whole package of care. Becky had attended a General Practitioner appointment with her father. She had obtained a pet dog which she wanted as a source of comfort. Depersonalisation was discussed. She reported that she had changed her medication to Prozac about eleven days ago

Becky's HAT data showed that Becky saw: "Just talking. and Getting stress out" as moderately helpful in this session.

Session 12

Becky had been contacted by the EIP team following my recent referral. She discussed her history, past lifestyle, friends, family. She reported experiencing difficult family issues. Becky felt under pressure from family members to work longer hours and I expressed concern regarding the potential negative impact of this. We discussed what might be realistic in terms of activities regarding her health and vulnerability. I was directive in suggesting concerns if she worked longer hours and outside of usual theoretical stance. Becky had an initial appointment to see the EIP team the next Monday.

HAT data showed that: "Talking and Just letting it all out." were seen as moderately helpful in this session.

PANSS Assessment

Session 13

Becky reported that she had maybe heard a voice in her head and felt "freaked out". She told me that she may have heard voices talking. Becky informed me of her awareness of a significant date re her loss coming up. She had planned to take a day of leave at work

HAT data showed that Becky described "Generally letting everything out and feeling some relief as greatly helpful in this session.

Session 14

Becky had coped with the difficult day (a significant date regarding the anniversary of her sibling's suicide) with others. Changes were noted on the CORE. She described her fears regarding losing control and madness. She discussed friends with whom she can be open with and a new friend. Becky discussed difficulties in managing her finances. For example, she had been on "spending sprees" then had no transport money. She asked to attend sessions monthly from that point and gave permission for me to access her PANSS score from EIP team. She informed me of a scheduled meeting with the EIP team re her medication next week. No interventions had been offered by this team at this point in time.

HAT data showed that a general catch up and "Getting things out" were rated as extremely helpful by Becky.

Session 15

Becky was now on reduced medication. She reported that she was experiencing visual problems. We used "miniatures" (small objects used as metaphors to help to facilitate process in therapy but only with the client's interpretation). She chose a "miniature", which she said, was "weird". She described her depersonalisation as "bad as ever" but said that she was "acting ok with others". She discussed difficulties with family dynamics. She informed me that she would be offered some treatment by EIP team and cut her medication totally (their view). New friendships were described positively but she discussed messages of rejection from family member. She described feeling disabled by mental health issues. She wanted "to come off her medications totally".

HAT data showed Becky as describing "Generally talking about what's being going on. / Bit of release" and this occurring "all over" the session as greatly helpful

Session 16

We talked about how Becky was feeling that she was building strength.

HAT data showed Becky describing: "Expressing how I felt" as a positive event because it was the only time she could as greatly helpful to her.

Session 17

Becky discussed anxieties

HAT data showed Becky Describing "Venting" which she described as bringing relief" as extremely helpful

Session 18

Becky arrived early. She engaged in person-centred creative expressive work. She discussed coping and "spacing out" (dissociating) and how to deal with this at work. Becky painted a symbol of herself in a box (trapped) and explored feeling regarding work pressure and coping. She reported not being engaged with EIP team yet and that she had experienced difficulties contacting them.

HAT data showed “Painting and talking was a positive therapy event as It was relaxing”. This was rated as extremely helpful.

Session19

I wrote a letter for Becky to take to work regarding support due to her difficulties. Only one measure was given as this was a short session and her work letter was prioritised by me. She reported feeling “No one really gets it”. Becky said that she was committed to therapy

Session 20

A letter had been received from the EIP team saying that the PANSS assessment conducted by the EIP team had shown that Becky was experiencing a “psychotic episode”.

HAT data showed that Becky described: “Talking, my therapist “getting” me. As helpful “Just because no one really does.” rated as “Greatly helpful” in this session

Session 21

Becky described how she had very much enjoyed a social event with friends. She explained that she was thinking of “testing the water” regarding travel which she had avoided until this point. She reported that she was “now coping well” in social contexts, which had been avoided at start of therapy. Becky reported that she had a job interview scheduled soon. She also informed me that she had appointment with the EIP team psychologist scheduled for the next week. We scheduled PANSS at our service for the following week. No risk issues were reported at this point. We discussed Becky being creative in her appearance.

HAT data showed that Becky stated: “I enjoyed paining and listening to music” and. that this was helpful as “It was nice to ‘chill out’’. .She also found “Generally talking. “as a positive helpful event and rated these as “greatly helpful”.

Session 22

This session was part of an ending as engagement was beginning with the EIP team. This appointment took place after a break in appointments. Becky was scheduled to see a psychologist in the EIP team. She discussed difficult family issues and explored a very problematic relationship with close family member. She reported being in a new intimate relationship and discussed Ideas for future which involved sharing a flat with a friend. Becky informed me that she had not told her new partner about her issues as he thought that she was “a bit weird anyway”.

Three months later

Becky contacted me and attended for five minutes for a requested ending session, and hugged me. She reported that she wanted to say “goodbye” but said that she did not feel the need to stay for the full session.

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D.2 Affirmative brief

Affirmative Brief: Person-Centred-Experiential Psychotherapy for Psychotic Process:

The case of Becky

Compiled by Wendy Traynor

Audited by Robert Elliott

In this document, we review the evidence demonstrating how Becky changed during therapy and how therapy as opposed to any other factors was the primary cause of this change. Consideration of factual evidence compiled throughout Becky's therapy shows the extent of positive changes which she experienced during the therapy. The evidence also shows how the therapy played a role in influencing these changes and Becky's attributions for these positive changes, which supports the credibility of the outcome evidence.

1. **Client Pre-post change did occur:**
    a. **General overall clinically significant improvement: CORE change**
    Table R-1 and Figure R-1 in the Rich Case Record (RCR) show how Becky's mean score changed from 2.33 (moderate) at screening to 1.24 at ending (mild). This shows a 1.06 change. Becky's overall change on the CORE-34 and CORE-10 is clinically and statistically significant (see Connell & Barkham, 2007; Barkham et al., 2013). Becky also showed fewer risk issues as the therapy progressed. Initially on the CORE-34 Outcome Measure Becky reported sometimes making plans to end her life, as therapy progressed she consistently indicated that she had not made such plans at all and there was no indication of thoughts or plans to self-harm

    b. **Specific pre-post qualitative positive changes**
    Becky reported to her therapist that she continued to experience difficulties but that her functioning and coping mechanisms substantially improved and she was able to lead a full life by the end of the PCT therapy with a job, partner and ability to socialise and self-soothe restored. She regularly discussed coping strategies in the therapy and looked at what might be realistic for her to do in terms of activities and engagement with others. By the end of the therapy Becky had gained a new job and was in a new relationship. She was mixing more socially and was able to go away on holiday again, which had been impossible at assessment stage. (See Table A-1.)

Table A-1

Change	**Evidence of Change occuring**
1.Feeling that things are more real	Very important" change which was noted and seen by client as "Very unlikely" without therapy (Change Interview): B: -*I thought my whole life wasn't real, that it was in my head. I still do think that a bit but it's not as strong as it was which is like good 1.1/12b*
2.Getting out more (locally [in the city that I live in])	This change was noted and described by the client as "Extremely important change" which was described by the client as "Very unlikely" without therapy (Post therapy Change Interview)
3.Getting out of the city I live in [going on holiday]	Client noted this change and seen as an "Extremely important" change and "Very unlikely" without therapy (Post therapy Change Interview): *B: Getting out of the city (named)—like I never used to be able to go—I went to the caravan the other weekend 1.1/56*
4.Coping better with meeting, being around, being around and talking to people	R: Is there anything in particular that you cope with better or— C: *...being around people, talking to people 1.11b&c (*Post Therapy Change interview)
5.Coping better, getting on with stuff more and less dwelling on bad stuff (depersonalisation, psychotic material, concerns)	*I can get on with stuff more, rather than dwell on it 1.1/10 (*Post Therapy Client Change Interview)
6.Coping better with anxiety/stress	Post therapy Client change interview: *"I'm leaving the stress here, relieving it"/ "coming here and being able to vent about stuff is good cause it's not all inside then" 1.1/20a*

2.Therapy Interrupted a Rapidly Deteriorating Condition

When Becky was assessed for therapy she described long standing personal and family difficulties which had been building into more serious dysfunctionality over time and exacerbated by two traumatic loss-related events. This left her with grief with guilt and a sense of disintegration of self and sense of reality. Family dynamics had become more difficult and stressful for Becky for several months and she contemplated committing suicide.

The therapist had training and extensive experience of working with patients experiencing psychotic processes. Becky's score on the Positive And Negative Syndrome Scale (PANSS) met the clinical criteria for psychosis in two independent assessments by the counselling service researcher and later as part of the screening by the Early Intervention in Psychosis (EIP) team. The EIP team attempted to assess and engage with Becky during the counselling. Becky found engaging with the EIP team difficult at first but she did try to use the services offered which commenced at the end of the PCE therapy.

Early counselling support for Becky reduced the severity of her issues and risk of harm to self as well as normalising her issues and enhancing coping at a critical window of opportunity to prevent further deterioration of her mental health. McGorry (2002) has provided an overview of studies which showed that the precursor state to developing a more advanced psychotic state manifests well before this, where difficulties in social functioning occur and where it is possible that a more severe course of illness is not inevitable. This is in contrast to earlier more medical model views of a prodromal phase leading to schizophrenia. Birchwood, McGorry and Jackson (1997) support this stance highlighting how the psychosocial impact of psychosis can lead to secondary social disability and that early intervention can reduce the risk of this. Meta-analytic research suggests that a long duration of untreated psychosis is correlated with poor outcome in the first year of psychosis (Penttila, Jaaskelainen, Hirvonen, Isohanni & Miettunen, 2014). Studies such as Marshall et al (2005) and Perkins et al (2005) support this. This reinforces the importance of therapy for Becky in reducing the rapid deterioration of her condition. Counselling was not only helpful for Becky but her reduction in distress meant that she was less likely to progress to a more severe and long-term condition.

