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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

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Signed: *W Traynor* Date:*27/6/19*

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Abbreviations used in this thesis

APA	American Psychiatric Association
BACP	British Association for Counselling and Psychotherapy
CBT	Cognitive behavioural therapy
CBTp	CBT for psychosis
CCT	Client-centred therapy
CfD	Counselling for depression
CMHT	Community mental health team
CPR	Change Process Research
DSM-5	Diagnostic and Statistical Manual, fifth version (APA, 2013)
EFT	Emotion-Focused Therapy
EIP	Early intervention in psychosis
HEP	Humanistic experiential psychotherapy
HSCED	Hermeneutic single case efficacy design
HVM/N	Hearing Voices Movement/Network
IAPT	Improved Access to Psychological therapies
ICD-10	International Classification of Diseases, 10th version
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
OCT	Open Clinical Trial
PCEP	Person-centred experiential psychotherapy
PCT	Person-centred therapy
RCT	Randomised controlled trial
SC	Supportive counselling
ST	Supportive therapy
TRS	Therapeutic Relationship Scale
WHO	World Health Organization

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Abstract

Psychotic processes may involve a wide range of experiences, including hearing voices or other hallucinations, delusions or paranoia, or unusual or disturbed thinking or behaviour. Some clients who experience psychotic processes may not be responsive to standard psychotherapy formats and can thus present challenges for therapies of all orientations. The mixed method research strategy presented in this thesis is an attempt to uncover more information regarding helpful and unhelpful practices and changes in clients who experience psychotic processes. First, I explored UK therapists' practice with clients who have unusual experiences or 'psychotic processes' and their perceptions of helpful and unhelpful practices and changes in clients. Second, I investigated clients' perspectives on helpful and hindering factors in person-centred therapy (PCT) as well as post-therapy positive or negative changes. Third, I investigated, in detail, one case of a client with psychotic processes who received PCT, considering causal efficacy. The three related studies carried out also considered, to some degree, the context of treatments offered and other impacting factors.

The first study involved semi-structured interviews with 20 person-centred practitioners working with clients with psychotic processes. The interviews focused on what practices they had encountered that were helpful to or hindered practice with clients, as well as any positive or negative changes they had observed in clients.

In the second study, 20 adult clients who had self-identified as hearing voices, having other unusual experiences or psychotic processes were interviewed mid- or post-therapy using the Change Interview protocol (Elliott, Slatick, & Urman, 2001). Studies 1 and 2 were analysed using grounded theory (Corbin & Strauss, 2008).

The third study consisted of a hermeneutic single case efficacy design study (HSCED; Elliott, 2001) with a client who was experiencing psychotic processes and who received 22 sessions of PCT. This HSCED study involved rigorous analysis of qualitative and quantitative data gathered over the 22 therapy sessions. The data was presented to a sceptic adjudicator and formally debated in a quasi-judicial forum with five independent judges: two therapists, a carer and two experts by experience. Following integration of the results of the judgement stage, conclusions were reached regarding the possible impact of the therapy and the possibility and degree of causal efficacy.

Overall results raised themes regarding helpful or unhelpful practices and changes in clients, from the perspectives of both practitioners and clients. Results indicated that most practitioners incorporated pre-therapy and contact work into practice, with positive and sometimes surprising results. Practitioners often worked in multidisciplinary contexts with careful attention to supervision, self-care and boundaries. They saw person-centred values and the real relationship as important. Unconditional positive regard (UPR) was the most critical condition named both by practitioners and clients in this client group, possibly because they often felt judged or diminished by those around them. Helpful practices were associated with person-centred values. Unhelpful factors included practices such as judgement and unwanted directivity, both of which deviated from the person-centred (PC) approach.

The main changes in all studies involved an increase in social abilities and positive sense of self, and an increase in specific aspects of wellbeing. There was some evidence of improvement in mood and reduction in unusual experiences.

Clients engaged in the real relationship in therapy. Studies 2 and 3 showed that most clients were evidently active agents in their own change process. Findings demonstrate that PCT can be helpful for adult clients with psychotic processes. Practice implications are discussed.

Limitations of the studies include the dual therapist-researcher relationship in the HSCED study, the homogeneity and small size of the samples, and concerns about data validity. Issues relating to measures used to ascertain changes in therapy are discussed. Results are promising and suggest that PCT can be effective for clients who experience psychotic processes, pointing to the need for further research.

Introduction

The three research studies described in this dissertation were inspired by both personal and professional experiences of supporting people in psychotic processes and awareness of the limited research and information which currently guides practice and care pathways. For 32 years I have worked in other supportive roles with adults and young people as clients and for more than 24 of those years I have worked as a therapist. This work has included supporting individual adults and young people who have had unusual experiences or psychotic processes, as well as involvement in the education and supervision of therapists working with complex processes. I have received training in person-centred counselling and psychotherapy as well as later undergoing pre-therapy international network-approved training in pre-therapy, and I have integrated pre-therapy into my person-centred clinical practice as a method of working with clients in complex process, where appropriate.

I have periodically drawn upon literature and other training, as well as client feedback and experience, to inform and improve my practice. Compared to some other popular approaches, such as cognitive behavioural therapy (CBT), person-centred practitioners have historically been less engaged in research, particularly research on a larger scale or of a quantitative nature.

I was therefore motivated to conduct research in this area in the hope of increasing the understanding of helpful and unhelpful practice, and the positive or negative changes that can occur within therapy with this client population. I hoped that this might contribute towards knowledge regarding how to work optimally with clients with psychotic processes. I was motivated to consider the interests and needs of clients primarily but also to consider those of practitioners in terms of the training or support that is needed to conduct such work and stay healthy.

The first study investigated practitioners' approaches to psychotic processes and their perceptions of helpful or hindering practice as well as observations of changes in clients. The plan was to follow this with a client trial with statistical power and then follow this with a rich case study. The original study 2 research design of an open clinical trial (OCT) set out to address the lack of large-scale robust research in this area. Following the completion of the first study, which was to become known as study 1, I received NHS approval to conduct an open clinical trial in the form of study 2. Unfortunately, updated UK care pathways referring to the support for individuals with "symptoms of" or a diagnosis of schizophrenia and psychosis (schizophrenia being medically classified as a psychotic condition) then began to state explicitly that supportive counselling was not recommended (NICE, 2009).

Counselling was therefore contraindicated and was no longer a 'usual treatment' (NICE, 2009, p. 290) for psychosis, as I will explain further in Chapter 1 (1.3); the implications of this change for the current research are explored in Chapter 3. This being the current climate in the UK, therefore, it was not feasible to gather data within the remit of the PhD and its time constraints. I therefore changed the design of study 2 (as illustrated in appendices A3-A12): Instead of an open clinical trial I conducted 20 structured interviews with clients to ensure that I gained a client perspective as part of my overall research design. It was important to be realistic within the wider parameters. Although my research journey was met with hurdles, and the design changed shape, I was nonetheless able to conduct three studies providing qualitative and quantitative data in an attempt to better understand this area of focus.

I therefore modified my design to replace my planned OCT with a study in which I directly asked clients about their experiences of therapy; this received ethical approval from both the University of Strathclyde and NHS ethics. The Change Interview protocol (Elliott, Slatick & Urman, 2001) was used as the basis for structured interviews in this (study 2). The process generated both qualitative and quantitative data which were analysed using a grounded theory approach (Glaser & Strauss, 1967).

The data in my final, HSCED study involved the use of outcome measures throughout therapy with an adult client with psychotic process and complex difficulties. The process of hermeneutic analysis (based on interpretation of data) then followed involving the primary researcher, a sceptic researcher and five independent judges, leading to final conclusions.

The three studies comprising this PhD are concerned with Person-Centred Therapy (PCT), including pre-therapy. PCT is a mode of practice that focuses more on, and encapsulates, “ways of being” rather than “techniques”, here in the context of unusual experiences and complex processes. The approach has often been the source of critical scrutiny, although many of the elements of the PCT approach, such as empathy and careful attention to power dynamics and respectful relating, are consistently cited as some of the key desirable features of therapy in mental health survivor literature as well as other elements including learning and social justice (e.g. Ochocka, Janzen & Nelson

,2002). Nurses and professionals in the wider multi-sector context of care settings such as acute psychiatric wards may struggle to offer relational approaches, even if desired, due to competing pressures (McAndrew, Chambers, Nolan, Thomas & Watts, 2014).

Critics in professional forums that question the PCT stance for psychosis is as at best benign or at worst dangerous (as discussed by Patterson,1985) have struggled to evidence their views, although Sommerbeck (2003) has refuted such critiques with case examples. However, in some areas of the UK many practitioners, including myself have historically been under pressure to undertake additional training in so-called evidenced modalities, developing more integrative or pluralistic practice in order to remain employable within mainstream or statutory services, or working in private practice or the third sector, making the best choices for themselves within current parameters.

I embarked on this doctoral research while continuing to work as a therapist. I often encountered other therapists in a similar position – facing complexity in the therapy room whilst simultaneously dealing with the wider challenges affecting clients and treatments such as discrimination, rationing of resources, socio-economic deprivation and the professional political context (e.g. Yoshimura, Bakolis & Henderson, 2018). Within the UK mainstream mental health treatment provision involving the medical model and its associated diagnostic framework was applied to many vulnerable clients who were often provided with differential diagnoses and limited or comprehensive care packages involving multi-sector treatment from a range of professionals and disciplines. There were also options in some areas of co-existing alternative third sector or survivor or user-led provision, as will be explored in Chapter 1.

PCT therapists, in particular, those working with difficult client processes, are often asked to provide a strong account of why they are offering counselling within a modality with a supposedly less robust evidence base and a comparatively less research-evidenced approach than, for example, cognitive behavioural approaches.

Since working in a fundamentally person-centred way could be so easily challenged, my research began by focusing on unpicking existing research, and listening to the stories of clients, therapists and significant others. I conducted the research while continuing to negotiate a world in which there was considerable lack of understanding and trust between therapists of different models. I became determined to build bridges, understand and communicate with professionals working with this client group, while always keeping the clients and their experiences at the centre of the work.

As I embarked on the research journey my attitude changed. I became less defensive or protective regarding the often-criticised person-centred approach and increasingly open and driven towards simply discovering what findings emerged. This echoes Rogers' conquering of his own fear of disappointing results and later Rogers' stance that "the facts are *always* friendly" and his view that even a small amount of data can lead one closer to the truth (Rogers,1961d).

I immersed myself in the scientific paradigm, focused on sifting through a growing body of data and found myself adopting a more pragmatic approach. I was curious to find actual emerging results rather than hoping for positive results, because I realised that I just wanted to learn what practice was the most beneficial to clients. This attitude change was driven partly by education and partly by the emotional impact of powerful interviews, describing both helpful and unhelpful therapy experiences. I was humbled by the integrity, openness and wisdom of participants and the support and encouragement offered to me by the many people that I met on the research journey. There was a definite shift in vision for me.

I felt myself surrendering to the data and what it taught me. It was as if I gradually became more ethically focused to stay true to the data and the messages within it, regarding both positive and more difficult or even unethical or damaging experiences of the therapy process. I wanted to really attempt to understand what many clients felt that they needed or wanted or found beneficial to them instead of resting on my own assumptions or prejudices. I still held some bias, which is inevitable in all research journeys; however, audit processes by my supervisory team, both of my data and at all stages of analysis, helped to take some account of any errors and bias, and to ensure I was as true to the data as realistically possible.

The rest of this dissertation consists of the following chapters:

Chapter 1 is the literature review. This is followed by three chapters detailing each of the studies and finally, Chapter 5 offers an overall discussion. Chapter 1 offers a selective review of the literature supporting person-centred practice for clients with psychotic processes including practice considerations and outcome studies and is more concise than the following two chapters as the study was published. Chapter 2 describes study 1, which encompasses twenty interviews with practitioners who have worked with clients in psychotic processes, analysed using grounded theory, concluding with an interim discussion of the implications. The two longer chapters following this practitioner study are both client studies and both have larger and more complex data sets, requiring more extensive analyses. Chapter 3 describes study 2, which consists of twenty qualitative interviews with adults who hear voices or have unusual experiences or psychotic processes. This study was analysed using grounded theory. The chapter concludes with a preliminary discussion of results. Chapter 4 describes study 3, which is a systematic, mixed methods case study of one client in psychotic process who underwent PCT, using the legalistically styled HSCED method. Results are briefly discussed. Chapter 5 then provides an overall discussion that firstly summarises the results of all three studies and compares these common results to one another and to the literature. This is followed by possible learnings, practice implications and practical and research implications.

Chapter 1

Literature Review

1.1 Introduction to literature review

This chapter explores key international literature supporting my research on PCT for "psychotic process" (Warner, 2001a). This is a selective review with a focus on relevant texts that were available at the time in English.

The focus of this literature review is on client-centred therapy or person-centred therapy, based on Rogers (1959), including pre-therapy (Prouty, 1994) either offered as a distinct approach or incorporated into a PCT therapy model in the context of person-centred and experiential psychotherapies, as well as some consideration of similar or complementary approaches. All participant practitioners and clients in the three studies conducted for this PhD stated that they offered or received PCT (classical PCT or other PCT "tribes"; see Sanders, 2004, 2012).

All three studies in this PhD are related to PCT for adult clients who have experienced unusual phenomena, such as hallucinations, paranoia, hearing voices or psychotic processes; have a diagnosis of psychosis or schizophrenia or similar diagnosis; are in their "first episode", sometimes referred to in specific treatment contexts as prodromal (the stage preceding symptom exacerbation); or are at ultra-high risk of psychosis, presenting with signs where onset of psychosis progress towards the medical definition.

This chapter is divided into three distinct sections which follow. The chapter introduction leads into Part A which focuses on the treatment context with Part B then following to consider the theoretical and clinical context and then Part C considers change process and outcome research with a final brief section concluding the chapter. In this chapter I will offer an account of the interplay between positions supported by the research literature and at times my own personal and professional experiences which both influenced how I made sense of sources and embarked upon the three studies in this dissertation. My own personal journey is integral to the research journey and to some degree impacts upon the interpretation of materials. I feel that transparency around this is essential.

I will first very briefly discuss understandings of unusual experiences/psychotic processes and possible causes. I will then proceed to briefly examine the wider treatment context and cultural context before focusing on therapeutic treatments. I will next briefly consider recommended treatment pathways for "psychotic processes" including schizophrenia.

After that I will discuss the medical model, which is the main UK treatment model and is often part of a package of care accessed by person-centred psychotherapy clients. An awareness of the wider treatment context is important in making sense of the data to be presented in later chapters.

I will next briefly explore the key features of the development of theory and practice of the person-centred approach. I will then describe important features of the growth of person-centred theory and practice specifically applied to clients who may have unusual ideas, have paranoid thinking, experience hallucinations, hear voices or have psychotic processes. I will consider how person-centred practitioners conceptualise and work with clients with these presentations. I will then explore the person-centred perspective regarding the medical model and diagnosis. This will be followed by a brief consideration of the interrelationship between trauma and psychosis. I will then consider research studies regarding change process and outcomes in person-centred and related supportive therapies with clients who experience psychotic processes. I will lastly explore some of the key controlled research trials related to outcome research for person-centred and experiential psychotherapies with this client population. Finally, I will summarise this review of literature and how this links to the three studies that follow.