Robust trials such as Tarrier et al (2004) have shown that supportive counselling for early psychosis has relatively successful outcomes compared to treatment as usual. Becky showed positive overall change with some fluctuations of symptoms, particularly early on as the alliance was built and she disclosed distressing events; after that steady progress was noted. Strauss (1989) suggests that there can be different recovery paths (such as "the low turning point" and "woodshedding") where a patient's progress from acute psychosis may include an initial worsening of symptoms before integration and progress.

PCT builds a nondirective therapeutic alliance with the client, with an authentic relationship at the heart of the therapy. Goldsmith, Lewis, Dunn & Bentall's (2015)

analysis of trial data states that psychotherapy alliance is causal in predicting better outcomes in psychotic patients and that alliance should be maximised. Table R-6 (see RCR) shows that the therapeutic alliance between therapist and client was rated by both as positive throughout the therapy, which may have been helpful to Becky.

3. The Client attributed her pre-post improvements to therapy (Retrospective Attribution)

The client is the central to this discussion and her opinions regarding the changes which she describes experiencing throughout the therapy are considered here. Becky attributed most of her post-therapy changes to the therapy. More specifically, Becky was asked to rate how unlikely it was that each of four changes would have been without the therapy. She rated 3 of the four changes as very unlikely (the lowest rating of likelihood) without therapy. (See Table R-2, RCR). This account therefore provides evidence of retrospective attribution of change according to the client herself.

Further exploration of Becky's responses in the Change Interview provides additional evidence. In the Change Interview Becky described her therapy as generally helpful:

> *C-I do think it's improving me.* 1.1a *I think it helps.* 1.1/1b

She specifically named valuing the opportunity to talk about issues that could not be shared with others and being able to "vent"/express problems:

> *C-Being able to talk about stuff that I wouldn't be able to talk about with family and friends. 1.1/2*

Becky felt understood by the therapist and this is supported both by her own comments within the Change Interview process which shows her consistent positive evaluation of the therapeutic relationship:

> *C-Yeh it feels REALLY helpful because if you ever explain to someone and they say they know what you mean and they will just say something and they've not felt like that at all but T (therapist's name) really gets it 1.1/31c*

Table A-2 summarises the client Change Interview, describing the specific helpful factors to which the client attributed her post-therapy changes.

TABLE A-2 Helpful Therapy Factors Identified by Client after therapy

1.0. Factors within the therapy
1.1. Immediate effects:
1.1.1. Feeling very understood (even when not clear): T [Therapist] just GETS me, completely, even when I say something and I think she probably won't understand she says the same thing in the proper way—THAT really helped (1.1/31a)

2. De-stressing I'm leaving the stress here, relieving it (R: and relieve –did you say stress?) Yes—stress and problems (1.1/20 to 1.1/22b)
1.2. Relational atmosphere
1.2.1. Valued opportunity to talk/vent about issues: Coming here and being able to vent about stuff is good cause it's not all inside then.1.122a When I come here I can vent it, I don't have to think about it in my head and I'm getting it out sort of 1.1/26a
3. Difficult but Potentially Beneficial Processes (Within and Outwith therapy)
3.1. Talking about painful experiences Like yeh---in the beginning talking about my "sibling" and also that was horrible but it helped at the time. 1.1/33…–just opening up about stuff I hadn't told anyone about 1.1/34

Note. Extracts from Table R3, Rich Case Record.

4. Post-therapy Outcomes Can Be Linked to Specific In Session Processes (*Outcome-to- Process Mapping)*

Outcome-to-process mapping involves linking specific events which took place within the therapy to overall changes experienced by the client. This process allows the establishment of the extent to which events within the therapy may be regarded as responsible for the outcome of the therapy.

Table A-3 shows evidence of the changes described by the client.

Becky's change in relation to "feeling that things are more real" was linked to sessions 15,16 and 20 in the therapist process notes where perspective on what was real or unreal was explored and her sense of self, identity and coping with a fragmented sense of self were worked on in the therapy.

Becky's ability to get out more was discussed regularly in the therapy and in session 16 she particularly highlighted how she had been able to go out and enjoy time with her friends, which had not been possible at the start of therapy.

Early in therapy Becky discussed feeling restricted by not being able to travel but explored her fears regarding this and eventually in session 16 the therapist process notes show that she felt able to experiment with nonlocal travel to see if this might be possible.

Becky regularly discussed how to deal with others and in sessions 14, 16, 17 and 21 therapist process notes show that she used the therapy to cope with others and gradually increase her ability to mix socially.

Table A-3

Post-therapy Change	***Corresponding In-Session Processes***
1. Feeling things are more real	Therapist Process Notes (TPN) for Session 15 and 16: Discussed

	depersonalisations, what was real and coping TPN Session 20: Depersonalisation discussed re: coping
2.Getting out more (locally [in the city I live in])	TPN Session 15: Discussing coping in social situations TPN Session 16: Client had a great time out. And a great birthday with friends.
3.Getting out of the city I live in [going on holiday]	TPN Session 16: Discusses trying to go on a day's flight to London or Ireland to see how travel feels –test the water as has avoided flights. Therapist process notes showed last 3 sessions discussing and going to travel outside of city.
4.Coping better with meeting, being around, and talking to people	TPN session 7 showed client improving social interactions and working on this. TPN session 14: *Talking about hurt, trust, relationships. Client talking about how to feel connected/relationships* TPN session 16*: Client had a great time out. And a great birthday with friends.* *Is coping well with social situations* *Has a job interview for a shop soon.* TPN session 21: Discussed family/ coping with others/relationships. Thus, therapist process notes showed that the last three sessions involved Becky describing being more able to mix -had great social time

During the lengthy period of waiting for Early Intervention in Psychosis team assessment and the potential intervention Becky was offered person-centred experiential psychotherapy which did include psychological holding of her distress, normalisation of her experiences and coping strategy enhancement. These issues stemmed from the client's having raised them in the context of person-centred experiential therapy as well as the "venting" and "offloading" which she repeatedly evaluated as "greatly helpful". Becky became more hopeful and less suicidal. The core therapy centred on person-centred principles and conditions where the therapist strived to offer empathy, congruence and a non-judgemental attitude and focus on the client as a unique person, working in partnership with them in a real relationship. These principles were central to the therapy as well as some overlap with wider rehabilitation strategies and links to the wider context of resources.

5. Event-Shift Sequences

Event-shift sequences show how significant events described by the client may coincide with changes in outcome measure scores. Becky's case does not demonstrate significant data in relation to this area of focus.

Conclusion

This affirmative brief has presented multiple lines of evidence that

-Becky changed during therapy.

-Becky attributed changes to the therapy

In particular:

-The therapy addressed and impacted upon long standing issues and diverted Becky from a spiralling deterioration in mental health into psychosis and risk of suicide

-Links have been shown which show a connection between Becky's process in therapy and her outcomes

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D.3 Sceptic brief

Skeptic Brief: Person-Centred-Experiential Psychotherapy for Psychotic Process:

The case of Becky

Compiled by Anna Robinson

In this document I present a skeptic brief as an alternative view to the Affirmative Brief. Specifically, this document reviews the claim that Person-Centred-Experiential Psychotherapy (PCEP) offered to the client referred to here as Becky was instrumental and the main causal factor of client change. I will review the factual evidence presented in the Rich Case Record and Affirmative Brief considered as the primary cause of this change. The Skeptic Brief will consider alternative causal factors considered plausible as accounts of the client's positive changes across treatment.

The main Affirmative case argument is that PCEP as a treatment caused changes in psychotic process in this single case study of Becky. Psychotic process includes symptoms such as unusual thoughts, perceptions or experiences such as hearing voices or paranoid ideas (American Psychiatric Association, 2013).

A. No Evidence for Change in Psychotic Process

A particularly damning piece of evidence is the fact that no reliable change in psychotic process was found on any of the quantitative measures used to evaluate pre- to posttherapy change. This is partly due to the reliance on CORE as the sole outcome measure.

1. General overall client pre-post change did occur but was not specific to psychotic process. The Affirmative Brief presents evidence for PCEP as a treatment for psychotic process through the pre-post scores of the CORE. Whilst the CORE demonstrates change across treatment this is the only quantitative outcome measure used to assess client change. This skeptic brief questions the justification of this measure to demonstrate the efficacy of PCEP as a treatment for psychotic process. The use of this measure for the purpose of measuring psychotic process symptom change is therefore challenged. It is proposed that other instruments should have been more suitably selected for this purpose. One such instrument more suitable in measuring the severity of psychotic symptoms is the Clinician-Rated Dimensions of Psychosis Symptom Severity (APA, 2013). The CORE-10 items cover anxiety (2 items), depression (2 items), trauma (1 item), physical problems (1 item), functioning (3 items - day to day, close relationships, social relationships) and risk to self (1 item). Therefore, the Affirmative Brief can only claim to have made quantifiable changes in these items and not in psychosis symptom severity.