1.2 Defining and researching "psychotic process"

1.2.1 A Working Definition

For the purposes of this dissertation I will refer mainly to "psychotic process" (Warner, 2001a, p. 183) and "contact impairment" (Prouty, 1990, 1994) These terms can be used to refer to a person-centred description of this type of difficult client process or presentation. They are the terms I will use for this dissertation, to encompass the following broad definition of these types of experience, whilst accepting that these terms will themselves still present ethical or political issues. I will often refer to psychotic processes in plural to acknowledge the enormous variation in types of experiences within this description and differing somewhat from a more diagnostic stance.

I have found no definition or description that neatly encompasses a societal consensus view of psychosis and person-centred psychology. I will, at times, adopt language used in other frameworks, such as the medical model, including psychosis and schizophrenia – considered as a psychotic condition in the Diagnostic and Statistical Manual-5 (DSM-5, American Psychiatric Association, 2013) and the International Statistical Classification of Diseases and related problems (ICD-10, 2016) to incorporate wider literature and perspectives. In order to encompass different literature and viewpoints on this subject I may sometimes refer to or use medical language, which I would not usually personally choose to do unless communicating across modalities or chosen by a client. This issue will be explored later in this chapter.

When Warner refers to psychotic process, she is referring to the client's process in what has been more traditionally described as psychosis. Warner, herself a person-centred practitioner, uses the term to enable her to refer to a process rather than a "disease model" description. Warner explains:

> When clients have a psychotic style of processing, they have difficulty forming narratives about their experience that make sense within the culture or which offer a predictive validity in relation to their environment. (Warner, 2001a p. 183)

For Prouty (1990, 1994), clients who experience psychotic processes may have impaired contact with "self", "world" and "other".

I am using this broad definition to fit with the ethos of the client-centred or person-centred approach. Psychotic process will be more fully described and discussed later in this chapter.

My supervisory team and I considered the use of language and struggled to avoid colluding with societal labelling to judge the informants; at the same time, we also felt the need for a useful term to describe the informants' process. I consulted mental health service users throughout the research, particularly during the initial stages and they told me that they used a variety of descriptive language at times, including diagnostic criteria. The term "psychotic" was sometimes simply used descriptively or in other groups consciously "reclaimed", transported from medical contexts or more consciously supported and affectionately adopted by some user groups ,paralleling activist movements such as "mad pride" where traditional hierarchies of social control are challenged by positive affirmation of difference (e.g., Farber, 2012., Lewis, 2016). This idea links to the historical movement of "queer pride" and activism around gender and sexuality where an oppressed minority group rebels and reclaims power. (Perger, 2009). Such decisions may have resulted in different views in relation to the client's own self-regard and how others perceived such terms. For example, if I embraced a diagnostic category and felt it was positive, I may still be scrutinised critically by others who have a different understanding of that term which is historically loaded with many assumptions and may reinforce a hierarchical power structure in different cultures or subcultures. Therefore, there remained a dilemma regarding the best language to use, together with feelings of unease in considering the balance between what would be acceptable and yet widely understood by a diversity of different service-user, professional, medical or public audiences.

1.2.2 Strategy and method of searching the literature

My literature search for theory, practice and change processes in PCT for psychoses included specific key terms (listed below) as well as many other searches targeting subsets of these terms and related terms until saturation appeared to have been reached in terms of key papers relating to theory and change or outcomes in this modality of practice for this client population.

On learning that specific search engines have different operators and deal with the same search terms with variance to each other, I adopted a more instinctive approach as well as a more controlled search in parallel to retrieve the most relevant sources viable in the period allowed, as suggested by the following: “Literature searching is a dynamic and iterative process; there is no one way to conduct a search and there are many variables involved.” (United States National Library of Medicine, 2017).

I regularly conducted searches of databases including the Cochrane Library, MEDLINE, Psych INFO, Science Direct and Google Scholar. I also sought links from relevant websites and sources such as organisations or individuals who were involved in related areas. I used combinations of key words in different forms including person-centred/centered, counselling/counseling/therapy/psychotherapy, pre-therapy, psychotic process, psychosis, hallucinations, paranoia, hearing voices, prodromal, early intervention in psychosis, psychiatric, change, research and outcomes.

I also conducted a Boolean search in April 2017 in Medline, Cochrane and PsycInfo databases, to ascertain if any further material was available but was advised by experts in the area of academic searches that a combination of simpler searches would probably be more effective and realistic in relation to the complexity of subject and resource parameters. The Boolean search using search terms as follows:

> (outcome OR effective OR efficacy OR effect OR effect* Or clinical trial OR stud* OR follow up OR impact OR improvement.ab.it AND ((person-cent* OR client-cent* OR pre-therapy OR non-directive Or Rogerian OR supportive) AND PsychoT* OR psychP* OR psychosis OR hearing voices OR hallucinat* OR paranoi OR unusual experiences OR schizo*)

All of the above strategies have influenced a selective literature review, based on relevant key sources.

1.3 Part A: Treatment Context

1.3.1 Understanding Psychosis and the context of treatment and recovery

1.3.1.2 Treatment overview

In the UK the medical model is the dominant mode of framing and treating mental health issues and is situated, somewhat uncomfortably, beside other models, although integration of approaches and more preventative and public health strategies are increasing. Diagnosis can be linked to treatment guidance which can include medication, psychological treatments and other approaches (e.g. Electro-Convulsive -Therapy). The psychiatric diagnostic system DSM-IV-R (American Psychiatric Association, 2000) was in place at the start of this research and was later replaced by DSM-5 (American Psychiatric Association, 2013). The World Health Organization's ICD-10 (2016) is also a widely used system of classification.

Psychotic conditions are commonly described, both in the UK and in many other contexts, by medical model definitions of types of "mental disorder" with a variety of related treatment models. This can be criticised as a deficit model of emotional wellbeing, focusing on "what is wrong" rather than normalising a wide spectrum of wellbeing and offering the holistic care which many people have specifically requested (e.g. Kapur et al., 2014). Medical model definitions incorporate schizophrenia and other psychotic disorders, along with some other disorders that may include psychotic features, such as types of personality disorder. In 2013, in a growing climate of fierce debate the DSM-IV-TR (American Psychiatric Association, 2000) was replaced by a revised version, the DSM-5 (American Psychiatric Association, 2013) as the psychiatric diagnostic tool most used by UK adult psychiatrists. Key features defining psychotic disorders in this document include delusions, hallucinations, disorganised thinking, grossly disorganised motor behaviour and negative symptoms (American Psychiatric Association, 2013, pp. 87–122). This document was widely criticised for being driven by social pressures rather than in client's interests. (Pickersgill, 2014; Kinderman, Allsopp & Cooke, 2017).

Another definition comes from NHS Choices:

> Psychosis is a mental health problem that causes people to perceive or interpret things differently from those around them. This might involve hallucinations or delusions. (NHS choices, 2016)

The World Health Organization (WHO, 2018) states that schizophrenia (a psychotic condition) affects more than 21 million people worldwide and is a treatable disorder. However, WHO also report that one in two people living with schizophrenia do not receive care for the condition, and that the care that is provided can be community-based and include active family and community involvement.

Worldwide there is a variety of contrasting understandings of psychotic processes, which may include a diagnosis of schizophrenia as well as other “conditions”. Philosophical and societal concepts of “madness” or emotional distress and how they are regarded or dealt with vary enormously. Psychotic experiences also vary according to cultural context (McCarthy-Jones,2012; Hugdahl and Sommer, 2018) and may be understood in different ways. Some individuals may find that having unusual experiences such as hearing voices is not problematic or they may see such experiences as positive, spiritually significant or even enlightening. However, others may find their specific experiences distressing and their whole quality of life may be detrimentally impacted as this interferes with their ability to fully participate in society and thrive, gain sufficient income or access resources.

Psychotic experiences can be seen as part of the self or they can be seen as symbolic. The focus of this research is PCT for adults who have unusual experiences. However, they are not necessarily seeking treatment with this as a focus or problem, although for some individuals such experiences could be distressing, and they may seek help accordingly. In some worldwide areas, where there are few resources, recovery rates have been historically better without formal support and many children and adults with unusual or psychotic experiences find that they make positive progress without treatment. (e.g. Romme and Escher, 1993).

Alternative treatment models to mainstream psychiatric services have included examples such as the Soteria project where a supportive environment led to 85-95% of patients returning to the community without any medication in six weeks. The project began in Berne, Switzerland and was replicated internationally in areas such as California with projects developing in the UK and other locations (Mosher,1999, Mosher, Hendrix & Fort, 2004).

Other examples of alternative models to mainstream care have include a project where therapeutic listening skills were taught to psychiatric patients in order to help other patients.(Hinterkopf, & Brunswick,1975) where patients showed the ability to support others and reflect psychotic material as well as help the patient to find meaning in the material and help them to move out of a psychotic place .This supportive role also helped clients to connect more to their own psychotic material and self- dialogue as well as normalise difficult experiences and feel empowered and better about themselves. On listening to staff vulnerabilities there were realisations that anyone can have vulnerabilities and I wonder if hopefulness was an implication of this. One client in this project commented: "I now try to listen to all the different voices in my head, just like a good listener would." (p. 12).

Alternative and parallel approaches to mainstream NHS care in the UK offer support, such as therapeutic community or facilitated or peer support groups where experiences and any precipitating factors can be discussed openly as well as simply being part of a social group with common experiences. “Symptoms” do not need to be discussed unless chosen. As part of my work in mental health services, and even before I trained as a therapist, I was privileged to attend and participate in one of the earliest UK hearing voices network groups in Manchester in the early 90’s. I later received training from the National Hearing Voices Network (Longden, Read & Dillon, 2018) and with their advice, helped to re-establish and actively support and attend a hearing voices group in Merseyside which was sought by individuals and is still in existence and politically active, offering a supplement or alternative to other mainstream support.

A few years ago, I also attended the “Time and Space” group in Glasgow who currently offer support and information to people who hear voices and people who self-harm and their supporters (n.d). The group supported me in this research venture as well as warmly welcoming me as a person with my own strengths and vulnerabilities. We collectively shared experiences whilst eating chips and drinking iron brew. I felt the strong bond between members and their affection for each other, pulling together through challenge. The generosity of this group and the powerful supportive experience within this community had a profound impact on me and my practice and has been a source of inspiration to me. The group ethos felt deeply connected with the values of the person-centred approach, simply supporting, prizing and accepting people in the moment and being based on real connection. The group website states “We believe that it is possible to find a way to manage and live with your experiences" (Time and Space, n.d).

When I attended hearing voices groups to support clients' engagement I was as likely to hear the discussion of literature or recipes as distress, but I also experienced groups that were firmly and sensitively supporting vulnerable individuals through extremely difficult times and offering both community and continuity of contact when others were rejecting them. Hearing voices groups and associated organisations can offer positive leadership and the normalising of experiences, while at the same time acknowledging distress. This goes beyond a traditional recovery model, which is linked to recovery from disease, to understanding voices in a broader sociocultural context (Blackman, 2007). Such approaches have recognised diversity and difference as well as embracing the political fight to free people from what they regard as the limitations and disempowerment associated with diagnosis (Boyle, 2002; Dillon, 2011). However, Jost (2009) has argued that although it may be a good idea to reframe mental illness and celebrate unusual experiences, therefore reducing stigma and negative attitudes, it is important not to ignore the suffering associated with poor mental health, including fatalities.

1.3.1.3 The UK context of guidelines and treatment pathways for psychotherapy and care for psychosis and mental health

The three studies in this dissertation emerged from a European context and specifically from England, Wales, Scotland and Belgium. The space available for this section is not sufficient to cover the wide range of treatment pathways in these four countries but will focus on some of the key frameworks which have developed recently in the UK, and in particular England where I reside and practice.

People with unusual experiences such as hearing voices, hallucinations, paranoia, psychotic processes and unusual thinking may seek treatment from their general practitioner (GP) or other care pathways and are often medically diagnosed with a psychotic condition such as schizophrenia or borderline personality disorder with psychotic features or other conditions. They may receive help as an outpatient or inpatient or be referred to a community mental health team (CMHT) or early intervention in psychosis (EIP) team for further help. Some people seek alternative support; others may not be troubled by the unusual experiences or may not wish to tell anyone about them; and the experiences may remain, be intermittent or disappear. If a person in the UK experiences psychosis or other emotional distress that affects their thinking or behaviour in a way that may pose a risk to themselves or others they may be compulsorily treated or admitted to inpatient care within the Mental Health Act (2007).

Early help is currently encouraged and supported by frameworks to reduce the risk of further deterioration, and GPs can refer adults and young people presenting with “early psychotic symptoms” to specialist care such as child and adolescent mental health services (CAMHS), EIP teams, CMHTs or other appropriate services. Studies show that the longer the duration of untreated psychosis (DUP), the worse the prognosis becomes (McGorry, 2002, 2015 ; Moncrieff, Cohen & Porter, 2013; Thomas, 2014).

EIP teams developed in the UK aim at early treatment for people aged 14-35 (since mean onset age was estimated as 22). This approach became central to the UK treatment strategies as well as being applied more widely.

Contemporary psychosis services have evolved through research with the aim of providing assessment and support early in presentation, identifying ultra-high- risk individuals, reducing the DUP and offering accessible services in community-based settings, all with a view to reducing risk of progression into more severe or chronic issues.

UK service development has been strongly influenced by the IRIS guideline (1998) and the recommendations in this document were embraced in the National Service Framework for Mental Health (1999) and the associated mental health Policy Implementation Guide (2001) which is widely and affectionately referred to as the “pig”. Practitioners, service leaders and researchers were closely involved in both the developments of these policies and the growth of EIP services.

The Department of Health’s document “No health without mental health” (2011) endorsed the efficacy of early treatment strategies which were resulting in a halved suicide rate and better recovery outcomes at eight year follow up.

The IRIS guidelines (2012) more recently replaced the original document and outlined steps for commissioners and service providers to try to intervene with comprehensive, specialist evidence-based practice in the critical period of early onset of psychotic symptoms, in order to provide a better recovery-based, long-term prognosis (see also Birchwood, Mc Gorry & Jackson ,1997). Commissioning of such upstream services is cost-effective, and care aims to reduce stigma by seeing clients at home or in neutral settings, rather than hospitals. Corrigan (2004) explores the barrier to help seeking caused by societal stigma and self-stigma and the interrelationship. Supportive, empathic relationships were promoted, as well as working with the client's individual strengths, aspirations and priority needs. Evidence-based interventions as recommended in the NICE guidelines were endorsed, such as CBT or CBT for psychosis (CBTp).

In Scotland frameworks emerged which supported treatment pathways for psychosis and wider mental health strategies. The Matrix (2011, 2015) was produced by NHS Scotland. This document supported evidenced psychological therapies for emotional wellbeing and assisted in service commissioning. The document references both efficacy evidence and other clinical guidelines. The Matrix outlines evidence-based therapeutic treatment of psychosis and schizophrenia which indicate high intensity CBT for early intervention and moderate symptoms and CBT and/or high intensity family interventions for more severe issues. The Matrix was updated in 2015 to include mindfulness, metacognitive therapy and monitoring for early episodes. The current Mental Health Strategy for Scotland (2017-2024) follows the previous Mental Health Strategy for Scotland (2012-2015) and includes prevention, early intervention and multi-sector team support. The Mental Health Strategy for England (2017) echoes this with NHS England (2018b) bringing innovations which include a training film on early recognition of psychosis for general practitioners.