2. Circumstantial evidence points to a lack of change in psychotic process. The initial screening measure used to ascertain presence of psychotic symptom severity was the Positive and Negative Syndrome Scale (PANSS; Kay, Fiszbein &

Opler, 1987). These scores are not presented in the Rich Case Record for Becky and as such it is difficult to ascertain the extent of change that occurred in these psychotic process symptoms as a result of PCEP treatment. An accurate timeline of events is also required to ascertain a true sense of the chronology of treatment and events. It is argued that a lack of this chronological timeframe prevents a robust evaluation of the evidence. However, it is noted that an external agency the Early Intervention Psychosis Team (EIPT) reported that Becky was experiencing a severe psychotic episode at a later point, sometime between sessions 7 and 14; however, it is difficult to ascertain when this assessment was conducted. Therefore, it could be stated that PCEP at this point had not had an impact as a treatment of psychotic process based on this external assessment. The scores from the initial screening would need to be compared to the EIP PANNS assessment to make any accurate claims of changes in

There is in addition a reported non-change in 'depersonalization,' which Becky recalls in session 15 as 'being as strong as ever'. Further, nontherapy events may have significantly influenced the change, including self-corrective processes. For instance, one of the noted changes, in Session 15 Becky reported a reduction in medication. During this session too Becky reports a significant extra therapy event, which is the development of a new friendship. In the following session 16, Becky reported 'feeling that she was building strength'.

3. Reported general change in general distress could be due to bias. Further, the CORE is a self-assessment outcome measure and therefore is subject to methodological weaknesses not considered within the Affirmative Brief. There is no consideration of the introspective ability of Becky; and even if she was trying to be honest, she may have lacked the introspective ability to provide an accurate response to questions about whether she was experiencing a severe psychotic episode. Further, self-reports such as the CORE are also subject to the client wanting to please the therapist. Furthermore, no consideration was given to response bias and whether Becky had a tendency to respond in a certain way, regardless of the actual evidence she was assessing. This might be indicated by repeated general report client reports of helpful aspects such as "Just talking and letting things out".

4. Qualitative change data do not point to change in psychotic process. Another piece of evidence that suggests the therapy provided to Becky did not have a significant, positive impact on psychotic process is the fact that the changes noted in the change interview did not refer to psychotic symptoms. In particular, the client indicated four changes noted in the posttreatment interview: feeling things are more real, getting out more (locally), meeting people and getting out of the city I live in. Three out of the four of Becky's qualitative change descriptions had no specific relation to psychotic process. These relatively thin qualitative data challenge the credibility of causal links of the factors of the PCEP factors contributing to reduction in psychotic process symptom severity.

Admittedly, one of the change factors that could be linked to psychotic process change is 'crying made me feel more real'; this was in session 7 and coincided with the expert assessment in which Becky was reported by the EIP team to be experiencing a psychotic episode. This is also then linked to an emerging sense of self, which is not reflected in the client's narrative.

To conclude this section, establishing efficacy of treatment requires multi-level analysis of multiple data gathering methods. Although there appear to be multiple measures applied to *create a rich and comprehensive body of client data* for Becky the data presented in the Rich Case Records is limited. This weak data set makes it difficult to triangulate quantitative and qualitative data to draw causal links of PCEP treatment and reduction in psychotic symptom severity. Further, there is a general inconsistency of session reporting and the therapist process notes rely on therapist recall. The inconsistency in therapist process data could be open to therapist recall selectivity and bias, which why for research purposes audio recording and transcription are essential to enhance credibility.

B. Other Explanations Adequately Account for Apparent Client Change

To further support the case that the psychotic process changes experienced by Becky have not been demonstrated to be more than minimal, the data were reviewed using Elliott's (2001) list of competing explanations for apparent client change. This list indexes nontherapy explanations for apparent client change, specifically with reference to PCEP for psychotic process. A number of major nontherapy explanations discussed by Elliott (2001) further suggest that the psychotic process changes experienced by Becky were no more than minimal. In addition, some of the explanations prove that those changes that did occur were not the direct result of therapy.

1. Negative or Trivial Change. As previously stated, the evidence for client change pertaining to psychotic process symptoms was not recorded and furthermore, what was recorded around session 12 did not demonstrate improvement, but rather validate that the client was experiencing a severe psychotic episode on the quantitative measure (PANNS) as indicated by the IEP assessment. This is a damning omission of the efficacy of the PCEP having a causal impact for client change in psychotic process symptom severity.

2. Extra therapy Events could have affected client change. As noted in the Rich Case Record there are a number of extra therapy events that occurred during the course of treatment that may be attributed to positive changes that are not therapy related. These include:

2a. *Impact of New Employment Opportunity:* It is reported that the client starts a new job (session 8) and that the 'job is going well' (session 9).

2b. Development of New Friendships: It is reported that Becky was developing positive new friendships (Session 15).

2c. Getting a dog: One of these client behaviours not directly linked to PCEP is briefly referred to in session 10 when Becky makes reference to the getting a new dog as a *source of comfort.* Animal-assisted therapy has a growing evidence base for a number of populations, specifically related to this case here is evidence reporting that service users with psychosis trust the animals and are able to confide in them (Chandler, 2012). It has also been shown to

aid non-verbal communication in people with schizophrenia (Kovács, et al., 2006). In one investigation Villalta-Gil et al (2009) analysed a pet intervention with 21 schizophrenic inpatients over 25 sessions. Participants received 45-minute meetings twice weekly with a psychologist, the intervention group consisted of a therapy dog and handler versus a control group without the pet intervention. The dog was the focus of interventions tailored to improved communication, social skills, and cognitive rehabilitation. They reported that inpatients in the intervention group had significantly better scores on the social contact score in the Living Skills Profile and total score on the Positive and Negative Symptoms Score scale. This intervention draws specific links to psychotic process through the PANNS as the outcome instrument. The Skeptic Brief draws attention to such extra-therapy factors that have not been explored or considered in the Affirmative Brief. Becky getting a dog is not equivalent to receiving animal-assisted therapy; however the soothing, claiming impact of having a pet has not been considered, nor has the positive impact of walking or caring for a dog.

3. Non-PCEP Intervention Activities by the therapist could have affected client change. First, the therapist was active engaged in numerous practical supports/interventions other than PCEP. These included the therapist supporting the client in accessing other services, communicating with the client's general practitioner (GP), who referred her to primary care mental health service, who then referred her to the Early Intervention in Psychosis (EIP) team. The therapist also wrote a letter for Becky to take to work explaining her difficulties. Such engagement with multiple agencies was discussed with Becky in therapy sessions. This level 'extra work' carried out by the therapist can demonstrate to the client how much they are doing to 'help' them and this impact was not explored as a contributing factor to mental wellbeing and change.

4. Other Agency Intervention could have affected client change. Additionally, a significant development in the course of treatment for Becky appears to have taken place around session 12 when the EIP team contacted Becky. The PANNS score from external team coincides with psychotic process language used for the first time in the therapist session notes (reporting that she was experiencing a psychotic episode). Becky was eventually assessed and offered directive interventions by the EIP team, but chose to continue to use the therapy in order "to vent feelings and to explore other areas". However, she did not regularly engage with the EIP team until after twenty sessions of PCT were completed. She engaged with the EIP team during one of her periods of unemployment when she expressed the view that engagement with the EIP team was easier for her.

5. Self-Correction: Natural healing in the Grief cycle. Consideration is given to changes that occurred because of self-corrective processes as opposed to the proposed PCEP treatment. A further aspect that may result in change that is not a direct impact of PCEP on psychotic symptom severity is the client engaging in self-corrective activities independent of therapy. Therefore, a competing explanation for

some of Becky's reported changes is the fact that she engaged in self-corrective activities independent of therapy.

There were a number of self-corrective activities reported by Becky; central among these is her natural grief process: One of the major factors bring Becky to therapy was the reported suicide of a sibling and one other significant trauma event, not specifically explored in detail. There is limited detail given regarding the impact of the sibling suicide and whether this could be attributed to a brief psychotic episode brought on by trauma. Further, it is difficult to ascertain the chronological timeline of loss through bereavement, but reference is made to a 'significant anniversary' of loss of sibling in session 13. This would indicate a one-year anniversary of Becky's sibling through suicide. According to the bereavement and loss the cycle of recovering from loss, Kubler-Ross (1969) identified five linear stages of grief which are denial, anger, bargaining, depression and acceptance and are a part of the framework that makes up our learning to live with the one we lost. Further, to the natural process of recovery a Dual Process Model (DPM) has been proposed that specifies the concept of oscillation. According to Stroebe and Schut (1999), healthy grieving means engaging in a dynamic process of oscillating between loss-oriented and restoration-oriented coping. A griever will oscillate between confronting the loss and avoiding the loss. This is a dynamic process that is actually part of the healthy grief process under the DPM, coping with our grief at times and seeking respite at times. In session 14 reference was made to how Becky coped with the significant anniversary of the suicide of her sibling. This may indicate an inner resourcefulness to the loss whilst indicating the natural process of healing.

6. Medication Uptake and Withdrawal. The impact of 'self-medication' may be a contributing factor to change. The client indicates that her use of medication (session 8) and Prozac (session 11) had an impact on how she felt and she took control in how she self-medicated. The client made reference to medication making her feel unwell, stopping medication and taking it on alternative days. There is a focus on medication from session 8-11.