In Wales, government papers and announcements (Welsh Assembly Government, 2005; Beecham Report, 2006;) have promoted efficient and evidence -based services to improve outcomes. The Welsh Government's "Together for Mental Health" (2012) is a ten- year strategy which incorporates many areas of development on a service and contextual/societal level and NHS Wales. More recent UK government papers address both education and treatment on many levels and the societal issue of public emotional wellbeing, resilience and a climate of understanding. Public Health England (PHE) supports strategies and resources for all people to have the chance to achieve mental health and offers resources and commitments to this that are within the NHS report "Five Year Forward View for Mental Health" (2014) with strategies targeting both treatment and prevention and public health. These UK guidelines have therefore supported both local and national service delivery and impacted upon recommended care pathways and all support early intervention in mental health.

Service development specifically regarding psychosis was also influenced by other key documents including the EIP network standards report and other monitoring and guidance (e.g. Healthcare Quality Improvement Partnership Ltd's EIP Audit report, 2016). In general, this body of guidance supports offering family interventions, psycho-education and CBT with consideration of some use of psychotropic medication. These developments in treatment pathways and policies paralleled public debates and studies suggesting that CBT may have biological positive impacts on the functioning of the brain and therefore may be an optimal treatment model (e.g. Goldapple, Segal & Garson, 2004) and received by a public increasingly accessing medical and pharmacological treatments.

This impact on public opinion was noted by myself as in therapy services where I worked it became increasingly common to receive specific requests from families or clients for CBT as a "superior treatment" to other therapies. I clinically trained in CBT in 2009, supported by my employer, to ensure that I could offer what was being requested by services and the public, integrating it into my practice. However, I later received further training in creative PCEP approaches and EFT which were part of the PCT tribes, and I found possibly suited my practice more and appeared to support positive outcomes.

Critics suggested that the evidence base supporting this widely regarded position of CBT superiority in terms of optimal service delivery is less clear than claimed and is biased in the way that it has been reported, a point that I will elaborate later.

The 2014 edition of the National Institute for Clinical Excellence "Psychosis and schizophrenia in adults: prevention and management" NICE guideline for schizophrenia and other psychoses (National Collaborating Centre for Mental Health, 2014) had stronger wording than previous versions (NICE, 2003, NICE, 2009) and rather than simply suggesting CBT in the 2003 version, by 2009 recommended that **all** patients should be referred for CBT. The earlier NICE guideline which impacted on this PhD study design (2009) also advised:

> Do not routinely offer counselling and supportive psychotherapy (as specific interventions) to people with psychosis or schizophrenia. However, take service user preferences into account, especially if other more efficacious psychological treatments, such as CBT, family intervention and arts therapies, are not available locally. (1.4.4.6)

The 2009 guidance resulted in UK PCT practitioners struggling to work accountably with this client population unless other recommended treatments were unavailable, or if the client actively chose PCT. The Scottish Intercollegiate Guidelines Network [SIGN] (2013) analysed the studies used for the NICE guideline (2009) and found that the difference in effect sizes between CBT and supportive counselling were trivially small. In other words, the promoted treatment showed limited advantage over the contraindicated treatment.

Ironically, despite NICE's recommendation, resource limits meant that it was unrealistic for many patients to be offered optimal care. Haddock, Eisner, Boone, Davies, Coogan and Barrowclough (2014) studied the implementation of NICE guidelines that recommended CBT and family intervention. They found that in a random sample of 187 service users with a diagnosis of schizophrenia, despite NICE recommending CBT, over a one-year period it was only offered to 6.9% and accessed by 5.3%, while family intervention was offered to 1.6% and received by 1.1% of service users. This suggests that a large majority of patients did not receive recommended treatments. However, NHS England more recently reported that 75.7% of patients presenting with early psychosis in May 2018 received some treatment within 2 weeks (although the specific care pathway or treatment is not stated) (NHS England, 2018 a).

The NICE guideline (2014) was last reviewed in 2017 with a supporting report highlighting the uncertainty of the efficacy of CBT but not making substantial changes to treatment recommendations at that stage.

The current NICE guideline does not suggest medication as an initial course of treatment for early signs or first episode of psychosis, but suggests it is an option to be considered if symptoms persist and that a psychiatrist should be involved in this decision.

Medication can be helpful for some clients, but efficacy is more limited than is often claimed by pharmaceutical companies and data can be reported in ways that can mislead others to view it in a favourable manner (see Moncrieff and Kirsch, 2007). In addition to this, medications can often produce unwanted side effects or withdrawal difficulties, (Moncrief, 2009) which are not always fully reported to patients when prescribing (Seale, Chaplin, Lelliott & Quirk (2005). Electro-convulsive therapy has also sometimes been used, particularly for sudden onset psychotic depression or depression with psychotic features with reporting of both positive and negative outcomes (e.g. Tharyan & Adams, 2005).

Corsico, Griffin-Doyle and Singe (2017) have recently reviewed good practice in early intervention in psychosis by examining 14 guidelines and procedural documents. Results highlighted the moral and ethical factors important to service delivery in EIP and the importance of competence, empathy, sensitivity and trustworthiness. They concluded that more long- term research evidence is needed to examine the efficacy of EIP services to build on the existing mixed reports and to address issues of biased reporting and reviewing of evidence.

1.4 Psychosis, schizophrenia, and a critical view of the medical model

1.3.3 Overview

The roots of modern psychiatric diagnosis for psychotic conditions lie in the nineteenth century development of psychiatric classification in Germany (Kraeplin, 1896), when a condition labelled *dementia praecox* was first described in 1896 as a diagnosis of a mental “disease”. Later, Bleuler (1912) developed the category of schizophrenia and published papers on his conceptualisation in 1911 and 1912 (see Bueler,1911, 1950; Bentall, 2003).

This eventually evolved into more recent versions of diagnostic criteria and diagnostic manuals such as ICD and DSM, which are periodically debated (see World Health Organisation, 2016 ; American Psychiatric Association, 2013). More recently, they have been widely criticised as based on unhelpful disease models, in the face of a growing diversity of thought, research and developments in the recovery and service-user movements which have challenged them. A movement of anti-psychiatry (Cooper,1967) with a political edge developed with the broad aim towards increased humanity in psychiatry, and challenging its' power base, and the development of critical position, supporting Laing (1960,1967,1970). Laing chose not to adopt this term but nonetheless created huge support for his seminal papers looking at more contemporary ideas without necessarily directly attacking psychiatry. This paralleled the increasing dominance of psychiatry, which is still growing today, with an upward trend in the use of psychiatric drugs in the UK in recent years (Council for Evidence-based Psychiatry, 2015) and no associated trend in improvement of emotional well- being.

The medical diagnostic framework is based on the notions of genetic or biological disease, chemical imbalances affecting behaviour and neurotransmitter theory, along with possible external influencing factors such as environment. This position has been widely challenged as without a firm foundation of evidence (e.g., Read, 2007).

Bentall (1990, 2003, 2009) mapped out the historical development of the diagnoses of schizophrenia and the psychoses, the heterogeneity of diagnosed persons and the lack of consistent theory or valid means of diagnosis. He pointed out that current nosology does not follow any pattern that relates to a disease or genetic basis but is merely a cluster of symptoms, chosen and modified by medical professionals, and that it is a poor predictor of outcome. Bentall ridiculed the medical classification, stating that the DSM is no more accurate than astrology. His later works reinforced this (e.g. Bentall, 2006). Bentall pointed out that people's emotional stress is often a way of making sense of difficult experience rather than a sign of disease and gave an example when speaking in a public forum of how people with a history of being in care are more likely to be paranoid which may be related to finding trust difficult and therefore makes sense of their experiences.

The debate continued with the publication of DSM-IV (American Psychiatric Association, 2000) and the current version, DSM-5 (American Psychiatric Association, 2013). Mirowsky & Ross, (1989), Ross (2004) and Moncrieff & Middleton (2015) and reinforced this position of diagnosis and the frameworks being both unhelpful to clients and unsupported by adequate evidence.

Medical treatments for psychosis can be helpful as part of a treatment plan for some clients but can have negative impacts. Diagnosis and research relating to treatment is sometimes supported by drug companies, who gain huge profits from the system. They also remarket drugs for different diagnosable conditions and there can sometimes be bias or misreporting and underreporting of placebo affects (e.g., Lexchin, Bero, Djulbegovic & Otavio, 2003).

Medical diagnostic categories such as schizophrenia and psychosis which are within DSM-5 are often used in UK psychotherapy psychosis outcome research to define the sample or inclusion criteria, allowing comparison between patients or studies in research and treatment. However, as noted, they have been criticised as having no scientific validity in themselves and are problematic in that they can reinforce stigma associated with labels, a passive stance, disease model thinking and other problems, as will be explored later. Therefore, I did not use them as an essential inclusion criterion for my research, although they are widely referred to in multi-sector contexts of treatment as a system of common language.

There have been heated debates in academia, the media, service user groups and service users' families regarding whether diagnosis is helpful or a hindrance. Whatever opinion a patient may have, they may find that they are dependent on a particular medical diagnosis in order to be able to access financial benefits or resources.

Read (2004a) argued that there is no validity to a diagnosis such as schizophrenia, and Kinderman, Read, Moncrieff (2013) and Bentall (2009) have strongly criticised DSM-5, which is used as a diagnostic tool by psychiatrists. Kinderman et al. (2013) promoted the idea that distress can be viewed as a normal part of life rather than a disease as implied by diagnostic frameworks; they stated that "diagnostic systems in psychiatry have always been criticised for their poor reliability, validity, utility, epistemology and humanity". They assert that even when diagnosticians agree on symptom clusters this does not mean the clusters are meaningful or useful, with specific pathophysiology and aetiology that would inform effective treatment paths. They also point out that symptoms may fall into different overlapping diagnostic categories, such as depressive symptoms in schizophrenia. Diagnosis has been also linked to poor prognosis, which can only compound distress for clients (Repper & Perkins, 2009).

1.3.4 Non-medical Frameworks

1.3.4.1 An alternative framework to diagnosis

Various attempts have been made to offer alternatives to diagnostic classification, including case formulation frameworks (e.g. Johnstone, 2013). A new framework, recently published after five years of work, is intended to sit alongside diagnostic frameworks and offers a way of supporting individuals that draws from both medical and wider sources of information. The framework, The Power Threat Meaning Framework (Johnstone, Boyle et al, 2018), contains questions that focus on working with a person or situation and are constructive and hopeful, building on the resources available. The questions are not focused on symptoms but instead constructed around what has happened to the person, its impact, the sense the person made of the situations or experiences and how they have survived, their strengths, skills, and resources. This forms a more individualised and meaningful narrative to inform support, and echoes Carl Rogers' trust in the individual and their own resources.

The Power Threat Meaning Framework sets out to restore the link between threat and threat response in people who may have experienced distress or trauma, and to gain an understanding of their journey, their context and the power dynamics facing them. The framework is organised by meaning rather than biology and works on the basis that threat responses serve to regulate emotions or mitigate against loss or other functions.

Behaviours that may be unfamiliar or not considered normative as expressions of distress in a specific culture are recognised to have meaning. This framework sits well with a person-centred framework and offers a radical development to rebalance power.

1.3.4.2 Alternative treatment models to medical and statutory service provision

There is much debate around the medical or disease model of distress, and alternative perspectives such as a social model (the historically respected stress-vulnerability model) or integrative model and debates which are centred around normalising distress (see, Rundle, 2017a, 2017b).

For Szasz (1961), mental illness is a normal reaction to an abnormal situation and is related to contextual triggers. Szasz challenged the existence of mental illness and suggested a more process-orientated and meaning-based approach (Szasz, 1961, p. 2). Now, more than five decades later, this thinking is gradually becoming more common despite the enduring dominance of disease-orientated treatment and more open attitudes to emotional distress and unusual experiences are endorsed by organisations such as The Hearing Voices Network (n.d.) , Mind (n.d.), Asylum (n.d.) and groups promoting “normalcy”.

1.4 Societal Context

1.4.1 Stigma and psychotic process

The word stigma originated from the Greek word “stigmata” referring to a mark of shame or disgrace (Oxford English Dictionary, 2018). Link, Yang, Phelan & Collins (2004) described stigma as involving a demonstration of power by means of labelling, stereotyping and discrimination against a group to demonstrate their perceived lower status. Rüsch & Thornicroft (2014) pointed out that stigma towards people with mental health issues often has a detrimental effect on their self-worth as well as deterring some individuals from accessing services. Crawford and Brown (2002) explained how stigma can originate from an ideal social identity not being attained. Goffman (2016) explored the notion that disability is "culturally constructed" and "socially sanctioned" and could lead a person to feel contaminated, dismissed and diminished.

Stigma around psychosis can detrimentally affect economic status, employment opportunities, social networks and other areas of life and shares similarities with other oppressed groups. Some groups, such as black or lesbian, gay or bisexual clients are both over-represented and over-diagnosed in psychiatric services in reflection of social and other factors (e.g. Brown, 2003; Read, Johnstone & Tatimu, 2013 ; Rees et al, 2016; Kidd, Howison, Pilling, Ross, & McKenzie, 2016) which means that a person is affected by multiple factors relating to stigma and inequality (Johnstone, 2001, p 99). Overton, Medina and Sondra (2008) recommended that counsellors' training incorporates stigma-awareness and that counsellor's actions can help to mitigate against stigma by challenging their own stigmatising beliefs.

Throughout the world, a diversity of meanings and attitudes is attributed to hearing voices, hallucinations, delusional beliefs, paranoia, unusual experiences or psychotic processes and how they are understood, treated and viewed and may be considered normative or evoke a wide range of reactions, depending on the context. Szasz (1996) wittingly captured an example of paradoxical interpretation and commented "If you talk to God you are praying; if God talks to you, you have schizophrenia" (p.13) and raises the idea that physical illness was discovered but that mental illness was invented.

There are some examples of increased acceptance in terms of cultural attitudes and flexible support, despite limitations on resources. Unusual experiences such as hearing voices are viewed positively in some cultures and sometimes embraced in religious or spiritual contexts, with connotations of special powers or insights such as speaking in tongues, or shamanism. A person's religious ideas may be distorted into traumatic content by emotional difficulties (Pfiefer, 2007).

Studies of schizophrenia across different cultures and locations find that both negative and positive content of hallucinations is common across different ethnic and religious groups. Murphy's (1963) large scale study involving worldwide data regarding hearing voices gathered from psychiatrists in 26 countries supports this. The content of hallucinations or other unusual experience also seems to be influenced by factors such as external context and cultural references.

Despite increased societal acceptance of mental health issues there remains stigma associated with mental health issues, especially psychosis. Stereotypes of "madness" associated with dangerousness are still perpetuated in films, novels and in society generally. In many cultures, including Western culture, people may hide their severe or acute mental distress, including psychotic process, because of feelings of shame or because they are worried about being judged or that others may view them with fear or laugh at them. This may both affect a person's motivation to seek early help as well as influencing prevalence data as rate of disclosure may be more affected by stigma in specific settings.

Acceptance, normalisation of distress and the promotion of early treatment and diverse treatment models, including informal support, are gradually growing in attempt to address these issues as well as support wellbeing. In the UK, media campaigns run by organisations such as the joint campaign by the charities Mind and Rethink (2018), organisational responses such as the Hearing Voices network (n.d.) and Asylum magazine (n.d.) have promoted accepting and supportive attitudes and the World Health Organisation (WHO, 2013) produced an international strategy to reduce stigma which was adopted by 94 countries. Consideration need to be given regarding what may be effective ways to reduce stigma regarding mental health ,unpicking the complexity of the issue. A range of solutions may be most effective (e.g. Read, Haslam, Sayce & Davies, 2006).