7. Reactive Effects of Research. Finally, it can be argued that the research conducted on Becky during the course of therapy influenced the client's reports of change. In conjunction with the weak data collection inconsistent gathering of outcome data may have had an influence on Becky reporting change. It is proposed that the late introduction (session 5) of the Helpful Aspects of Therapy (HAT) may have impacted on client expectation and pressure to please the therapist. There may also be researcher bias as the researcher was trained by the therapist and was a colleague. Further, this researcher may have felt under pressure to seek out positive changes as they had awareness of the therapist's investment in demonstrating the efficacy of the PCEP as an effective treatment for psychotic process.

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D.4 Affirmative rebuttal of Sceptic Case

Person-centred and experiential Therapy for Psychotic process: The case of Becky

Affirmative Rebuttal of the Sceptic Case

Compiled By Wendy Traynor

Audited by Robert Elliott

(The arguments presented here are to facilitate critical analysis of process and not necessarily the personal views of the author)

This rebuttal draws upon evidence to systematically challenge the arguments stated in the sceptic brief that Becky did not show a substantial reduction in her psychotic process and that other changes were trivial or attributed to factors other than the therapy. This rebuttal claims that although it is possible that other factors may have somewhat influenced Becky's outcomes, there is no direct evidence for this. However, evidence does demonstrate that the therapy was itself a causal agent of positive changes. Becky experienced some important symptom reduction, decrease in distress and increase in self-regard, well-being, coping and functioning. There is rich evidence of improved outcomes and in her own self reports she attributes specific changes to the therapy.

Treatment Context regarding Psychotic Process

Becky experienced small but significant positive changes in psychotic process which can be to a certain extent attributed to the therapy. Additionally, reduced self-stigma, terror, guilt, and distress in relation to Becky's response to her "psychotic symptoms" and increased coping were changes of central importance, as Becky initially reported the fear that she was "going mad"; thus, there is evidence of a reduction in risk factors associated with escalating psychotic process.

Becky found her psychotic processing terrifying and distressing but this fear diminished as the therapy progressed. Bendall, McGarry and Krstev (2009) describe accounts and literature supporting how psychosis itself can be terrifying and may cause post-traumatic stress symptoms in around half of those who experience psychosis.

Becky presented with layers of interrelated issues. The process of therapy did not emphasize diagnosis and symptom reduction but instead reflected a more person-centred ethos and focused on normalising distress and supporting client-initiated issues and goals. Freethe (2017) supports this stance, highlighting the power-based issues associated with traditional medical model treatment, while rejecting traditional symptom based notions of recovery in favour of a more subjective patient-led stance.

The current National Institute for Clinical excellence guidance (NICE, 2014) for the treatment and management of psychosis provides the United Kingdom government endorsed evidence based treatment guidance. The guideline in place at the time of Becky's therapy (NICE, 2009) recommended interventions including Cognitive

Behavioural Therapy (CBT) and the option of psychotropic medication. However, Becky initially found it very difficult to go out at all or engage with any service.

The service where Becky was offered person-centred-experiential psychotherapy (PCEP) was particularly flexible and accessible and suited to working with young people who may have chaotic patterns and find engagement difficult. Later in the therapy Becky did attend an assessment with the EIP service and felt able to take up this service by session 20 of the counselling, when she had already started to experience some positive changes and was more emotionally stable. It could be argued that the progress made in the PCEP is what enabled Becky to access other services.

The current NICE guideline now states in the section regarding user experience that it is important to “take time to build supportive and empathic relationships as a part of care” (NICE, 2014, 1.1.1.1). In this case there was evidence of a strong therapeutic relationship in the perception of the therapist and even more strongly in Becky’s perception (see Table 6, Rich Case Record). The Therapeutic Relationship Scale was not seen by the therapist until after the completion of the therapy. A growing body of evidence suggests that therapeutic alliance is the most influential factor in determining positive outcome in psychotherapy (Horvath & Bedi, 2002; Norcross, 2002). Goldsmith, Lewis, Dunn and Bentall (2015) conducted a trial of 308 clients with psychosis who received either supportive counselling or CBT and showed that a positive therapeutic alliance improved outcomes for both treatments.

Castonguay et al (2006) suggested that the client’s assessment of therapeutic alliance is more predictive than the therapist’s assessment. Table 6 in the Rich Case Record shows that Becky consistently rated the therapeutic relationship as positive. Becky gave the highest rating on this scale on every session measured showing her feeling that the therapist accepted her no matter what she said. This strong therapeutic alliance was established with Becky in the context of a flexible service which formed a solid foundation for therapeutic work and change. Becky’s HAT data from sessions 16 and 18 (Rich Case Record, Table 5) shows that she felt understood by the therapist and that it was the only place where she could talk about certain issues. Becky felt totally understood by her therapist (Table 3, point 1, Change Interview data, Rich Case Record). The therapeutic relationship was a relationship of “relational depth” (Mearns & Cooper, 2005) and was close and dynamic, providing a platform to self sooth, build confidence and embrace and manage unusual ideas as well as reduce risk and manage family conflict and trauma.

The PANSS measure (conducted in the service after session 5) was suited to measuring psychotic process change; however, at time two the measure could not be administered because at that point Becky did not feel able to repeat the process of a lengthy measure with the researcher. Becky’s psychotic process was later found to be present by two independent assessors in addition to the therapist and one was in a totally independent service. The EIP service sent a written report to the therapist stating that Becky was experiencing psychosis and recommended continuation of the PCEP therapy after fully assessing Becky and her presentation and views. Contrary to what is suggested in the Sceptic Brief, the CORE measures were not actually

intended to measure psychotic symptoms but did measure other areas of distress and this included improvement in some areas which were associated with Becky's unusual experiences such as feelings of terror.

A. There is evidence for change in psychotic process.

1. General overall client pre-post change did occur and was specific to psychotic process.

Contrary to the Sceptic claim, there was specific change in relation to psychotic process which was evidenced in Becky's first named change in her post therapy change interview, that is, a reduction in a psychotic process. Becky named "feeling things were more real" in her post therapy change interview with a researcher who was not the therapist (Table A-1 Affirmative Brief). This issue of not feeling real or that not things were real had initially been raised by Becky at assessment and from session 1 and was explored in depth from session 2 where it was noted in the therapist process notes (Rich Case Record, Summary of Therapy Process notes, sessions 2 & 5). Becky stated that this change was very important to her and was very unlikely to have occurred without the therapy. Other data supports this change, including clinical notes, therapist process notes and related items in the CORE; this all constitutes strong evidence of some reduction in psychotic process.

At the end of the therapy Becky still had some depersonalisation and unusual ideas but reported that the voices had stopped. Clinical case notes indicated that her risk to self and others was reduced and CORE data supported this. She became more able to function and be with others rather than this being overwhelming. There were some setbacks but she showed more resilience and was engaging more with others. She also reported less fear of death or of hurting herself or others. These factors link into standard assessment criteria for ultra-high risk of psychosis used by EIP teams in the UK.

A.2.Evidence supports change in psychotic process

Becky's PANSS scores were initially in the clinical range for psychosis and showed anxiety and feelings of torment. She did later show diminished psychotic symptoms (voices ceased) and commented on this, but still had some problematic experiences. Becky reported "crying made me feel more real' in session 7 (HAT data, Rich Case Record, Table 3).

Becky's change interview transcript gives further support to this claim where Becky explains that things are a bit more real and that the idea of her whole life not being real was just a bit present as less strong and she considered this change to be very unlikely without the therapy. She also reported coping better with existing "symptoms" (see Table A1, points 1 and 5, Affirmative Brief).

In Becky's service post session 5 PANSS assessment she reported, "Now I think I'm not real". Within the PANSS assessment Becky reported "not knowing who I am," unable to recognise her voice as her, "I'm not who I am", and feeling "terrified that I'll lose control". She presented as sometimes "really sad and down" because of

torment and described herself as having problems that were "pretty bad" and feeling " tormented", poor sleep.

She specifically reported to the PANSS researcher who was not her therapist that probably if she did not get better her life was in danger. She reported hearing voice and noises which reminded her of family members including a deceased family member, visual snow for a year, twitches, olfactory hallucinations, visual hallucinations, feeling sad, tormented and lacking trust, thoughts of ending her life, and sometimes, "I wish that I wasn't there" but no plan. She reported in her PANSS assessment that she felt guilty about not going to see her sibling who then committed suicide and that she might "deserve a little punishment". Jones' et al (2016) study explores how agency may be employed in developing and reinforcing psychosis for some individuals who may feel that the symptoms originate from or play out moral struggles or issues. In the long term she stated on the PANSS that she wanted to travel one day, which she was able to do by the end of the therapy.

By the end of therapy she reported no further incidents of voices although some unusual experiences remained

***A.3. Reported general change in general distress is not due to bias*.**

The Sceptic brief suggests that methodological weakness in the CORE measure and client wanting to please the therapist might have been significant factors in creating the changes recorded. While there may be measure limitations and bias operating, the outcome measure, therapist process notes and Change Interview data transcript showing the client's own words spoken to the researcher all do support one another in showing positive changes. The CORE is a validated measure and was chosen as it is respected for having "good psychometric properties" (Barkham et al, 2013). It is short and relatively non-intrusive. Becky expressed extremely vulnerable feelings and despite positive changes did not hesitate to disclose any setbacks (shown on the CORE graph (figure1, Rich Case Record) which suggests a level of honesty. Validated and yet ethically viable measures were selected for this case study which might show a range of changes which could be seen with such a client population but focused on distress reduction and not just a specific symptom focused stance as the outcome of PCEP was unknown.