Integration of destigmatising service principals into UK services such as normalisation which was later reformulated as social role valorisation (Wolfensberger & Tullman,1982, Brown & Smith, 1992) complemented community care legislation of the late eighties and early nineties and attempted to positively impact on both vulnerable populations and how they were viewed, valued and integrated on a societal level.

Some cultures have taken direct action to minimise stigma which could inspire others. For example, in Japan the diagnosis of schizophrenia was successfully changed to “integration disorder” to reduce stigma with young people who had linked the idea of schizophrenia to criminality (Takahashi et al., 2009; Koike, Yamaguchi, Ohta, Yasutaka, Watanabe, & Ando, 2016). Despite some movement in positive acceptance and increased rights increasingly there remains much room for further work both internationally and specifically within the UK.

1.5 The interrelationship between trauma and psychosis

1.5.1 Overview

PCT focuses on the person and the issues which they bring to therapy. It aims to connect with the person in a real relationship rather than having an agenda that involves a focus on diagnosis without a basis in research or symptoms. Clients presenting with psychotic process often describe multiple difficult past or current life events, which may include difficulties with treatment context or outcomes. This is in addition to the distress that some clients experience from the unusual experiences themselves. For some people this may not be a problem but for others, perhaps those who hear threatening voices or have other more challenging experiences, it could lead to feelings of terror or further health or social problems in every area of the person's functioning. Some clients dissociate or "split" into parts to cope with overwhelming experiences such as abuse. When this has occurred in a young child there may be even more serious emotional consequences when attachment has been affected and may present with complex processes. This may require careful consideration by the therapist. A therapist may help the client to decide whether to disclose or symbolise events and regulate emotions and they may benefit from some more directive support such as being offered transitional objects such as a soft toy or other ways to help to attend to a child part of themselves. (Warner, 2017; Ringrose, 2016).

Growing bodies of research suggest that individuals are at increased risk of developing psychosis if they have experienced multiple childhood adversities, including traumatic experiences such as hostility and threat, with such factors seemingly influential in the complex path to psychosis rather than directly causal in themselves (e.g. Morgan & Gaya-Anderson, 2016; Baudin et al., 2017). More research is needed in this area to uncover the complex factors involved including adversity and neurological impact (Read, Bentall, & Fosse, 2009).. Studies also suggest that psychosis itself is often traumatic (Morrison, Frame, Larkin. 2003; Rodrigues & Anderson, 2017).

Therefore, both the path to psychotic process may involve traumatic experiences although this is not inevitable, and the experience of psychotic process may be experienced as traumatic by some individuals although others may have positive experiences or a changing relationship with unusual experiences which may vary over time. The relationship between trauma and person-centred theory is further integrated within the section in this chapter which focuses on client-centred therapeutic perspectives in section 1.6.

Therefore, a person who is experiencing a psychotic process may have a history of trauma and additionally could encounter traumatic “symptoms” or experiences as well as the possibility of traumatic encounters with systems of care. Indeed, in Study 3 in this dissertation the client known as Becky presented initially as “terrified” by her voices and other unusual experiences which seemed to be triggered by upsetting events in her life; she also encountered some treatment which she felt had extremely detrimental outcomes.

1.5.2 Trauma and risk of psychosis

Kraan, Velthorst, Smit, de Haan and van der Gaag (2015) conducted three random-effects meta-analyses. A meta-analysis assessed the prevalence rate of childhood trauma in individuals who were "ultra-high risk of psychosis" (a term often used within E.I.P services to offer pro-active preventative treatment to those showing specific signs of possible emotional difficulty which research suggests can be a pre-curser to psychosis). A further two meta-analyses were conducted on the experience of childhood trauma and recent life-events, which compared individuals who were ultra-high risk to a control group of subjects. Six of the twelve qualifying studies provided a trauma prevalence rate. The results suggest that childhood trauma is highly prevalent among individuals who are ultra-high risk and reinforce studies where populations with psychotic process have disclosed trauma. This meta-analysis did not show that recent life events were linked to an ultra-high-risk status.

Rodrigues and Anderson (2017) conducted a meta-analysis investigating whether psychosis was likely to lead to post-traumatic stress disorder (PTSD). Outcomes suggested that one in two people with psychosis experienced PTSD symptoms and one in three people with psychosis experienced a full PTSD diagnosis after psychosis. There was a lack of clarity regarding the degree of trauma. It was not clear how much of the trauma may have related to or been induced by psychotic symptoms themselves and how it could be attributed to other factors, such as hospitalisation or difficult treatment experiences. Nonetheless, the results do suggest a connection between psychosis and PTSD. Lieberman & Fenton (2000) also found that a delay in detection and treatment of psychosis, which can often be a period of two years could lead to distress and trauma.

Viewed from the perspective of the person-centred practitioner, the implication of this information is that the client should be viewed as someone who may have experienced life events and trauma leading to their distress. It supports the stance of working with the person, their presentation in the moment and the experiences they choose to bring. Murphy and Joseph (2013) discussed trauma from the perspective of PCT and affirmed the importance of the therapeutic relationship (2013). Murphy and Joseph (2014) advocated the provision of the PCT therapeutic relationship, supporting the position of allowing the client to take the lead but being open to psycho-education, techniques or skills if client-instigated.

Krupnik (2013) adds further weight to this position, citing evidence that alliance shows large effect sizes with survivors of trauma and recommending ways of working with great care and sensitivity to mitigate against possible alliance ruptures (2013). Links between psychosis and history of trauma are grounded in numerous studies (Larkin & Morrison, 2006; Moskowitz, Schafer & Dorahy, 2008; Read, Rudegeair & Farrelley 2006).

Part B: Theoretical and Clinical Context

1.6 Client Centred Therapy and the Development of PCT for Psychotic processes

1.6.1 Client-centred and person-centred therapy: a brief overview of development and theory

PCT is a humanistic therapy with its roots in phenomenology. Phenomenology (Husserl, 1965; Heidegger, 1962) is a philosophical theory with a naturalistic position which refers to the nature of being and understands reality as being composed of objects or events as they are experienced or perceived in terms of subjective experience. Rogers' theories are rooted in this realm of experience and encompass experience in the moment including sensory of visceral experiences (Rogers,1959).

Therapies aligned with Carl Rogers' original model are often referred to as classical client-centred therapy and later as PCT and developed to take on a number of variations, or "tribes" (Sanders, 2007, 2012). PCT is still widely practiced in both its original form and in other variations resulting from later developments and interpretations with some forms undergoing critical scrutiny by others. This PhD research project PCEP provided data relating to some of these tribes or applications of PCT and does not happen to include some of the later forms of the person-centred range of approaches such as emotion focused therapy or counselling for depression (CfD). However, it does include the integration of non-directive person-centred creative approaches. This reflected the range of practice from the data gathered from a convenience sample of participants who volunteered rather than being limited in inclusion criteria when seeking the data.

Carl Rogers, the founder of client-centred therapy, developed a theoretical perspective regarding personality, distress and positive growth, which was rooted in his observations of clients in clinical contexts from the 1940s and 1950s. He presented his "nondirective" approach publicly in 1943, following which he developed papers outlining his theories of how to therapeutically support clients in distress (Rogers, 1957, 1959, 1961b). His theories developed in relation to practice; this contrasted with experimental findings, which were more frequent sources of practice innovation at that time (e.g. Wolpe,1958). Rogers developed a theory of the relationship that involved the notion of change process, with a view that humans grow positively to their best potential in the situation within which they are located and receive genuineness, unconditional positive regard and empathy (Rogers, 1957, 1961b).

Rogers originally referred to his approach as non-directive therapy, later using the terms client-centred therapy (Rogers, 1951) and, in the late 1970s person-centred therapy or person-centred counselling (Rogers, 1980). The term *person-centred* was widely adopted in the UK by practitioners; however, while Rogers did use this term, he also continued to refer to client-centred therapy when in therapeutic contexts.

1.6.2 Person-centred theory

Person-centred theory is composed of personality theory (Rogers, 1951, 1959), “the actualising tendency” (Rogers,1951), the six therapeutic conditions (Rogers, 1957) which are considered necessary and sufficient for actualisation of the organism, and the therapeutic position of non-directivity. The actualising tendency (Rogers 1951) is described as a person’s tendency to develop in the direction of positive growth and is central to what the organism actually is:

> “Whether the stimulus arises from within or without, whether the environment is favourable or unfavourable, the behaviours of an organisms can be counted on to be in the direction of maintaining, enhancing, and reproducing itself. This is the very nature of the process we call life." (Rogers, 1980, p118)

Rogers’ model of personality incorporates the key elements of theory already described here as well as further concepts. A basic overview of person-centred theory applied to practice is described by Merry (1999).

1.6.3 Model of therapy

Rogers developed a practice model of client-centred therapy that was based upon six necessary and sufficient conditions described firstly in his 1957 paper and then more fully in his 1959 paper (Rogers, 1957, 1959). He stated that these six conditions are facilitative for constructive personality change if they exist and are sustained over time (Rogers, 1957, pp. 95–96).

The six necessary and sufficient conditions are:

1. Two persons are in psychological contact.
2. The first, whom we shall term the client, is in a state of incongruence, being vulnerable or anxious.
3. The second person, whom we shall term the therapist, is congruent or integrated in the relationship.
4. The therapist experiences unconditional positive regard for the client.
5. The therapist experiences an empathic understanding of the client's internal frame of reference and endeavours to communicate this experience to the client.
6. The communication to the client of the therapist's empathic understanding and unconditional positive regard is to a minimal degree achieved.

Rogers (1957) stated, “No other conditions are necessary. If these six conditions exist, and continue over a period, this is sufficient. The process of constructive personality change will follow.”

The first condition is important to note when considering the focus of these studies which relate the PCT to psychotic processes as clients with such presentations can sometimes have difficulty with being in psychological contact. We will consider this issue further later in this chapter.

PCT involves being in a real and authentic relationship which is also professional and has boundaries. Usually contemporary PCT practice in the UK involves the therapist and client being in an explicitly contracted counselling relationship with the therapist adhering to an ethical framework (e.g. British Association for Counselling and Psychotherapy (BACP, 2018).

This emphasis on the real encounter contrasts with some other approaches such as CBT which has traditionally placed more focus on the problem and delivering techniques, considering cognitive distortions, coping strategies and other areas (see Kurken, Padesky & Dudley (2011) for critical components of CBT). However, some forms of CBT and related approaches are increasingly highlighting the importance of alliance in the therapy (Dunn, Morrison, & Bentall, 2006 ; Leahy, 2008 ; Goldsmith, Lewis, Dunn, & Bentall, 2015) and CBT can be integrated with other models (Stricker, 2006). CBT was originally developed for treating depression (Beck, 1967) and later evolved (see Mander and Kingdon (2015) for developmental phases). Tarrier and others developed CBT for psychosis from the 1980 (e.g. Tarrier, Harwood, Yusupoff, Beckett & Baker, 1990). The increase in focus on alliance in other therapies such as CBT is an important common factor but PCT and PCEP remain in contrast to this in its their distinct position in focusing on the relationship as the therapy and its sufficiency to effect change as opposed to being intervention focused.

PCT emphasises the therapeutic encounter, which is considered “a way of being” (Rogers, 1980). The therapist meets the client as a whole person, rather than being limited to a professional façade (Rogers, 1967). Rogers refers to the importance of the quality of the relationship, staying close to his inner intuitive self and the healing aspect of presence (Rogers,1980). PCT is historically not problem-focused but attends to the individual person as they are in the “here and now” relationship and aims to support the client on a personal journey towards a more creative, fully functioning, self-actualised and socially constructive self (Rogers 1959). Rogers identified the qualities of a fully functioning person (see Rogers,1961b). Knowledge of specific client groups or presentation, while this may be advantageous, is not generally regarded as a prerequisite in person-centred practice (Mearns, 2003), although practitioners within the EFT tribe take issue with this (e.g. Elliott, Watson, Goldman & Greenberg, 2004).

The person-centred approach and its variations are continually developing whilst being closely connected to Roger’s original theories which are still central to current practice. For example, Mearns and Thorne’s (2000) exploration of configurations of self was an important recent conceptualisation relating to a person’s symbolised or pre-symbolised parts of themselves, all of which a person-centred therapist would strive to prize within therapy. and was particularly helpful in adding to the understanding complex client processes such as psychotic processes which may involve dissociation. The growth of exploration of relational depth and associated research (e.g. Mearns & Cooper, 2005) also significantly added to the approach as well as work in the area of mutuality, post-traumatic growth (Joseph, 2011), and links to positive psychology (e. g. Compton, 2005) which will be debated further later in this chapter.

Sanders (2004) described some of the historical and developing tribes or variations and subcultures of the person-centred approach with the second edition (Sanders, 2012) of his book including additions including existentially informed person-centred therapy (Cooper, 2012) and Counselling for Depression (CfD) (Hill, 2012) and Emotion Focused Therapy (Elliott, 2012). Person-centred creative expressive approaches were included which were particularly developed by Natalie Rogers, the daughter of Carl Rogers (Rogers, 1993) and Liesel Silverstone (1997) and have been sometimes applied to work with vulnerable clients. Other important more recent contributors to PCT include Michael Behr and Cornelius- White (2008) who have been involved in the developed and dissemination of person-centred play approaches with children which can be applied also to other client groups. Different responses have emerged these developments, with some criticism but through these developments the approach has been widely applied in a diversity of settings.

More recently, the term *person-centred* has become widely used in different contexts, such as medical care, with different meanings that do not necessarily have any connection to PCT. In addition to this, although there are many qualified, competent practising person-centred therapists, some other therapists report that they are person-centred if they feel some affinity for the model, potentially leading to confusion.

1.6.4 Criticisms of person-centred therapy and person-centred experiential psychotherapy

Despite a growing body of evidence to suggest the potential helpfulness of PCT for a variety of client populations, including psychosis (e.g. Elliott et al, 2013), more robust evidence is needed and PCT has undergone much criticism specific to parts of the theory as well as more generally being looked down on as benign but ineffective for complex process. Although BACP use the terms *counselling* and *psychotherapy* interchangeably, person-centred counselling has often been considered lower in the hierarchies of therapeutic models or as preparation for "real therapy" which are certainly attitudes which I regularly encountered in a variety of forums over two decades of clinical practice.

Some critics argue that the actualising tendency is less important or critical. For example, Greenberg (1996) disagreed with Rogers that therapy releases the actualising tendency, while Greenberg and van Balen (1998) preferred a developmental tendency which moves towards adaptive flexibility. There have also been debates regarding whether the six conditions are necessary but not sufficient.

PCT has also been criticised for being too optimistic and individual-focused, and for resting on a basis of unsubstantiated anthropology (Straub, 2012), as well as being simplistic to be suited to severe issues and yet ironically later in this chapter this simplicity has been more recently valued by professionals who have conducted trials including PCT as a control treatment and shown surprise that this simple and cost effective model can offer positive outcomes and so " the tide is changing".

Importantly, Rogers' concept of self and self-experience (1959) within the theory has been criticised as based on an ethnocentric Western cultural view emphasising individualism, which is not a majority world view (Sanders, 2006a). Rogers (1959) himself described the limitations of the "cultural and personal soil" beneath his theory, seeing this foundation of autobiography and cultural origin as central to understanding his work (Rogers,1959, p185).