The Sceptic Brief asserts that the client uses brief descriptions of her venting in the sessions but although the client was a teenage adult woman who was expressive, she did not talk with the sophistication of some of the more educated clients who may often be seen in case studies. Just because the client was unable to give complex descriptions of process or self-reflection does not mean that we should discredit her statements and the therapist's session notes show that the client was able to leave sessions early, cancel them and speak up and access other services. Becky did show variations in her assessment of the helpfulness of each session (e.g. Table 5, Rich Case Record) and the ability to differentiate between and evaluate the individual and relative sessions with honesty. Becky chose to come back to see the therapist in the end and participate in the research and hug the therapist as well as complete outcome

measures. This does not sound like a coerced client but one who could self–advocate. In her TRS measures (unseen by the therapist during the therapy) Becky consistently rated question 15 with the highest rating of 3 indicating that she felt it was ok to correct or disagree with her therapist. The fact that she rated the first three sessions at a 2 demonstrates honesty in her responses as she developed the alliance and confidence to change the therapist from initially "quite a lot" to the maximum rating pf a great deal. For question 7 "I felt that I needed to please my therapist", every session but one (rated "a little) was rated "not at all" showing the client's ability to be assertive. Any therapy may have some considerations and feelings of needing to please due to the inevitable power differential between therapist and client. The client completed 20 TRS measures during the therapy so significant data supports a positive relationship with an empowered and understood client. Becky felt close to her therapist quite a lot on two measures and the rest gave a maximum score of "a great deal". The therapist independently rated this last item as quite a lot or a great deal suggesting mutuality.

Becky's disclosures of setbacks, missing data and variation in scores despite overall positive change would not be consistent with the theory posed in the Sceptic Brief of client compliance. Becky "wanted the changes to be faster" (Change Interview) and if anything despite her finding the therapy helpful she was often frustrated that she was not making faster progress. Becky expressed this freely to the therapist and the independent researcher. (Rich Case Record, Table 4, 3.1)

At session 1 Becky was in a state of emotional torture and finding it difficult to be with others or function in relation to daily tasks. As the therapy progressed Becky reported changes and appeared less distressed and her appearance changes and she embraced positive self-identity and sense of self. She connected to her own creativity more, appeared more animated and dyed her hair and paid more attention to her appearance and connections to others as identified in her clinical notes when earlier she said can't be bothered in relation to her appearance (Rich Case Record, processes in therapy, session 3)

Becky's initial CORE-10 shows that she felt panic or terror "often" at the start of therapy, progressing to "sometimes" from session 2 onwards, and then this drops to only "occasionally" and or "not at all" in later sessions. Becky's final CORE measure did show a "not at all" response. For the statement "unusual or unwanted images were distressing me" Becky had initially chosen "often" or "all of the time" in the first three sessions with the option "sometimes" mid therapy then "only occasionally" from session 12 onwards.

At the final CORE-10 on session 20 Becky reported no difficulties "getting to or staying asleep" which was reported as a major problem in her PANSS assessment and on her initial CORE assessment. She did continue to experience some difficulties but her overall coping and quality of life were improved and self -stigma was reported as reduced and the overall mean score was reduced. By session 20 Becky was more open to engage in work with the Early Intervention in Psychosis (EIP) team which seemed more possible for her when her emotionally well-being was more stable and her patterns were less chaotic.

Part A Summary: Qualitative change data do point to changes related to psychotic process

The evidence in this rebuttal addressing points 1-2 also specifically demonstrates how qualitative data pointing to change in psychotic processes from the change interview, session process notes and is additionally supported in related items by CORE data.

B. Other Explanations do not Adequately Account for Apparent Client Change

1. Change was not Negative or Trivial Change.

The Sceptic Brief claims that any change in psychotic process was minimal but in fact the change of feeling things were more real was cited by Becky as very important and very unlikely without therapy. Given how distressing Becky found this experience earlier in the therapy (as already discussed) some significant reduction in psychotic process was evident.

2. No evidence exists that Extra therapy Events substantially affected client change.

The Sceptic Brief points out extra therapy events which may have impacted upon changes. This rebuttal argues that such events were initiated as part of the therapy itself and part of their success in themselves is from therapy based work relating to coping. These events then may, of course, have offered their own positive impact but come from sessions looking at self-soothing and coping and so their relationship in terms of outcome is complex and they were initiated in the therapeutic process itself.

2a. ***New Employment Opportunity does not necessarily positively impact.*** Becky did get a new job and had discussed this in the therapy and used the therapy to discuss and manage challenges in her job caused by her emotional wellbeing issues. The job in itself may well have had a positive impact. However, Becky also reports that work is stressful.

2b. Development of New Friendships would not be possible without the therapy and are an outcome. At the start of therapy Becky was finding it hard to mix with people and found this overwhelming and had withdrawn from friends or going out. In the Rich Case Record, the therapy session notes show examples of this. In session 3 Becky talked of "coping**,** difficulties with friends and being with others as well". In session 7 Becky talked about feeling the risks of going out and mixing with people as "it made her feel freaked out" and in therapy she worked on her self-caring and self-soothing at her initiative to build to a point where social situations were more possible as she the symptoms lessened and she developed greater coping. By session 15 new friendships were discussed.

The mixing with people was a sign of her improvement in therapy and ability to be with people and then mixing with people when she felt more able to deal with them could well have brought its own benefits. This Rebuttal moreover argues that the therapy helped Becky to mix more. The Change Interview transcript shows the

following example of Becky describing her increased ability to be with people and talk to people (Affirmative Brief, A1 point 4).

The Change Interview transcript also shows insight into Becky's view that the therapy was somewhat helpful with regard to her "getting out more" and was somewhat unlikely without the therapy.

2c. Getting a dog to self sooth was a product of changes instigated in therapy. The sceptic case argues that Becky's changes could be somewhat attributed to her getting a dog and indeed the dog may well have had a soothing impact, but it could also be argued that Becky may not have been able to work or get a dog in the state she presented at assessment where she had thought of taking her own life rather than getting a job or a dog or having sense of control or future. Becky continued with the therapy after she gained a pet dog, suggesting that the therapy still may have been additionally helpful and important.

3***. Intervention activities were part of the therapy and within the modality of the "tribes" of the person-centred approach and may indeed have been helpful***

The sceptic brief argues that referral to other services and writing a letter to Becky's employer may have been helpful and yet was not a PCEP intervention and was extra to the therapy. I argue that on the contrary the contemporary pluralistic PCEP approach can work to goals and include more directive intervention if led by the client and their presenting needs with the therapist working as a team with the client. Such actions on the part of the therapist may have been helpful to the client but were part of the therapy and positive changes were reported from the overall therapy with all its components. Becky was indeed glad to receive the referral to the EIP team but I had explained to her that this was seen as best practice and I recommended her to consider what was offered although until session twenty as she did not feel able to access the EIP service fully or easily. The Sceptic Brief claims that this 'extra work' carried out by the therapist can demonstrate to the client how much they are doing to 'help' them and this impact was not explored as a contributing factor to mental wellbeing and change. I argue that the therapist's commitment to Becky was legitimately demonstrated in both this and many other ways and since in PCEP therapy the alliance and real relationship are seen as central to the therapy, then this is part of what might be expected rather than compartmentalizing additional tasks as non-therapy events.

B4 ***There was no evidence that Other Agency Intervention could have affected client change***

The sceptic brief states that Becky said that when she finally engaged with the EIP team it was "easier for her". This was not in comparison to the counselling but was just relatively easier in her more stable state than earlier on which was explored in the therapy. The therapist encouraged contact with this team but it took time for Becky to engage

B5 ***There is no evidence of Self-Correction: Natural healing in the Grief cycle***

The sceptic brief suggests that changes may have occurred because of self-corrective processes as opposed to the proposed PCEP treatment and looks at how theories relating to grief may fit with a natural healing cycle. Becky had a history of family difficulties which were present for at least two years before her sibling's death. This included three recent losses, two of which were close and traumatic losses including a sibling suicide with circumstances leading to being treated very badly in relationship which had ended. Even with exact chronology, how clients process loss and trauma is rarely linear or predictable. Much exploration of loss and trauma, initiated by Becky occurred in the therapy with cathartic purging of the sadness and guilt and reframing of emotions. The fact that Becky repeatedly brought issues of loss and trauma to therapy suggests that they were very present for her and that repeated exploration suggested positive feelings about her bringing such material and its usefulness

Becky's post therapy change interview shows how Becky found this exploration of loss difficult but helpful (Table A2, point 3.1)

The sceptic brief refers to session 14 regarding how Becky coped with the significant anniversary relating to the suicide of her sibling as possible evidence of natural healing but even if this were the case the therapy clearly brought additional benefits. The change interview shows Becky affirming the use of sessions to discuss difficult or taboo topics and explains that this was particularly helpful (Affirmative Brief, Table, A2, point 3.1)

B6 Medication was unhelpful and caused negative change

The sceptic brief asserts that Becky's progress may have been affected by the uptake of, self-management of or withdrawal from medication.

Clinical records and Becky's initial PANSS assessment evidence how antidepressant medication quickly worsened her symptoms and caused her to think about suicide more and to think of acting on suicidal ideas. On withdrawal from medication Becky reported. In her initial PANSS assessment Becky commented *"I didn't want antidepressants prescribed as I am not depressed"*.This position is additionally supported by Change Interview data (see Rich Case record table 4, point 3)

There is no evidence that Becky experienced medication as helpful and only had brief periods of taking medication and it would be difficult to assess the impact of withdrawal other than her own view of returning to how she was before taking it. Therefore there is no evidence that compliance with or withdrawal from medication was helpful and no evidence of placebo effect as Becky did not want the medication or believe be it to be helpful.