In considering the Westernised roots of this approach we should perhaps consider that PCT may have roots that are culturally limited in the context of offering therapy to a population in psychotic process.

1.6.5 Person-centred theory and practice for psychotic process

A person-centred understanding of psychosis emerged in the early writings of Rogers (1951) as he developed his ideas in relation to severe psychopathology. Struggling between 1949 and 1959 with a client with a diagnosis of schizophrenia, Rogers felt that as a therapist he was becoming lost in the process and confused regarding his own sense of self. This led to a difficult learning process for him (Kirschenbaum, 2004). He found that people labelled as schizophrenics were particularly sensitive to the therapist’s unnamed feelings and he felt that therapists congruently naming their feelings and “being” those feelings would help to ensure that they did not disrupt the therapeutic process. This also permitted moments of existential encounter with clients, which Rogers saw as therapeutic with this client population. He felt that it was important to pay empathic attention to all experience with equal weighting, that a person with schizophrenia had not yet developed strong self -configuration and that extreme incongruence with self leads to an inability to guide behaviour. Rogers’ condition of prizing, or unconditional positive regard, also involved offering warmth to the client’s mature and social parts as well as their defensive, withdrawn, suspicious or regressive parts. He noted that the experiential nature of such an encounter involved the therapist taking a gentle approach, with physical contact, or more directly engaging with the person to ascertain how to connect. (Rogers, 1958, pp. 4-11)

Rogers, Gendlin, Kiesler and Truax (1967) and other authors continued to develop theories of psychosis within a person-centred framework, partly in response to research that will be described later in this chapter. Prouty, who began as Gendlin's student, later stated :

> The problematic status of relationship and experiencing in the psychotherapy of schizophrenia places a boundary on the person-centred/experiential treatment of psychosis and raises new questions. (Prouty, 1990, p. 647)

Holdstock and Rogers (1977) stated:

> [I]f experiences are extremely incongruent with the self-concept; the defence system will be inadequate to prevent the experiences from overwhelming the self-concept. When this happens the self-concept will break down, resulting in disorganization of behavior. This is conventionally classified as psychosis when the disorganization is considerable. (p. 136).

This idea builds on Roger's earlier descriptions of awareness as "the symbolisation of some of our experiences" (Rogers,1959, p.198) and how free symbolisation of an experience which is free of denial (as a form of defence) leads to availability of awareness. Rogers referred to "the psychotic" and explained that symbols constituting our awareness do not necessarily match the "real experience" and are "transactional in nature" and constructed from past experience with a hypothetical or predictive element which can affect interpretation or perception (Rogers 1959, p 198). He gave the example of a person who may think a gnat is a plane but then physically brushes it and the awareness shifts towards it being a gnat. He incorporated Lazarus' and McLeary's (1951) construct of *subception* in his understanding of how a person as an organism may perceive threat not only at the level of conscience recognition but also at a deeper level of experiencing that is not reliant on conscious, verbal awareness. This may be relevant to individuals who have unusual ideas or psychotic processes and experience fears and sense of danger from events, objects or people, such as the client who is frightened of a person removing a cardigan in hot weather but may, even if there is no associated memory, sense danger based on child sexual abuse experiences linked to this action and traumatic events that followed.

Following Rogers, Biermann-Ratjen's (1998) initial assumption was that the fully functioning person is congruent. She described incongruence as occurring when a person does not feel understood or unconditionally accepted and significant others, demonstrating feelings which are directed towards their experience and, to them, unreconcilable with UPR. She added that incongruence could also emerge from a lack of self-acceptance of self- experience and described four types of incongruence:

> "1. The person may be unable to symbolize completely and communicate verbally certain experiences.
>
> 2.The person may be unable to understand and/or accept certain experiences.

> 3.The person may experience certain ways of defending against experience (stress reactions, acute incongruence) or different forms of stagnation in self-development (chronic incongruence).
>
> 4.In any case experiencing incongruence will include experiencing physical tension."
>
> p.127

Biermann-Ratjen (1998) explained that if the organisation is in danger this echoes threat to self -concept and self-esteem and upsetting events can trigger acute reactions (p.121) Worsley (2009) later endorsed Biermann-Ratjen's account and noted that her explanation helps to dispel myths relating to specificity and specific causes to "mental illness. Hipólito (2011) also stated that trauma can limit expression and actualisation.

Berghofer (1996) felt that transparency and openness could lead to a deeper relationship with persons diagnosed with schizophrenia, thus enabling them to develop greater trust, and saw the establishment and maintenance of a reliable interpersonal relationship as the most important element (p. 492).

In a 1961 paper, Shlien offered important contributions to understanding and working with psychosis and schizophrenia from a person-centred perspective. He viewed psychosis as "having an impossible life to live", where the person may be in unbearable painful humiliation or self-deception or self-negation. He saw psychosis as a point of loss of control with maladjustment manifesting itself in exaggerated behaviour and defences in vulnerable areas such as identity confusion. He explained that self-denial can lead to the disappearance of the self that one knows, and possibly complete loss of self, in an acute psychotic state that can be isolating and terrifying (Shlien, 2003). He discussed the relational aspect of self, drawing upon Sartre's social psychology (Sartre, 1958) and the concept of the lie of self-deception when one lacks awareness of the truth. Shlien saw psychotherapy as offering a possible road back to reality and identity through contact and the therapist creating conditions in which the person can move positively towards self-actualisation.

Shlien (1961/2003) also described the importance of Rogers' therapeutic conditions, emphasising the importance of openness and readiness for any contact. Shlien comments:

> The schizophrenic to be sure can only rarely and fleetingly and fearfully avail himself of such an encounter but it is these moments, I believe, which are therapeutic. (Shlien, 2003, pp. 46–47)

Shlien also advised accepting and staying with the client in his own world, as that world is at that moment, "whether it is wildly bizarre or delusion, a moment of essentially rational self-control or a chaotic disorganization" (Shlien, 2003, p. 46–47).

Some client-centred practitioners have found that the meaning of psychotic content can be unravelled in the therapy and that unusual experiences can be processed and evolve into forms that are more related to consensual reality. Hallucinations may represent a traumatic experience or some other significant piece of information for the client. (see Raskin 1996a ; Raskin 1996b; van Werde, 1998; Prouty,1994)

Texts on PCT often describe case examples where there is an emotionally close and reportedly helpful connection between a specific vulnerable client and the therapist (e.g. Mearns and Thorne, 2000c) and more recent developments in theory and research demonstrating the positive impact of relational depth (Mearns & Cooper, 2005; Knox, Murphy, Wiggins & Cooper, 2013). However, some clients with difficult processes such as psychosis may feel overwhelmed by emotional intimacy. Thus, one cannot assume that closeness is always optimal; sometimes it may feel violating for the client, as Binder and Binder (1991) affirmed. This supports some earlier findings by Rogers and his colleagues in the Wisconsin Project which will be explored later in this chapter when referring to this research study. Binder and Binder (1991, p. 169) discussed the importance of respecting the changing need for closeness and distance for some clients, citing case examples to support this.

For example, Teusch (1990) discussed implications in the development of understanding of PCT for psychosis and noted that the therapeutic encounter may be emotionally overloading. Others who have made substantial contributions to this area include Teusch et al (1981), Berghofer (1996), Biermann-Ratjen (1998) and Lambers (2003).

Bozarth (2001) described inspirational experiences of working in a psychiatric counsellor in a State Mental Hospital in America in 1958 and how he learnt that by just being with clients, paying them attention and respecting them provided a powerful means of helping and that they would take the lead. He described some of the changes which he saw in clients:

"They discovered what they wanted to do and could do" and further added" To my surprise, many of these individuals quickly started to demonstrate progress by becoming "more normal', by working on assignments in the hospital, by being more interpersonal. Their improvements were buttressed by objective evidence of reduced recidivism rates, functional employment, independent living, self-evaluations and increased quality of life. It was a relief and a great discovery that such "dysfunctional" individuals could find their own ways without guidance." (pp.174-175).

1.6.6 Pre-therapy

As discussed earlier, Rogers proposed six necessary and sufficient conditions for constructive personality change (Rogers, 1957, 1959). Rogers stated that within any therapeutic model, one of these six conditions, psychological contact, is a necessary condition to engaging in a relationship. Psychological contact may be partially, totally, or intermittently interrupted for a person who has unusual experiences or has psychotic processes as well as other conditions such as dissociation, dementia, autistic processes, or other client presentations. A client may lose contact for minutes within a session, warranting a different mode of responding by the therapist; or they may be out of contact when a therapist meets them for a psychotherapy session on a ward, in a residential care home or in another context. This raises challenges with general communication and specifically within therapy. Pre-therapy and contact work comprise an important more recent dimension of person-centred theory and practice, which addresses this difficulty.

Pre-therapy was developed by Garry Prouty, who first described this approach in 1976. Subsequently, he and other authors have described the practice as it developed and was widely and productively applied (e.g., Prouty,1976, 1990, 1994, 1996; Prouty, van Werde & Portner, 1998; Sanders, 2007; van Werde, 2016) Prouty and colleagues' writings on the theory and practice of pre-therapy have developed pre-therapy and contact work as effective ways to support clients to potentially re-establish contact functions when these have been disrupted by, for example, psychotic process. Pre-therapy attempts to restore some degree of shared reality and mutual contact. If this contact is established the client may be more able to benefit from therapy or other support. Pre-therapy was initiated as a person-centred approach that can be used exclusively or integrated into a PCT and offers the potential of restoring such psychological contact when it is briefly absent, limited or not present for longer periods.

Prouty grew up in America with a brother, Bobby, who was contact-impaired and had learning difficulties, which fuelled Prouty's ideas in relation to contact. Prouty was a psychologist who was taught a person-centred therapeutic approach by his mentor Eugene Gendlin. Gradually Prouty developed his own ideas and a framework for working around contact-impaired clients, which was eventually acknowledged by Carl Rogers.

Pre-therapy, rooted in phenomenology (Jaspers, 1972), is described within the context of psychotherapy and the wider application of contact work. The application of the phenomenological attitude when working psychotherapeutically with clients who experience psychosis is discussed by Deleu and van Werde (1998). Pre-therapy forms a distinct and significant development and mode of practice that is complementary to and can be integrated into PCT, as appropriate.

Pre-therapy emerged in and was developed from the 1970s and is practiced within a therapeutic relationship; more recently, an application of a version of pre-therapy known as contact work has been practiced with different client groups.

Prouty describes three historical stages in the development of pre-therapy. The first, from 1966 to 1985, involved the formation of basic concepts and methods in the US. From 1985 to 2005 the practice was developed more in Europe and within this stage new practice forms were developed (Prouty, 2008). Following Garry Prouty's death in 2009 the pre-therapy approach has continued to grow, with training opportunities for practitioners, incorporation into professional training programmes and training for support workers as well as increased research and developments in relation to specific applications such as for people with autism, learning difficulties, and alzheimer's disease (e.g., Carrick & McKenzie, 2011; Dodds, Bruce-Hay & Stapleton, 2014; Segers, 1999).

The Pre-therapy International Network, founded by Jill and Garry Prouty in Amsterdam in 1985, is still coordinated by one of the founding members, Dion van Werde, and meets annually in Ghent, Belgium, to support the approach. The network continues to develop this approach and has offered consultation and training in this area.

Prouty (1998, in a 2002 translation) described levels of contact, which consisted of contact reflections, contact functions and contact behaviours. Contact reflections are the work that the therapist does; contact functions consist of the client's process, which is measured by contact behaviours. The therapist offers contact reflections to the client when the client is unable to be in affective or communicative contact or is not engaged in the shared reality with the therapist (Prouty, van Werde & Portner, 1998 in 2002 translation).

Prouty explained what pre-therapy is and how it can work with a client who may be out of psychological contact. Prouty (1990, 1994) described clients who experience psychotic processes sometimes having impaired contact with “self”, “world” and “other”, and experiencing voices, hallucinations or delusions that are neither culturally accepted nor easy to process (Prouty, 1977, 1983, 1986.)

Buber (1964) described the act of pointing towards the concrete. In his 1976 paper, Prouty suggested that the practitioner may offer different types of concrete reflection to increase the possibility of contact if the client is responsive. In Prouty’s later works (i.e. Prouty, 1998), his descriptions of his theories and practices including the reflective responses are slightly more complete. The contact reflections are:

1. **Situational reflections (SR):** These involve the therapist reflecting the client’s situation or environment and the client’s behaviour in relation to the environment or milieu, for example by saying, “You are holding the cup”.

2. **Facial reflections (FR):** These involve the therapist observing the client and then reflecting the facial response, for example by saying, “Tom frowns”.

3. **Body reflections (BR):** Sometimes clients in complex process or with disabilities take on different postures or movements, such as catatonic posturing: “Tom is shaking”.

4. **Word-for-word reflections (WWR):** These capture what is either understandable or emotionally charged.

5. **Reiterative reflections (RR):** These involve slow, careful repeating of the other types of reflection and the primary process content to heighten the impact of the reflecting and experiencing process.

Hallucinations may be “gently accepted” and reflected with reiteration of image structure and emotional contacts (Hinterkopf & Brunswick, 1975). Prouty stated that this may eventually result in experiential processing of early trauma (Prouty, 1976).

For example, Prouty (1976) gave an example of working with a patient using careful facial and word-for-word reflections, then observing the gradual emergence of the phenomenological basis of a hallucination. Prouty explained that the client described “a picture with feelings in it – like a painting only with feelings in it – gigantic with a lot of pull to it …big, purple, orange and yellow”. With acceptance and the continuation of the verbal reiteration of the structure and emotional content of the hallucination, the hallucination changed into: “purple, terrorizing, demonic, laughing, cruelty, with considerable hate in it”. After weeks of reiteration, structure and feeling, the client described “an orange square with anger in it”, then after more weeks, “woman with orange hair – who looks pretty mean” and finally a nun, a schoolteacher who had beaten the client as a child with a yard stick. The hallucination process then ceased. Prouty described how this example illustrates that the reflection of the structural phenomenological properties and associated feelings – the experiential processing –

reconnected to early trauma in the client. (Prouty, 1976; Prouty in Prouty, van Werde and Portner, 1998, p16).

Literature is gradually emerging with specific and explicit guidance on working with clients who experience complex and psychotic processes. Prouty, van Werde and Portner's (2002) book has been an important influence on practice, as have other related works such as van Werde (1998), Coffeng (2002), (1998) Binder (1998), Binder and Binder (2001). Sommerbeck (2003) has also developed the practice of pre-therapy in psychiatric contexts and used extensive examples in texts as well as offering international workshops in this area.

Prouty (1990, p. 645) reviewed Rogers and Gendlin's findings relating to client-centred psychotherapy with schizophrenia and the apparent difficulties in contact and clients being able to perceive the therapy attitudes and conditions. There was evidence of a correlation between clients receiving the highest level of therapeutic relationship and a reduction in schizophrenic pathology. Prouty described how for clients who received treatment hospital discharge was more likely as well as improvement on Thematic Apperception Test protocol. Rogers had spoken of individuals with a diagnosis of schizophrenia fending off relationships or "flood of over talk", both being difficult for them.

Prouty (1976) attributes contact deficits in this client group to institutionalisation, over-sedation, psychological withdrawal and social isolation, explaining that these clients cannot share a mutual "here and now" with the therapist. Prouty's view is that these clients are unable to access feelings or emotions or be verbally expressive, and states that, “Clearly, reality, affective and communicative contact are ‘pre’ conditions for therapy that must be rendered functional”.