Becky reported that she had felt very suicidal and she attributed this to the effect of medications as the feelings had increased since she had commenced the medication. She reduced medication herself (antidepressant) and the pressing idea of acting on suicidal feelings diminished. Suicidal feeling are occasionally a documented occasional side effect of some anti-depressants (described in contraindications). Moncrief (2011) points out that anti-depressant efficacy, despite their intense

marketing and high usage there is little evidence of specific reduction of alleged brain abnormalities and efficacy may be limited with small potential effect sizes and rather than rectify abnormalities may tranquilize or relax a patient to mask symptoms

B7. There is no evidence that Reactive Effects of Research impacted on Becky's reporting.

The sceptic brief argues that the research process itself may have affected Becky's reports of change. The researcher had just one meeting with Becky and if there was bias this may not necessarily have been in favour of the therapist as the researcher was trained in a different theoretical modality and may have been negatively biased. The Change Interview was recorded and there was no evidence of such bias or leading the client. Becky demonstrated self-agency and the ability to cancel sessions. She chose to return for an ending, then was able to decide the length of the session.

Conclusion

The evidence described suggests that the therapy did have a significant impact on Becky's positive changes. Reliable change in reduction of distress was shown by the CORE data as well as positive outcomes in a number of qualitative measures. Some psychotic process symptom reduction enabled Becky to resume activities. This important reduction in symptoms was reported by the client herself. Although other factors and biases may have impacted to some degree it is clear from Becky's reports of her therapeutic alliance and self-reporting that she experienced the therapy as positive and significantly impacting on positive changes. Despite any apparent inconsistencies or minimal missing data (which is common in clinical practice) the change record transcript and CORE and HAT and TRS records are accurate and themselves reflect positive changes outcomes. Changes in CORE outcomes are statistically valid in demonstrating reliable change. The Change Interview shows Becky herself attributing key changes to the therapy which she felt would have been unlikely otherwise and evidence throughout shows a strong therapeutic alliance and positive feedback from Becky. The therapy was central in supporting this vulnerable young woman to positively progress from a point of being a safeguarding risk and severe distress and isolation to increased personal and social functioning and reduced distress.

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D.5 Sceptic rebuttal

SCEPTIC REBUTTAL

The case of Becky

Compiled by Anna Robinson

It should be noted that the arguments presented here are not the direct views of the author but rather are made to help facilitate the analysis of change in this case through the presentation of contrasting views.

After reading the affirmative rebuttal it is my contention that, although it does present some important points regarding Becky's treatment, it does not provide sufficient evidence to support all the arguments posed. That is, although it is evident that some changes were seen in Becky over the course of Person-Centered-Experiential treatment, it remains unclear, at best, that the client's changes were more than minimal or that these changes were the direct result of PCE therapy itself in reducing psychotic symptoms. Therefore, this rebuttal, does not simply challenge each point made in the affirmative brief, but instead questions the main conclusions drawn from the analyses.

In the sceptic brief, attention was drawn to an important piece of information regarding the outcome data: No reliable change in psychotic process was noted on any of the quantitative measures used to evaluate change in such psychotic processes. The affirmative rebuttal also fails to address this point, instead reiterates qualitative data as evidence of quantitative change in psychotic process. As such, this key point remains unaddressed. Rather, the affirmative side relies on creating arguments from literature to support why the CORE-OM is an adequate quantitative measure for measuring psychotic symptom change. Further, the affirmative brief and rebuttal rely on making quantitative claims of psychotic process change by drawing on qualitative outcome data, which may or may not directly support the claim that Becky's psychotic process changed substantially and that any changes seen were specifically due to PCE therapy.

That is, even within the qualitative data, doubts may be cast about their validity because of the weakness of such qualitative data. For example "feeling things were more real" at the end of therapy hardly warrants a deep description that the client's psychotic process has changed as a causal result of the PCE therapy treatment alone. The affirmative side has continued to rely on the unwarranted assumption that the CORE-OM is a valid

measure of psychotic process change whilst also reiterating weak qualitative data. Thus, there is no convincing evidence here for quantifiable change in psychotic symptom severity.

Overall, methodological weaknesses in the data set makes it difficult to triangulate quantitative and qualitative data to draw causal links between PCEP treatment and reduction in psychotic symptom severity; this is not addressed in the Affirmative Case rebuttal. There are questions over the corroborating evidence and authenticity of the data, as some qualitative outcomes reported by a PANSS researcher could not be located in the Rich Case Record, specifically claims that the client reported, "her life was in danger." This could indicate how the affirmative side reported evidence selectively. The Affirmative Brief rebuttal criticises the point made in the Sceptic Brief asserting that the client uses brief descriptions of her venting in the sessions. This argument appears to miss a methodological point that is aimed at the weakness of the research data collection methods. The lack of audio transcripts meant that the affirmative side had to rely on limited client self-reports and potentially biased therapist recall. This is a methodological weakness and one that is not addressed by the Affirmative rebuttal.

The Sceptic brief previously asserted the point that the client was trying to please the therapist, the researcher, and to positively influence the research endeavour overall. In response, the Affirmative rebuttal has put forward qualitative data supporting the argument that 'the client does not sound like a coerced client but one who could self–advocate'. However, it has failed to address alternative kinds of possible people-pleasing behaviours, such as expressing a desire to hug the therapist. The Sceptic brief pointed to people-pleasing behaviours and the questions these raise about an excessive reliance on qualitative data, especially when client self-reported changes in psychotic processes have not been triangulated with appropriate quantitative outcome measures of psychotic process.

In the section entitled, "No Evidence Exists that Extra Therapy Events Substantially Affected Client Change", the Affirmative Rebuttal proposes that any extra therapy events were 'initiated as part of the therapy and part of their success in themselves is from therapy based work relating to coping'. This is in itself a claim not backed up by evidence. No attempt was made to gather data on any additional extra-therapy events, which could have been done using the Therapist EFT Session Form. Instead, the Helpful Aspects of Therapy was used in isolation, with the focus of asking the client to name the actual aspects of the therapy that they could identify as helpful. In fact, the therapist engaged in several important extra-therapy activities on behalf of the client, including making referrals for additional services and writing support letters to employers. Unfortunately, the client was not asked to identify any additional aspects extra to the therapy or tasks carried out by the therapist that

they could identify as helpful. Further, the Affirmative rebuttal asserts an argument that the extra-therapy activities of the therapist on behalf of the client fell within the expectations of a PCE approach. This Sceptic rebuttal then poses the question of what are the necessary and sufficient conditions of PCEP that can be causally attributed to the reduction in psychotic processes? These causal treatment factors resulting in psychotic symptom change become harder to identify due to this expansion of what is considered the actual treatment or therapy.

In addition, the Sceptic Brief put forward additional extra therapy client activities that could have an attributing factor to reduction in psychotic process symptoms, such as the acquisition of a pet dog. The sceptic brief put forward an argument drawn from empirical research findings on animal-assisted therapy and its growing evidence base for a number of populations, specifically service users with psychosis. The Affirmative Rebuttal does not address the argument regarding empirical research on the therapeutic impact of animal-assisted therapy, but focuses on the actual behaviour of getting a pet dog, again, missing the argument that additional factors other than PCEP treatment may have contributed to psychotic process symptom reduction.

Therefore, it is still the contention that the Affirmative Rebuttal has failed to demonstrate sufficient evidence that PCEP therapy alone is responsible for reduction in this client’s psychotic process.

D.6 Affirmative and sceptic summary narrative

Becky: Affirmative and Sceptic Summary Narrative

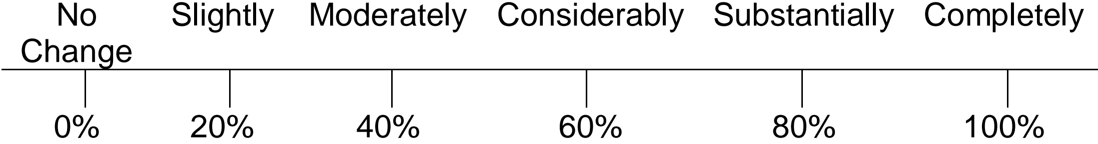
Affirmative Summary narrative	Sceptic Summary narrative
Aim: To show that evidence supports the case that Becky's therapy had a causal impact on substantial positive outcomes	*Aim:* To show that Becky did not change substantially as a result of the therapy and that reported changes were influenced by researcher bias, Becky wanting to please others ,natural events, other interventions and events
Client Relevant Background (Moderators): Becky's psychosis process (which caused her to consider suicide and to become afraid of harming others) was precipitated by a series of traumatic losses, in the context of a long standing history of family difficulties.	Becky was experiencing grief and other distress. She presented to therapy and other interventions and sought her own coping
Within-therapy change processes (Mediators): In spite of her difficult, chaotic process, which made hard to access services, Becky formed a positive alliance with the therapist. This alliance enabled her to "vent" and explore her anxiety, grief, unresolved conflicts and family issues. As a result, she developed self-soothing and coping mechanisms as well as self-acceptance and exploration of multiple unresolved relational issues. Over the course of therapy, there were fluctuations but consistent measureable progress.	Becky was compliant and reported positive progress on measures and to the therapist and researcher as she wanted to please them. Some progress occurred anyway, regardless of whether interventions were given. Factors such as extra interventions and Becky gaining a pet were therapeutic and significant to her progress.
Outcomes: Becky's psychotic process reduced as a result of the therapy. Things seemed more real and the voices ceased. Her risk of harm to self and others reduced. She was more able to mix with others and go out. Feeling more stable towards the end of therapy, she was became able to access other services.	Some changes occurred but they were not substantial. The PANSS time 2 measure was not conducted and other measures did not sufficiently capture change in psychotic process.