Prouty felt that Rogers did not fully explain what psychological contact is (Prouty, 1990) and that the development of pre-therapy addressed this need. Prouty developed the theory and practice of pre-therapy to establish contact functions (p. 648) and positive ways of working with psychotic process, defining contact reflections, contact functions and contact behaviours as an interdependent theoretical system. (Prouty, 1990).

1.6.7 PCT and its relationship with the medical model and diagnosis

Throughout twenty years of clinical practice experience of offering PCT to many clients in psychotic processes I have observed and experienced a diversity of issues posed by the wider treatment context. Practitioners of person-centred psychotherapy, such as myself, who work with difficult process with clients who experience acute or chronic mental health issues often work with clients who at times receive multi-disciplinary community-based or inpatient support from a range of services and professionals. These might include psychiatrists, social workers, clinical/counselling psychologists, psychological therapists, psychiatric nurses, crisis or acute home treatment or community mental health support teams. Such clients may receive a range of treatments such as medication, CBT, occupational therapy, social work family interventions or other care.

The person-centred therapist may support clients to navigate and receive care with different services as well as accessing the therapy (Sommerbeck, 2003, 2017b). This may at times bring clashes of ethos and difficult dilemmas for both the practitioner and client. The clients may struggle to retain power to make the best choices for themselves, given the resources available, including services where treatment may be clashing with the therapy. It may be difficult to work these things out as the therapeutic journey proceeds and the choices to be made are often complex ones with limited resources (Rundle, 2017b).

Berghofer (1996) described rejecting an emphasis on diagnosis that hinders the establishment of an authentic relationship, citing Rogers' (1951) criticism of diagnosis as detrimental and linking it to the adoption of an expert role by the therapist, implying the objectification of the patient, which would conflict with the basis of the person-centred approach. Berghofer explained that psychiatric patients can become "derived persons, characterised by symptoms, deviating behaviour patterns and deficient social relationships"; and preferred to focus on supporting the patient in the joint venture of "knowing the self" (Berghofer, 1996, p. 484).

Rogers (1957) later modified his position, however, suggesting that diagnosis could sometimes help therapists encounter clients with real empathy and acceptance. This stance was supported by Binder and Binder, who felt that acceptance of bizarre behaviour in clients can be enhanced through diagnosis (Binder & Binder, 1991), which they saw as helpful to comprehension and action. They said this would inevitably emerge, anyway, when working with patients with a diagnosis of schizophrenia. Teusch (1990) also asserts the necessity of the therapist to accept diagnosis.

The debate surrounding diagnosis has continued to develop more recently, with mixed views. For example, a person-centred practitioner, van Blarikon (2006), described his stance of regarding schizophrenia as an illness, while Sanders (2007) strongly opposed this position and described diagnosing distress as an illness as potentially damaging.

Rather than either completely adopting differential diagnosis or totally rejecting it, Warner (2001a, 2007) referred to an alternative stance that is growing in popularity. This involves process diagnosis rather than person diagnosis and discusses the concept of "psychotic process".

Sommerbeck (2003) has successfully worked in psychiatric inpatient settings within medical model services in Denmark and stated that in her experience the person-centred model and psychiatric model are complimentary. Freeth (2007) also inhabits the boundaries between mental health psychiatric care and PCT, as both a psychiatrist and a person-centred therapist. Whilst rooted in person-centred ideology, she has developed strategies for real-world practice. Freeth (2007) described how mental health nurses may sometimes reduce the person-centred model to superficiality or listening skills, rather than as the philosophy it is, in much the same way that mental health practitioners are sometimes caricatured or stigmatised as a result of ignorance. Freeth explained that person-centred practitioners can misrepresent the approach by positioning themselves in a radical stance, lacking clarity of language when explaining what they do, or deviating in their practice from the fundamental basis of the approach. This perpetuates myths and misunderstandings (2007).

My own prejudices were reduced by working closely with child and adult psychiatrists for more than 20 years; during this time, I often encountered practitioners who were client-centred and reluctant to diagnose. I sometimes came into contact with psychiatrists who prescribed minimal amounts of medication where patients had severe conditions and who encouraged client self-empowerment instead of focus on a disease model where care may be in part surrendered to treatment styles and concepts. On the other hand, I encountered supposedly person-centred practitioners who misused their power by stereotyping clients or claiming expertise. Thus, within what may in theory be a case of clashing models, in practice it may not always be foreseeable how treatment will proceed or be delivered and how the patient may retain a sense of being regarded as a unique individual and being in control as much as possible, as the person-centred approach would imply.

There is a history of lively debate regarding the relationship between person-centred practice and the medical model that is the main model in the UK, the country where most of this PhD research is based. Many practitioners have opposed diagnosis whilst others have supported it, and alternative models such as formulation which could work in parallel with the medical model are currently being more widely used and promoted (Berry, Barrowclough & Wearden (2009). Johnstone, 2013).

I support the idea of building bridges and understanding between practitioners, rather than stereotyping and demonising each other or creating hierarchies of modality. This provides the PC practitioner with a foundation for understanding the care and treatments offered to clients so that they can optimise supporting them to self-advocate, or advocate on their behalf if they are unable to do so. This stance is supported by Joseph (2017), who asserted that person-centred practitioners need to be careful of resting on radical assertions that may further marginalise the approach. He recommended that PC practitioners pay attention to respecting and communicating more with practitioners of other disciplines. Joseph also suggested that person-centred practitioners clearly explain their approach to working with severe and chronic issues (p 5-10).

1.6.8 Psychotic process as a "difficult process"

Professor Margaret Warner (2000, 2001a, 2001b, 2014, 2017) and her colleagues (e.g. Trytten, 2003) have developed person-centred theory and practice in relation to difficult client process including psychotic process and has conducted research in this area that is derived from her extensive experience of working with complex client process.

An overview of recent developments in PCT is discussed by Cooper (2007), who explained how Warner's development of theory around difficult client process – including fragile process and dissociated or psychotic process – rather than focusing on what is wrong or abnormal, made a large impact on the person-centred field.

Warner (2001a,2001b, 2007, 2017) supported Prouty's understanding of impaired contact and discusses psychotic client process from a person-centred perspective, integrating theory and practice. As already stated, she described psychotic process as a difficulty in forming narratives that make sense within a cultural context or that offer predictive environmental validity (Warner, 2001a).

As well as describing psychotic process, Warner described fragile and dissociated processes and explains that a client may experience more than one difficult process. (2001a).

As discussed earlier, Warner suggested that a psychotic style of processing is evident in clients "when they have difficulty forming narratives about their experience that make sense within the culture or which offer a predictive validity in relation to their environment" (2001, p. 183).

Warner and Trytten (2008) have conducted research in this area in relation to textual analysis of a specific client with a diagnosis of schizophrenia, known as "Luke", over a period of at least a decade. This study enabled them to develop an increased understanding of psychotic process. Warner and Trytten saw that Luke's dialogues that reframed or indirectly represented factual content did make sense if one understood their symbolic content. This was a different perspective to more traditional approaches in which the client was not encouraged to explore disordered speech in case it encouraged the client to be less linked to reality in their thinking. Warner and Trytten supported Prouty's position that the content was meaningful. They found that Luke experienced "metaphact processing", which they described as a very difficult but productive process. This form of processing utilises what are broadly described as "metaphors including similes and personification and complex wholes". This is a single case, but Luke did not have any diagnosis other than his diagnosis of schizophrenia and so Trytten and Warner felt that his process may be typical of many clients with what may be seen as such "thought disorders". Luke also showed increased engagement in social activities, amongst other positive changes (Warner, 2002).

1.6.9 The importance of specific therapeutic conditions applied to psychotic process

The relative importance of specific therapeutic conditions is considered by different authors. Sommerbeck (2003) stated that unconditional positive regard (UPR) is the primary therapeutic factor in PCT with clients seen in psychiatric services. She suggested that UPR is more critical, due to the shallower level of experiencing and more external focus of evaluation on the part of the clients typically seen in these settings. Sommerbeck viewed a lack of UPR as the primary obstacle in clients who were out of contact. She explained that with this client population, empathic understanding was limited because the therapist is not able to experience the inner framework of the client.

Sommerbeck (2005, 2017), however, dispelled the myth that empathy colludes or reinforces psychotic ideation and highlights other misunderstandings of the approach. (Sommerbeck 2005, 2017a, 2017b).

Rogers’ (1967) Wisconsin project findings also suggest that UPR is particularly important for clients with a diagnosis of schizophrenia, for whom the real relationship seemed to be of critical importance. Prouty (2001) explained that people who are judged and labelled may “suffer many conditions of worth” (p. 78), so that receiving UPR is particularly important for this client population.

Shlien (2003) named therapist congruence as the most important condition with schizophrenia. The importance of congruence is also discussed by Mearns and Thorne (1988), who suggested that when people are psychotic they are by definition at least partly divorced from external reality, and what is needed is a consistent human relationship where the counsellor “gives the client a clear picture of her part of that external reality” (p. 94). van Werde (1998) explained how a client experiencing psychosis is likely to be very sensitive to incongruence and only if they are satisfied that the climate is safe will they take risks. However, Warner (2000) discussed the importance of sensitivity in the use of congruence with fragile, dissociated, and difficult process.

Shlien (2003) discussed the importance of empathy. He wrote:

> “I would like especially to note that in dealing with the schizophrenic the therapist at his best, empathizes with the client’s world as it is at that moment and the meanings it has for the client at that moment whether it is wildly bizarre delusion, a moment of essentially rational self-control or a chaotic disorganization.” (p. 47)

Similarly, Warner (2001a) emphasised the particular importance of empathy and relational depth in difficult process, while Berghofer (1996) discussed disabling therapist reactions, including fear, and how to get beyond such obstacles in order to stay with the emotional experience of the client.

Warner (2001b) saw flexibility, boundaries and contracting as important, building on Berghofer’s earlier discussion of similar points for consideration in issues of adjustment of closeness, distance and boundaries and the need for flexibility (Begenhofer,1996). Lambers (2003) discussed the crucial nature of therapeutic context and attention to issues such as a safe holding environment. Mearns (2003) also discussed contextual issues and the need for both flexibility of working, balanced against control of the work, working within limits with full support.

Part C: Outcome and Change Process Research:

1.7 How are change and change processes measured in psychotherapy research for unusual experiences, psychotic processes or psychosis?

Elliott (2012, pp. 69–81) described how Change Process Research (CPR) was developed. CPR builds on earlier and perhaps more limited attempts by researchers to collect data that specifically links process to client change or outcomes. Greenberg (1986) suggested there was a need to designing research methods focused on both *how* and *why* change occurs” Elliott (2010). Elliott (2012) described essential elements in CPR and devised the following research questions:

> What *therapist* processes facilitate client change?
>
> What *client* processes (types of action, content, style/manner or skilfulness) facilitate (or constitute) client change?
>
> What *relational processes* facilitate change?

Elliott also described the need to consider immediate or more distant impacting context as well as immediate or delayed effects of specific change process, and the need to consider different perspectives from therapist, client, researcher or other party. With these principals in mind then comes the focus of how to capture such data for clients who are experiencing complex processes and may present complex data.

1.7.1 Research methods used to study change in clients with psychotic processes.

In this section I will briefly consider research for psychosis generally, give a brief overview of the range of methods in use and outline some of the issues and methodological decisions facing researchers.

Further exploration of research methods used for the three studies in this dissertation and their selection are discussed in the chapters describing those studies.

People who experience psychotic processes may be vulnerable and at risk of coercion into research; in addition, if they are allocated unhelpful treatments, they may be at risk of feeling worse. Research is a sensitive and complex area. Methods ranging from scientific-like trials to case studies and user-led strategies all add knowledge but are regarded in different ways by different audiences.

The Cochrane register (n.d.) requires meta-analyses of RCTs with RCTs seen as the highest form of evidence, usually containing a primary measure of change.

Other research methods, such as non-controlled trials or qualitative studies including case studies, are regarded to be of lower hierarchical status. Some schools of therapy, such as CBT, have conducted extensive trials that fit the Cochrane standards.

An RCT is an experiment in which patients who may benefit from a particular treatment are treated in parallel with a control group. This can be carried out with a large group of patients to gather statistically significant evidence in relation to the treatment. RTCs of psychotherapy for psychosis have usually involved the random allocation of patients to comparative treatments, such as different talking therapies and/or psychotropic medication. Control groups might be comprised of patients receiving treatment as usual, for example, together with batteries of measures. One main measurement is then observed, which captures any change. The outcomes can be generalised to apply to all patients like those treated in the trial and so specific criteria for trial eligibility are needed. Patients must not be allocated a treatment that is known to be inferior and, in most UK trials, must have given informed consent and be aware that they can withdraw at any stage (Matthews, 2006).

RCTs can be effective in establishing whether a treatment is effective and causes positive change. Patient details such as diagnosis and manualised therapies and the use of outcome measures that are validated are intended to allow comparisons with other trials. Change is usually measured pre- and post-trial, and at regular intervals. Other less rigorous trials may be conducted that are non-randomised or more naturalistic and may provide valuable insights but would not fit UK National Institute of Clinical Excellence (NICE) evidence standards, which usually require appropriate evidence from rigorous RCTs to warrant influencing UK government endorsed treatment guidelines.

RCTs can produce what may be considered as robust evidence but they may lack rich change data and involve ethical complexity; they can also sometimes objectify the participant (e.g. McLeod,2003). The research environment is competitive, with high financial stakes, and the RCT has been described as a “horse race” (Stiles, Hill & Elliott, 2014). Jackson (2018) commented that the NHS is the biggest psychotherapy employer and uses NICE guidelines, so it is the aim of every therapeutic approach to be in those guidelines. The trials are not scientifically perfect, and some have flaws and sometimes major bias; they can sometimes be withheld if they do not produce the desired outcome.

This issue was captured and reinforced by Rogers & Murphy (2017) who pointed out the incongruence of PCT within the climate of accountability and the politics of efficacy evidence and the importance of engaging in active dialogue to encourage a suitable climate for PCT to flourish.

As well as quantitative methods that involve trials, experiments or surveys, qualitative evidence relating to psychotic process, generated by both professionals and clients continues to grow and has a place in the gathering of rich data (e.g. Wood, L. & Alsawy, 2018). Rather than considering the choice between qualitative or quantitative methods, each of which has its strengths and vulnerabilities, psychotherapy is currently seeing a growth in methodological pluralism (see Stiles, Hill & Elliott, 2015). Shifts in research trends include an increase in the number of qualitative meta-analyses (Timulak, 2008) and systematic case studies (McLeod, 2010). key studies to 2015 are listed by Lietaer's bibliography of person-centred research from 1940s to 2015 (2016)).

1.7.2 Survivor research: "experts by experience" – academic-led or user-led

Beresford and Rose (2009) described the conflict between this need for robust research and self-developed measures or methods that develop organically from mental health survivors, who may place less value on objective methods. Survivor research initiated by "experts by experience" provides an important contribution to evidence. The history of "user involvement" in health and social care contexts was mapped out by Barnes and Cotterell (2012) who concluded by affirming the need for continued involvement of service users to accompany researchers in evaluating provision. User involvement began by the early1970s with creation of community health councils and was followed by later moves to embrace the views of specific public audience and outcomes which could influence policies as well as forms of consumer satisfaction surveys evolved. The NHS and Community Care Act (1990) and further government papers encouraged user consultation and involvement.

Gradually service users were more regularly involved in initiatives such as expert patients' programmes and patient reported outcomes. Client feedback processes and resulting outcomes have become increasingly embedded into UK service delivery (DH 2009b, 2010a). Mental health user-led movements have evolved, closely linked to disability rights and the Equality act of (2010) which aims to support people with disabilities in having equal rights and preventing discrimination such as in the case of employment where the disabilities has been disclosed and should then be taken into account .The act acknowledged long term mental health conditions which impact on very day living as well as other disabilities (Lockwood, Henderson & Thornicroft, 2012).

Clients have also become more vocal in demanding their rightful voice in the shaping of services. User-led services have become more common and such services have developed measures which evaluate services according to service user defined recovery model and priorities (Neil et al, 2009). However, criticisms, tensions and concerns have often arisen regarding feelings of tokenistic involvement and whether service users' voices are less visible with integration into mainstream initiatives. Survivor research has developed with this path and is increasingly recognised but still faces challenges, including funding. Much research regarding people who hear voices, hallucinate or have unusual thinking or psychotic processes still follows diagnostic categories and medical model definitions rather than aligning with a more social or integrated model of disability (Beresford, 2009).

Within the three studies conducted for my PhD are mainly academic-led I have incorporated two experts by experience and a carer into the HSCED (study 3 in this PhD research) as independent judges, alongside two psychotherapists, to provide valuable insights. This results in an academic-controlled collaborative position (see Ostrer & Morris, 2009).

1.7.3 Selective review of studies relating to outcomes and change process regarding Person-Centred Therapy

1.7.3.1 The research context for PCT and PCEP trials and change research for psychosis

A growing climate of evidence-based practice, which is present in the UK as well as many other countries, has seen the growth of trials that compare different therapeutic models for specific and non-specific issues and client populations. However, significant research suggests that regardless of the approach the outcomes are similar with reference to the "dodo bird affect" (Stiles, Shapiro & Elliott, 1986). The quality of alliance and other relational factors (Norcross, 2011) appear to be important factors in influencing positive outcomes. More specifically within the field of psychosis this position is also supported by research including two RCTs conducted by Bentall et al (2002) and Bentall et al (2003). These trials studied CBT for patients with a diagnosis of schizophrenia suggested that a positive therapeutic alliance may enhance the outcomes of both pharmacological and psychosocial interventions.

Jung, Wiesjahn & Lincoln (2014) further explored research relating to the complex relationship between alliance and conducted a study of 56 patients with schizophrenia spectrum disorders who received CBT and found that negative symptoms could present a barrier to therapeutic engagement. Therefore, although alliance appears to be important in relation to outcome, the challenges of establishing alliance have been noted in both CBT, client-centred therapy and wider contexts.

Until recently, much research in person-centred experiential psychotherapies (PCEPs) focused more on qualitative studies which were often considered to be closer in ethos to person-centred values (see Wilkins, 2010). Gradually more outcome research is emerging regarding PCEP, both generally for diverse populations but there is still a great need for robust research focusing on particular issues such as psychosis. Whilst it is important for a wide range of research to be generated, with its' strengths and limitations, there is a particular need for research which meets market demands for accountability in sectors such as the United Kingdom National Health Service. This research is even more needed in the climate of being commonly subjected to misunderstandings and misrepresentation, often historically viewed by some medical practitioners as worse than no treatment or seen as ineffective. There has even been speculation that, for those with more severe psychopathology, the practice is even harmful.

Despite some developments in PCT research the situation remains that it is a difficult balance to hold onto the real relationship at the core of the therapy when operating in RCTs. In this forum, treatment is standardised, and the surrounding contextual scientific paradigm requires sufficient statistical power to claim causal efficacy. Rigorous outcome research is necessary to support efficacy and treatment pathways and secure service funding. In practice, the manualisation of client-centred therapy (CCT) may also be difficult, as discussed by Rundle (2017b) although in the UK government endorsed Improved Access to Psychological Therapies program (IAPT) which commenced in 2007 and included the person-centred-based counselling for depression (CfD) mode of treatment has been successful in this (Sanders & Hill, 2014) although this was not without its' own politics and complications, as documented by Proctor & Hayes, 2017).

There is an absence of robust outcome research regarding PCT for psychotic process compared to other commonly practiced therapeutic models such as CBT. This could be viewed as surprising if one considers Rogers' early devotion to scientific research. The ethos of the person-centred approach and the emphasis on the real relationship, and possible culture clashes with medical treatment, diagnosis and trials may be relevant. This reluctance of PCT therapists to conduct trials has been discussed by Cooper (2007), who commented:

> It is ironic that, for an orientation that is so founded on empirical observation, the person-centred approach has developed something of a reputation for being research-aversive. This is not entirely unfounded: person-centred therapists can be wary of "imposing" evaluation tools on their clients, and of categorising them according to predefined diagnostic indicators.
>
> (pp. 33-36)

However, Cooper also affirmed that the climate is now changing. This change is aided by researchers such as Gibbard & Hanley (2008), Elliott (2016) and others who are carrying out meta-analyses as well as conducting and supporting change and outcome research. There has been a growth in large scale trials for diverse client populations (e.g., Stiles, Barkham, Mellor-Clark & Connell, 2008).

The debate relating to the notion of finding the most effective treatments for specific conditions does not fit neatly with person-centred theory, which is neither problem-focused nor specifically aimed at symptom reduction. The fact that so-called “supportive counselling”, presumably linked to PCT was explicitly contraindicated in Britain as a treatment of choice due to an insufficient evidence base, as discussed earlier, generates pressure in the PCT community. This leads to dilemmas in terms of balancing the demand for RCTs and evidence-led practice against arguments for more qualitative studies that may fit in more naturally with person-centred practice. However, irrespective of one’s stance on the relative value and importance of different types of research, the situation remains that these standards are currently in place and have a substantial national impact on service delivery and funding. The onus is on researchers to generate more robust “gold standard evidence” that meets the threshold for NICE consideration, when testing whether a treatment is effective for clients with psychotic process.

Results of outcome regarding person-centred psychotherapy for psychosis that has been nationally recognised to a sufficient level to impacted on care pathways in the UK has not yet emerged. Elliott et al. (2013) pointed out that although a growing body of relevant studies show superior effect sizes when comparing humanistic-experiential psychotherapies (including PCT) to other treatments, PCT for psychotic process has been overlooked. The production of research in the person-centred approach for all types of client difficulty may have been limited by the values of the approach. This issue is explored by Brodley (2003, 2006), who concluded that psychotherapy is essentially practical and ethical, and that research activities and influences should be secondary to this, limited and considered cautiously.

Also, the fact that the approach is person-centred and not problem-centred could have historically limited comparisons to other treatments, although this is shifting as CfD and theories relating to specific client populations or processes gradually emerge (e.g., Warner's description of difficult processes; Prouty, 1976). Rogers himself took a scientific stance. However, much research has been developed by other modalities with PCT as a control treatment; some may argue that in some trials the treatment itself may not replicate that of a qualified PCT practitioner, and a lead CBT researcher has informed me of one well-publicised trial in which just six weeks' training was offered to supportive counsellors, where a person-centred psychotherapist would usually train for several years.

Traditionally, PCT has not been problem-focused but research does exist that points to its general effectiveness for diverse populations as will be explored in the following section in this chapter.

1.8 Meta-analyses and systematic reviews of change and outcome studies in client-centred therapy, supportive counselling and pre-therapy for psychosis

This section will describe an overview of and selection of metanalyses and specific studies, prioritising more recent studies and those relating to change and outcomes in PCT for psychosis and then briefly consider their collective implications. A more comprehensive review would fall beyond the scope of this study. However, I will refer to key studies and trends in this area and capture the emerging picture of change research for PCT and related therapies for psychotic processes.

1.8.1 Meta-analyses and systematic reviews

Several meta-analyses and systematic reviews of humanistic experiential psychotherapies for psychotic process have been conducted. These cover a wider group of modalities than the focus in this thesis and are not specific to PCT including pre-therapy, but they do highlight important studies in PCT or pre-therapy and show research development.

Recent meta-analysis and systematic reviews show increasing activity in change and outcome research into humanistic experiential therapies, including PCT and supportive counselling. Development in research has been shown and brought some positive results

1.8.2 Humanistic and Experiential Psychotherapy meta-analyses

The first meta-analysis of PCE therapies was conducted by Greenberg, Elliott and Lietaer (1994) showing mixed outcomes but with little differences in effect sizes between studies fitting the criteria. This was the beginning of a series of regular meta-analyses incorporating PCT and was important historically in the context of PCT research and was followed by meta-analyses by Elliott (1996) and Elliott (2002b).

1.8.2.1 Elliott, Greenberg and Lietaer (2004)

Elliott, Greenberg and Lietaer (2004) conducted a meta-analysis that included attention to studies relating to schizophrenia. The meta-analysis found just three relevant studies relating to treatment and possible symptom reduction for clients diagnosed with schizophrenia (Teusch,1990; Eckert & Wuchner, 1996; and Tarrier et al (1998) and Tarrier et al (2000). Tarrier et al., (2000) was the only trial. In this study, supportive counselling was a control against CBT and did demonstrate some minimal change at first and more significant positive impact at long term follow up. Elliott, Greenberg and Lietaer concluded that HEPs showed promise for schizophrenia.

1.8.2.2 Elliott, Greenberg, Watson, Timulak & Freire (2013)

Elliott, Greenberg, Watson, Timulak & Freire conducted a meta-analysis of humanistic experiential psychotherapies (including PCT and pre-therapy) from 2008, which included a section devoted to humanistic experiential psychotherapy (HEP) for psychotic process. It included approaches such as Emotion Focused Therapy (EFT), which, as discussed earlier, is within the “tribes” of the person-centred approach, as well as Gestalt therapy and psychodrama, which fall outside of the person-centred approach. The meta-analysis team considered nine studies, six of which focused on PCT/pre-therapy. small effect size differences between CBT and humanistic experiential counselling which demonstrated significant effect sizes.

The authors concluded that the outcomes of this meta-analysis were promising, demonstrating that HEP may be effective for this patient population, but that more research was needed (Elliot et al., 2013).

1.8.2.3 Buckley, Maayan, Soares-Weiser & Adams (2015)

Buckley, Maayan, Soares-Weiser & Adams (2015) conducted a systematic Cochrane review of supportive therapy for schizophrenia with the acknowledgement that this was often a treatment of choice specified by patients but was difficult to establish what supportive counselling was in the studies and it is hard to establish if specific therapies do have an advantage over supportive counselling due to the poor quality of evidence currently available.The study considered 24 trials and concluded that there was little evidence difference in outcome between supportive therapy and standard treatment and no information relating to adverse effects of supportive counselling. The review recommends that future research is conducted in the form of larger trials that use supportive therapy as the main treatment instead of as a comparison.

1.8.3 HEP Psychosis Meta-analysis Update (Bergmann, Elliott, Sharnabee and Peyton, 2015)

Preliminary findings from a much- needed updated systematic review and meta-analysis of humanistic experiential treatments (HET) for psychosis was reported in 2015 by Bergmann, Elliott, Sharnabee and Peyton. Some of the initial results have been made available through conference presentations and dialogues with the team.

Preliminary results from this ongoing meta-analysis of HET, including PCT/pre-therapy for schizophrenia but also other treatments, so far indicates clinically significant pre–post effect sizes that are not distinctly different in effect size to CBT and have a small or 3medium effect size additional to advantages of routine treatment.

1.8.4 CBT/non-specialised therapies meta-analyses

Newton Howes and Wood (2013) published a systematic review and meta-analysis study First published in 2011) which set out to ascertain whether CBT was more effective in reducing psychopathology in patients with schizophrenia than non-cognitive psychotherapies and considered the outcomes of nine RCTs which met the study criteria. No significant differences regarding changes in psychopathology were found between post therapy treatment groups at the end of treatment in respect of psychopathology and there was no evidence found of publication bias. The study acknowledged the historical biases in favour of CBT with its theoretical position and possible positive research biases. The authors concluded that whilst CBT was demonstrated to be effective it did not show superiority in psychopathology reduction over “more accessible and simpler forms of therapy” and that less expensive and less complex supportive therapy could be the subject of research trials for consideration to treating patients with psychotic mental disorder as well as the consideration of modification of CBT to maximise its potential.

Kennedy & Xyrichis (2017) conducted a systematic review and meta-analysis which examined the evidence for the superiority of CBT compared to non-specialised therapy in alleviating auditory hallucinations in community patients with schizophrenia. There were 105 participants from two qualifying trials that used the Positive and Negative Syndrome Scale (PANSS) to measure symptoms. A conclusion was reached that there was no clinically significant difference between the two treatments in the reduction of positive symptoms of schizophrenia.

1.8.5 Outcome/change studies of pre-therapy

Steps have been taken towards developing research in pre-therapy. Dinacci (2000) developed a measure-objective evaluation criteria for pre-therapy, and Dekeyser has developed a pre-therapy psychological contact measure (Dekeyser, Prouty, & Elliott, (2008). These measures are helping to assess the impact of pre-therapy on clients.

One intensive case study studied pre-therapy that took place in taped sessions with trained therapists over two years. Recordings were later analysed in terms of frequency of contact behaviours, and client outcomes were documented. Outcomes included significant gains, affective and communicative functions, more motivation to articulate, more attempts to communicate, more sociable, more eye contact, less autistic, ritualistic, communicates needs more, better tolerance, esteem, more bodily contact, more aware of the therapist as a person, better grooming habits, less hallucinating, less aggression and maladaptive behaviours, and more emotional stability (Prouty, 1990).

Dekeyser, Prouty and Elliott (2008) conducted a research synthesis on measures and outcome research on Pre-therapy for clients diagnosed with chronic schizophrenia. This involved case studies and a small randomised pilot study. The three systematic case studies incorporated a total of 5 clients accessing 103 sessions, with a very large effect size of 1.08. The RCT included 18 match-paired clients in a pre-therapy 50-session treatment programme. The trial used the Pre-Therapy Rating Scale (PTRS-1) and the Evaluation Criteria for Pre-therapy Interview (ECPI G11) and gave a weighted effect size of 0.64 compared to routine care. The trial showed some limitations. Seven therapists offered non-manualised treatment, which may have varied. Although the small participant numbers limited statistical power, the findings of the meta-analysis do suggest that pre-therapy could be effective for improvement in communication for clients with a diagnosis of chronic schizophrenia. This research synthesis supports the need for further larger scale research on Pre-therapy.

1.8.6 Specific outcome and change research studies for PCT with psychosis

In this section I will describe some of the key studies in change and outcome research in PCT and pre-therapy for psychotic process, the development of research in this area and an outline of key research and results identified in both recent meta-analyses and studies identified from my own formal and informal searches (described).

1.8.6.1 The Wisconsin Study

The Wisconsin study (Rogers, Gendlin, Keisler, & Truax, 1967) was the first major research undertaken of PCT for psychosis. The study is historically important in research development in this area despite the results not providing statistically significant outcomes. The five-year study (1958–1963) was conducted by Rogers and his research team at the University of Wisconsin with psychiatric inpatients at the Mendota state hospital. There were 48 participants consisting of 16 volunteers from the community who did not have a psychiatric diagnosis, classed as “normal” in the context of the study, 16 patients with “more chronic schizophrenia” and 16 more acute patients with less than eight months in patient admission. Later inspection of the sample did not find the differences in these samples distinctly distinguishable .Each of the three groups of 16 participants was made up of eight matched pairs with similarities in age, gender, socio-economic status and degree of disturbance. One member of each pair was randomly selected for PCT, with the remaining community volunteers serving as a control to compare processes and outcomes. Rogers wanted to measure change processes at points over a series of therapy sessions, which were audio recorded and later using audio-visual recording). Eight therapists worked on the project, with a battery of measures applied at three and six months. Transcribed sessions with samples from the beginning, middle and end of sessions were used for independent rating by trained researchers using measures developed to capture process variables. The study's main aim was to compare core conditions offered by the therapists to client outcomes.