D.7 HSCED Instructions for judges/ pro forma

HSCED Instructions for Judges and Opinion Pro Forma (Version 3.3, Oct 2017)

Completing the adjudication process
Please highlight your answers on the scales provided (for example, use your mouse to highlight the appropriate answer and change to bold type or a different colour.)
In answering the rest of the questions, please use whatever space you need in order to give a full response.

1a. To what extent do you think this client *changed* over the course of therapy?



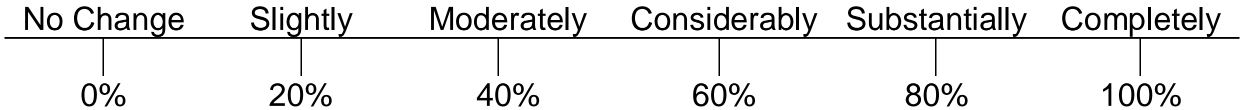
1b. How likely do you think it is that the client in this case showed at least *substantial* change over the course of therapy?

1c. Please describe the basis for your judgement:

1d. How much did you weigh (take into consideration) the following case elements in evaluating *client change* over the course of therapy?

	Not provided in this study	Not at all 1	Slightly 2	Moderately 3	Greatly 4	Extremely 5
a. Background data (from assessment interviews)						
b. Quantitative outcome data						
c. Change Interview data (including transcript)						
d. HAT data						
e. Affirmative Case						
f. Sceptic Case						
g. Affirmative Rebuttal/Closing argument						
h. Sceptic Rebuttal/Closing argument						
i. Other						

2a. To what extent do you think that the client's changes were due to the therapy?



2b. How likely do you think it is that the client's changes were at least *substantially* due to therapy?

2c. Please describe the basis for your judgement:

2d. How much did you weigh (take into consideration) the following case elements in evaluating the extent to which client change was due to therapy?

	Not provided in this study	Not at all 1	Slightly 2	Moderately 3	Greatly 4	Extremely 5
a. Background data (from assessment interviews)						
b. Quantitative outcome data						
c. Change Interview data (including transcript)						
d. HAT data						
e. Affirmative Case						
f. Sceptic Case						
g. Affirmative Rebuttal/Closing argument						
h. Sceptic Rebuttal/Closing argument						
i. Other						

3a. Which in-therapy processes do you feel contributed (either positively or negatively) to the client's outcome?

3b. Which extra-therapy client characteristics or personal resources do you feel contributed (either positively or negatively) to the client's outcome?

3c. Which aspects of the client's extra-therapy life situation/circumstances or events do you feel contributed (either positively or negatively) to the client's outcome?

D.8 Completed Combined Judges Proforma

HSCED Judge verdicts (combined)

1a. Extent of change over course of therapy

A 40

B 80

C 80

D 30

E 30

Mean = 52% Median =40%

1b. Likelihood of Substantial Change over course of therapy

A 20%

B 100%

C 80%

D 20%

E 50%

Mean = 54% Median =50%

1c. Basis for judgement (for a and b) :

Judge A

It is clear from the CORE scores that the client has improved on reported distress symptoms, with a statistically significant result. The client's qualitative self-report measures also indicate she has considers she has changed both in terms of emotional experience and in terms of behaviour. This is also the therapist's contention. The client reports better contact with reality, higher levels of social engagement, better coping skills and more meaningful work and relationship experiences. Therefore, it does not seem controversial to me to accept that the client has experienced considerable change.

However, it is unclear to what extent these changes also extend to psychotic process, and this damages the affirmative case. There is evidence from the qualitative measures that the client continues to have experiences that the

therapist suggests are indicative of psychotic process, so it is much more difficult to demonstrate change here. In the absence of an opportunity to triangulate data, as PANSS data was not provided, whether the client's psychotic process changes as a result of therapy is difficult to verify and be confident about. The sceptic brief highlights that complex grief can induce similar experiences, and in order for this argument to be refuted, the affirmative brief needed to articulate more clearly why the client's experiences were better articulated as psychotic process than grief, or why one could be an expression of the other. Reporting of PANSS scores would have been very helpful, even if they were incomplete and not administered by the same researcher.

Likelihood of rating the change as substantial would also have increased if the client had crossed the clinical cut-off on CORE. I found the change interview data difficult to make sense of, not knowing the case intimately. What was presented was a summarised the client's post therapy changes in a list of codes, but as they were in some ways already represented in the Rich Case Record, it was difficult to gain extra value from them. I wonder if a more narrative summary would have helped get a richer sense of the case. In addition, a Personal Questionnaire and presentation of its results would have given a much clearer demonstration of what the client found problematic and how this changed.

Judge B

Given the case and all the data presented, it seems to me that the negative and downwards going spiral of symptomatology and not-well-being was stopped. Even positive change was registered, although a certain vulnerability stayed, as shown on occasions when still symptoms there.

Judge C

The outcomes that Becky stated changed during therapy can be said to be the impact of psychosis and evidence that during this process further deterioration was prevented. This is not out of line with other recovery narratives that work on impact of psychotic processes rather than the voices and or paranoia themselves. It is often the functional impact of psychotic processes that people find most problematic and this that causes further deterioration in psychotic processes. There is no evidence that Becky gave good feedback to please the therapist as the measures were carried out by another professional. All research into the impact of therapy could be said to be confronted with this issue. Becky states within the outcome measures several times that she was very surprised that this change had taken place indicating that an out of the ordinary shift had taken place in her mental health.

Judge D

Using the percentage scale, I would say that the client changed 30% over the course of the therapy. I find the phrase "at least substantial change" difficult

to understand, but would say somewhere around 20%. The basis for my judgement is as follows:

- Rich Case Record Figure 1 shows a clear general reduction for the weekly mean outcome data scale over the 22 week period of therapy, using the CORE 10 and corresponding CORE 34 questionnaire. The data appears to show that Becky's distress and difficult symptoms are gradually decreasing over the 22 weeks.

- Rich Case Record Table 2 shows specific changes that Becky could identify at the end of therapy which were reported in the Client Change Interview. These changes are: "feeling things are more real", "getting out more", "meeting people", "getting out of the city I live in" and that three of these would have been very unlikely without therapy.

- Also reported in Client Change Interview, "being more in control", "coping better in general", "coping better with anxiety", "getting on with stuff", "coping better around people" and "coping better talking to people". These are definite results which will improve Becky's mental health. These are also life skills that we all improve and refine as we mature. Hopefully Becky will be able to access more therapy if she wants it in the future. She can prioritise and understand her own needs better.

- For me, there are two elements of change going on. There are the identified changes like "coping better" and immediate changes which are co-incident with the therapy. Then, in the longer term, there's a change about being able to ask for help and support when it's needed –a familiarity with the idea of therapy as a tool to deal with issues.

- Client Change Interview -Global effect of therapy "stuff has just changed a tiny bit", "I didn't expect it to be that quick" and "I wanted though to be a hundred percent better". It sounds as if the therapy has made a change, though perhaps she would have wanted a more significant change or improvement. It sounds as if she's surprised that the 22 weeks of therapy seemed to pass quickly.

Judge E

Becky's quality of life (socialising and functioning) had improved considerably, she had found more autonomy, and accessed her creativity. She had formed a trusting relationship with her therapist and had been able to speak about matters which had been impossible / v difficult previously - generally to be able to move on in her life. Thoughts of suicide and voices had gone, she was sleeping better and her self- stigma had reduced.

1d. How much did you weigh (take into consideration) the following case elements in evaluating *client change* over the course of therapy? (judges A,B,C,D,E)

	Not provided in this study	Not at all 1	Slightly 2	Moderately 3	Greatly 4	Extremely 5
a. Background data (from assessment interviews)			D	A E	B C	
b. Quantitative outcome data				E	B D	A C
c. Change Interview data (including transcript)			A C		B D E	C
d. HAT data		D	C		A B	
e. Affirmative Case			C D		B E	A
f. Sceptic Case			D	B E	C	A
g. Affirmative Rebuttal/Closing argument		D	C		A B E	
h. Sceptic Rebuttal/Closing argument		D	E	B	A	
i. Other						

2a. Extent Of client's changes due to the therapy?

A 40%

B 80%

C 80%

D 60%

E 50%

Mean + 62% Median =60%

2b. Likelihood that client's changes were at least *substantially* due to therapy

A 40%

B 80%

C 80%

D 40%

E 40%

Mean 56% median =40%

2c.Basis for judgement:

Judge A
As this was an early intervention case, we do not have a comparison to what would have happened had the client not had therapy, and the evidence provided by the affirmative brief points to the importance of the therapeutic relationship for longer term outcome. As this was rated consistently highly by the client, this goes some way towards giving credence to the hypothesis that therapy was responsible for helping the client change. The sceptic brief suggests that it is suspicious that the client is only positive about therapy and the research process because she wants to please, though there is no evidence to support that claim, and therefore, I am inclined to give more weight to the affirmative brief on this point.

Reading through the documentation, it appears to me that therapy has contributed to increasing the client's stability, which enabled her to cope with life again, finding some normality in day to day activities (employment, socialising) and relationships (boyfriend, friends). It is possible that therapy has acted as releasing her actualising tendency which was constrained by conditions of worth, both imposed by parents and self-imposed guilt after her brother's death. However, it is hard to evidence this on the basis of the documentation provided.

Judge B
The quality of the therapeutic offer made,
as well shown/proven/lying in the characteristics of the relationship itself, – very much in line with the so called "necessary and sufficient conditions for constructive personality change", as described by Carl Rogers (1957) -
in the referral as
in the help with practical things, made change possible.

I understand the substantial change that became visible and measurable, as the spin off of this high quality (read: therapeutic) relationship.

Judge C
The fact that Becky clearly states she felt understood by the therapist and on numerous occasions was able to release emotion suggests that she had a strong therapeutic alliance with the therapist. This together with the sense of control of things she felt were problematic in the outcome measures that were likely a response to psychotic processes indicates that the changes she made can be attributed to the therapy process. The fact that Becky chose to return to therapy for many sessions indicates that she felt she was benefiting from the therapy.

There were other factors that could have had a positive impact on her mental health such as getting a dog, being in a new relationship or changing employment. This makes this research imperfect in relation to providing an evidence base for this approach. However, all research into any approach designed to benefit someone mental health does not happen in isolation to the service user's life. This indicates that more research into this approach is needed to test is validity on a greater number of people who are facing the challenges that can be associated with psychosis.

D-I think that the client changes were considerably due to therapy, a value of 60%. Again, I find the phrase "at least substantially" difficult to use, but would give a value of 40%. The basis of my judgement is as follows:

- Rich Case Record Table 5 shows information from the HAT (Helpful Aspects of Therapy) questionnaire which she filled in each session. It shows that Becky appreciates the time to talk to the therapist, express how she feels and be understood, often valuing it as "greatly helpful" and sometimes "extremely helpful".

- The Client Change Interview indicates the specific processes that helped during therapy. The theme of opening up seems to be important -someone trusted to talk to. Becky cites, "Being able to talk about stuff that I wouldn't be able to talk about with family and friends", "being able to vent about stuff is good 'cause it's not all inside then". The therapy has given Becky an important space to express herself in. The relationship with the therapist is sufficiently good that she can be open, find relief and be understood.

- The Skeptic Brief discusses other events that could have effected client change, including changes in Becky's employment, getting a pet dog, involvement of other sources of support such as Early Intervention in Psychosis team and Becky's own natural grief healing processes. These things probably would help Becky too. But that is the nature of therapy, it is co-incident with real life and real life doesn't stop. Having a weekly commitment to spend time with a therapist at least allows the opportunity to look at it all, prepare for what's happening and process what needs to be processed.

E- So far as I can assess, Becky seemed to have valued and enjoyed the therapy sessions, by being responsive and turning up regularly, even if there had been set-backs. She felt free to explore other options, tried EI, took the decision to come off meds, so she felt more confident and in control of her own life. In many ways, I think therapy (any kind) is a trigger to allow clients to explore options for themselves, so I see this as a success. People are not predictable clockworks and so the times for further developments and the directions chosen, will be individual, might happen quickly, or may take many years. Aren't we all explorers of and throughout our own lives?

2d. Weight of case elements in evaluating the extent to which client change was due to therapy

	Not provided in this study	Not at all 1	Slightly 2	Moderately 3	Greatly 4	Extremely 5
a. Background data (from assessment interviews)	(item not completed by D)		A	E	B	C
b. Quantitative outcome data		D	C	B	E	A
c. Change Interview data (including transcript)				A	B C D E	
d. HAT data				C	A B D E	
e. Affirmative Case			D	C E	B	A
f. Sceptic Case			E	B D	C	A
g. Affirmative Rebuttal/Closing argument			C D	B E	A	
h. Sceptic Rebuttal/Closing argument			C D E		A	
i. Other						

3a. In-therapy processes which contributed (either positively or negatively) to the client's outcome?

A It seems clear to me that the client valued the opportunity to talk and that feeling understood was one of the most important parts of therapy. She consistently rated the therapeutic relationship highly and several aspects of change as unlikely to have happened without therapy. I also think that therapy allowed the client to access her inner resources to rebuild some structure to her life and that this enabled her to start a more positive process of change overall. It's not always easy to tease apart what is caused by therapy and what is the client's determination to make changes outside of therapy but I think that therapy in this client's case enabled the client to access coping strategies and self-initiated change processes. However, I think that these are generic processes, and cannot find enough evidence to link them to reductions in psychotic process. In addition, without any evidence, I would not be able to confidently distinguish between the complex grief the client is experiencing and psychotic process, and whether they are even different or part of the same thing. It is hard to tease apart completely what is extra-therapy resources and what has been initiated in-therapy, partly because there are gaps in the quantitative data and (for me) some question

marks about the uniformly positive ratings of the client, with a market absence of unhelpful therapy events.

B Relationship offered and the actual help given, constituted a layer of trust upon which the client could start taking charge of her own life more, paralleled by the diminishing of feelings of anxiety, depression, fear…

The case shows that the therapist was not treating psychotic symptoms to reduce them, but working with and for a person to be with her and empower her by means of the quality of the relationship offered.

C-The familiarity of the therapist with psychotic processes. The therapeutic alliance with the Becky feeling like she was understood.

D-Looking at the Client Change Interview, it appears that positive processes include:

- space and time to talk to the therapist
- quality of the therapeutic relationship
- validation of Becky and her thoughts
- being and feeling understood
- Becky's relationship to her stress, relieving it and leaving it behind
- validation of the therapist -a valued specialist member of a multidisciplinary support system

Looking at the Rich Case Record, some of the positive processes mentioned also include:

- painting
- use of miniatures

I'm not sure about what negative in-therapy processes might be. I did feel that maybe the many questionnaires that Becky had to complete as part of the research might have been a little intrusive. Committing thought to paper, analysis of yourself and the session, might interrupt the natural ebb and flow of ideas about oneself and self -narratives. When I've had therapy, there has always been the choice whether to journal something or not. Sometimes it's nice to hold on to powerful statements for further reflection and sometimes it's nice to just let something go and not write about it.
E- PCT Becky stuck with this, it enabled her to build self confidence and trust. EI tried it for a short time. Meds abandoned as she did not like the adverse effects

3b. Extra-therapy client characteristics or personal resources which contributed (either positively or negatively) to the client's outcome?

Judge A

It seems that the client has <u>quite a few difficulties in relationship with family and friends</u>. During the period therapy took place, she made a number of

quite radical and practical changes in her personal life such as increasing her social life, changing employment, travelling more and getting a dog. This is not unusual for someone her age and from my experience in working with young people, I note that change can often happen very quickly. In addition, she was offered a referral to a specialist service, and was supported in the time waiting for this to take effect. I'm not sure what to make of the variations in taking medication, as the medication appears to be antidepressant, rather than specific to psychotic process. In my experience clients vary enormously in personal responses to medication and planned or unplanned changes to this.

Judge B
Nevertheless neither intellectual nor emotional sophistication, she could engage in relationship, and once this specific therapeutic relationship installed/operating, she was psychologically strong enough to be able to take some risks, to speak out, to let somebody in and share her world, and try out new things.

Judge C Becky exhibits the ability to release emotion in the sessions. She shows a willingness to learn new coping strategies.

Judge D I think it is a shifting situation. During therapy I have found that some weeks can seem like there's a lot to discuss and other weeks one might not feel like it at all. Some weeks an area of improvement can appear obvious and sometimes one feels there to be not so much improvement, it feels like treading water. But the main thing is to keep at it and attend week in and week out –which is something that Becky was able to do. That *perseverance* and *tenacity* is very valuable. Her *motivation* to utilise the help available is a powerful facilitator of change.

Judge E
Becky showed tenacity, even when life was difficult, she could be assertive, and showed optimism leaving an unsatisfactory job, making plans to holiday and leave her home city, developing new social relationships and not being bogged down by past family problems.

3c. Which aspects of the client's extra-therapy life situation/circumstances or events do you feel contributed (either positively or negatively) to the client's outcome?

Judge A
The client appears to have difficult relationships with family members and I think that the lack of support after the loss of her sibling contributed significantly to the emotional difficulties she experienced, particularly because she does not appear to have had the support she needed from her parents and friends. Stabilising relationships seem to me to have contributed to the client's improved functioning.

Judge B Being successful in the steps she made in the world out there, created an upward spiral of trust, resulting in positive change.

Judge C

Getting a dog, changes in her medication, being introduced to the early intervention team and a new relationship.

Judge D

Looking at the Background Information, there is the family grief about the recent loss of Becky's sibling.
Looking at the Client Change Interview, there is the familial relationships and difficulty in communicating with her parents, the lack of apparent emotional support at home.
The Rich Case Record Table 3 notes her leaving her stressful job and finding new employment.
The Rich Case Record Table 4 Becky talks about spending time with friends who would like to go to a music festival.
The Skeptic Brief discusses the health benefits of getting a dog.
The Rich Case Record therapists notes /timeline talks about the life situations that Becky was dealing with.

I get the feeling of a young person who needs support following a family tragedy -the loss of a brother. Becky's parents who she can't always speak with. There are other relationships with friends and work and other areas of Becky's life which she is also able to bring to the therapy. I find it difficult to say how much these are contributing to the final outcome. To me, it appears that at the end of therapy Becky understands herself better and knows where further help is needed. She also appears to hold some hope for the future in the form of a new relationship and exploring options around sharing a flat with a friend.

Judge E

Socialising more widely and acquiring a dog.