There were many complications and difficulties in various aspects of the project (see Gendlin 1961, 1962, 1966; Kirschenbaum, 2007); it was ethically difficult to conduct measures as regularly as had been hoped and measures were deemed to be coarse There was no control group of patients who did not receive any treatment as this would not have been ethical, and further complexities arose in that the consent of hospitalised patients was required in order to minimise the risk of coercion, but this reduced the amount of data. Institutionalised or seemingly unmotivated patients were difficult to negotiate in a ward context. The research was on a small scale and was conducted by the team, who were new to working with this client group and the frequent very long silences in sessions, which were totally unfamiliar territory for them. Additional data was provided by the ward availability project, where therapists were available and could be approached by clients on the wards and form an encounter without coercion. (Rogers, 1967, p. 57).

The results were initially met with disappointment as they did not show any significant difference in process movement between the therapy group and the control group. Only a small difference in outcome was shown, with therapy participants experiencing higher hospital discharge rates, greater ability to manage environment and positive personality change. However, the results did bring some new insights that were not linked to the hypothesis, and some hypotheses were supported by data (Kirschenbaum, 2007). Rogers (1967) reported that the study showed an overall reduction in psychopathology and an improved ability to manage relationships in both PCT and usual treatment groups, thus showing no advantage in offering PCT. Therapy process levels rather than outcomes were correlated with high levels of the core conditions that were offered by therapists and deterioration appeared to occur when these conditions were low. The presence of UPR and genuineness seemed to be the most effective practice elements for this client group (Data from the ward availability project (Rogers, 1967) suggested that the availability and experience of a relationship to a person with disturbed process was positive. Many clients in the ward availability project gradually engaged with the therapists and demonstrated the ability to form a kind of relationship and move forward in the direction of self-actualisation.

The Wisconsin project is now becoming increasingly recognised as having demonstrated some positive outcomes in this client group, especially when clients were more in “contact”. The data indicated that less disturbed patients experienced the PCT as more helpful and that “the deeply disturbed psychotic” was unable to perceive or report understanding, warmth and genuineness to the same degree as the less disturbed person, which impacted on outcome. However, the results demonstrated that as therapy progressed the patients showed an increased ability to perceive a higher level of these therapist conditions (Rogers, 1967, p. 75), suggesting that Rogers' theories of the conditions affecting change carried some validity. Findings indicated that unconditional positive regard and genuineness were most effective with this client group. Those who perceived higher levels of the core conditions showed greater improvement and there was a correlation between process level and outcome (Rogers, 1967), This also influenced later psychotherapy research; this early finding provided an early sense of both the necessity and difficulty of psychological contact in this client population, which was later developed both clinically and theoretically in the form of pre-therapy (Prouty, 1976).

Gendlin (1973) highlighted how non-imposition on the part of the therapist was important with this vulnerable patient sample (pp. 121–124).Gendlin (1967) also recommended that therapists should restrict their own expression of how they related to the patient, paying attention to themselves and what they expressed in order to prevent them from getting in the way of the client's process. Empathy was not easily received by the clients. He advocated clear, brief, expressions to avoid overwhelming patients with complex statements (p. 81).

Trytten (2004) analysed the study outcomes and highlighted how the patients with schizophrenia developed more emotional distance from emotionally charged experiences, demonstrated more appropriate emotional expression, were better equipped to deal with interpersonal relationships and showed an improvement in their ability to do so.

Sommerbeck (2005, pp. 317–336) critically evaluated the Wisconsin study. She suggested that the therapy carried out by inexperienced therapists was clearly not client-centered therapy and therefore that the results did not prove the failure of CCT with people diagnosed with schizophrenia but that in fact it was a nondescript approach applied to unmotivated clients. She challenged the commonly held notion of CCT being unsuitable for clients with severe psychopathology, claiming that this was unsupported and not based on evidence.

A study by Truax and Mitchell (1971) later confirmed the Wisconsin findings but the accuracy of this later study has been informally questioned as the results indicated very high outcomes (Kirschenbaum, 2007). Lietaer (1990) critically analysed this study and suggested that Truax may have showed a tendency to conceal negative findings. The same research was reported in various publications describing conflicting reports of results (Parlow, Waskow and Wolfes 1978, pp.242-252).

The Wisconsin study therefore had mixed outcomes and a mixed reception, but it was nonetheless significant in the path to developing robust psychotherapy research methods and did raise interesting questions for further study. Following the Wisconsin study, a substantial period elapsed before any further significant studies of PCT for psychotic process – or even general client populations – was conducted, although there were significant theoretical developments in the understanding of difficult client process, which are discussed here in a separate section. This historical period was discussed by

Lietaer (1990), who compiled a PCT literature bibliography in the 1970s and 1980s and acknowledged that many undocumented activities were emerging but that there was an absence of research. A growth in research studies was seen in Germany with some developments in the Netherlands but less activity in France. Most contributions originated from the English-speaking countries, with diminishing activity in the US.

1.8.6.2. Coons and Peacock (1970)

In 1970, Coons and Peacock published their study of 56 chronic inpatients (38 with a diagnosis of schizophrenia) at Ontario Hospital, Hamilton. Participants were gender-matched and randomly referred to client-centred group therapy for 30 sessions over a period of six weeks (Coons & Peacock, 1970). The inclusion criteria for each participant was group therapy suitability as follows: “1) Ability to maintain at least passive attention; 2) Sufficient contact with reality to be minimally disruptive to the group; 3) Grade VIII education or a pre-treatment I.Q. of at least 90; 4) No known organic impairment” (Coons & Peacock, 1970, pp. 349). The battery of measures applied consisted of the Wechsler Adult Intelligence Scale (Wechsner,1958); the Hospital Adjustment Scale (McReynolds & Ferguson,1953); and the Rorschach Technique of Personality Diagnosis (Klopfer & Kelly,1942). Results demonstrated significant improvements in IQ and cognitive functioning in clients after receiving group client-centred therapy. Limitations of the study have been debated (e.g. Klein, 1980).These include the issue that symptom changes were difficult to assess with the chosen measures, with limited internal validity; and that measure raters were psychiatric ward staff so there may have been bias. Also, the groups were facilitated by trained therapists with greater status than the regular ward staff supporting the participants, who were not allocated to group therapy.

1.8.6.3 The Essen Study

A study was published in 1983 based on research conducted in the Essen Psychiatric University Hospital in Germany. Participants in the Essen study consisted of 60 inpatients with a schizophrenia diagnosis in chronic or sub-acute phase (Teusch, Beyerle, Lang, Schenk & Stadmuller, 1983). The study involved person-centred group therapy offered by four trained, experienced therapists. The research team's practice was influenced by Gendlin's (1966) published observations in the Wisconsin project and in specific situations used slight modifications, such as active experiencing and self-disclosure, in attempts to try to connect to the more autistic patients or when met by long silences. Concreteness was used when patients were not concerned with their problems or abilities (Truax & Carkuff, 1964), confrontation was used when there was thought disorder and the relationship was good (see Truax & Carkhuff 1967) emotional overstimulation was avoided.

Each therapy session was rated using Eckert, Schwartz and Tausch's (1977) Client-Experiencing Questionnaire (*Klienten- Erfahrungs-Bogen*, KEB) for a total of 517 sessions (Teusch et al., 1983). The study used the Freiburg Personality inventory (Fahrenberg & Selg,1970). Results found evidence of personality changes under therapy (Teusch et al., 1983) involving reduced emotional distance, less vulnerability, less physical complaints and reduced depressive mood. Patient self-assessment showed more self- confidence and sociability, reduced frustration and less self-restraint. In all, 75% of patients (apart from early failure in the first 30 days of treatment) “showed a distinct reduction in psychopathology and a distinctly better social adjustment on a global clinical rating” ; 18% showed slight improvement; and 7% were unchanged or deteriorated (Teusch et al., 1983). Data suggested that most patients experienced therapy as reassuring and helpful. Improvements were shown in areas such as insecurity and verbal inhibition. The study was limited, with no control group, and the measures are now considered coarse (Teusch, 1990). Teusch (1990) concluded that CCT can be viewed as helpful and effective regarding schizophrenia but that it is not the method of choice and should be integrated with a multidimensional therapy plan including social intervention and neuroleptic drugs. Teusch supports using diagnosis to develop a therapy plan. He described how results indicated that:

> Standard conditions with regular individual and/or group therapy sessions are only possible or useful if the psychopathological symptomology is not acute or severe and if the patient is at least minimally motivated in psychotherapy. If these conditions are considered, nearly all patients benefit from treatment in a measurable way: There is evidence of reduction of psychopathological symptoms and improvement of social adjustment. (Teusch, 1990, p.642)

Important changes were observed in areas of self-assessment, especially a reduced need for patients to deny or emotionally distance themselves from their experience, a reduction in depressive mood and physical complaints, and more self-confidence and sociability. The study showed that client-centred therapy within a multi-dimensional therapy model with drug therapy can contribute effectively to improvement in patients with a diagnosis of schizophrenia. Generally, the administering of drug and therapeutic approaches by the same practitioner worked together, with better outcomes for less disorganised clients.

There are some similarities between these results and Rogers' earlier Wisconsin study; both showed less disturbed patients having more helpful experiences of PCT and being less sceptical. Evidence of positive personality change was found in Essen and Wisconsin (Teusch, Beyerle, Lange, Schenk & Stadtmuller,1983; Teusch, 1990).

Elliott et al. (2013) described how naturalistic studies of CCT principles used with inpatient populations began to emerge at this time (Teusch, 1990; Tscheulin, 1995), and some in outpatient or day care services (Snijders, Huijsman, de Groot, Maas & de Greef, 2002; Tschuschke & Anbeh, 2000).

1.8.6.4 Eckert and Wuchner (1996)

In 1996 a research programme conducted by Eckert and Wuchner in Germany was published. Client-centred psychotherapy (group and individual) was offered to patients with diagnoses of borderline personality (who may experience psychotic process) compared with patients diagnosed with depression and patients diagnosed with schizophrenia. Two patient groups of the study therefore potentially experienced psychotic processes. All three groups received CCT. This study of inpatients and outpatients in the University Hospital in Hamburg and the University Hospital in Lübeck over a four-year duration included 13 schizophrenia patients in a 100-day programme, as a comparison group.

The patients were assessed using borderline diagnostic tools. The results showed a significant drop in psychotic symptoms in borderline patients (1.7 to 0.36) with a significant drop in patients diagnosed with schizophrenia (0.8 to 0.4).

Elliott et al. (2004) included this trial in the 2004 HEP meta-analysis, highlighting the 0.59 pre–post effect size.

1.8.7 Randomised controlled trials with “supportive counselling” as a treatment or control groups

1.8.7.1 overview

The late 1990s, saw a growth in robust research trials for psychotherapy for psychosis. Most trials studied CBT as the main treatment with some trials of other therapies and interventions. I have also included some examples of this research lastly in this section as although the treatments offered are not necessarily “bona fide” PCT they may have many common factors with PCT and therefore warrant some attention.

CBT was the most frequently recommended and most popular individual psychotherapy offered to clients in the UK as a first line of treatment for psychosis or schizophrenia, along with other interventions such as family therapy and medication. This was endorsed by NICE (2009), which cited trials that were used to inform the guidelines for endorsed treatments.

1.8.7.2 The CBT trials

From 1999, CBT trials have generated further relevant data about what was broadly supportive therapy, which emphasised many of PCT's qualities and provided further considerations of what may be helpful with this client group to inform future research. The supportive counselling was often used as a control or placebo rather than as an active treatment. Some of the key trials are described below.

Supportive therapy (ST) treatments varied and were not necessarily fully consistent with PCT. Person-centred therapists would usually have the benefit of full training, experience and person-centred supervision. Instead, in this case, a more general counselling was delivered by practitioners who may have had allegiances to other modalities and sometimes limited training (e.g. six weeks, in one trial according to one of the trial co-ordinators in a personal communication). However, the supportive counselling in some trials may be similar in some respects to PCT in their focus on Roger's core conditions and sometimes the absence of psycho-education in order to be distinctive from CBT. Therefore, the outcomes of these trials may be relevant here and raise useful questions or highlight the need to duplicate such trials with actual manualised PCT delivered by professionally qualified PCT therapists.

In one of the earlier recognised trials Haddock, Tarrier, Morrison, Hopkins, Drake, & Lewis. (1999) conducted a pilot study of CBT for early psychosis in 30 in-patients with supportive counselling as a comparison treatment which found little difference in two-year outcomes and recommending either treatment. Relapse patterns differed with readmission occurring sooner with CBT patients than the SC group, but CBT patients relapsed less and showed slower recurrence of symptoms.

Tarrier et al (1998) conducted an RCT of intensive CBT for 78 completing patients with chronic schizophrenia. (control of supportive counselling showed non- significant improvement. Regression analysis demonstrated that clients who received CBT group were 8 times more likely to improve than without CBT).

Tarrier et al (1999) conducted a trial of the durability of the effects of CBT in the treatment of chronic schizophrenia. This was 12-month follow-up comparative trial with supportive counselling. and usual care.72 clients remained in for follow up assessment and both CBT and supportive counselling were found to be more effective than routine care regarding negative symptom reduction. Results indicated that CBT demonstrated superior results in positive symptom reduction and whilst supportive counselling saw positive outcomes compared to routine treatment.

Tarrier et al (2000) conducted a single blind two year follow up trial of CBT compared to SC and routine treatment. Authors expressed surprised that the SC which had been usually seen as a control was more effective than routine care with CBT as most effective but at post treatment follow up. CBT and supportive counselling demonstrated convergence in recovery pathways, with some measures recording supportive counselling as giving better results than CBT.

Tarrier et al. (1998, 1999, 2000) conducted an RCT of CBT with chronic outpatients who were experiencing psychosis. An additive design study used supportive counselling as a control or treatment as usual. Whilst post-treatment outcome saw CBT as more effective, in the long-term 24-month follow-up CCT appeared to be more effective. Following this the use of supportive therapies as control treatments for CBT and other therapies have continued to present day and as discussed earlier collectively , when referring to meta-analyses, have sometimes shown positive and similar outcomes to CBT (e. g. Bechdolf et al 2007; Cottrauxa et al 2009 ; Addington et al, 2011, Stain et al, 2016).

1.8.7.3 Avatar therapy and supportive counselling

Virtual reality assisted therapies are showing promise in this client group and also include comparative studies which highlight supportive counselling as effective (Rus-Calafell., Garety, Sason & Valmaggia, 2018).

Craig et al (2018) conducted a single blinded trial of avatar therapy (invented by Leff, 2008) with supportive counselling as a control treatment at the South London Maudley NHS Trust. During avatar therapy, people who hear voices engage in dialogue with the "avatar" of their perceived persecutor, with the therapist voicing the persecutor. The aim is for the client to become increasingly self-empowered by responding assertively to the avatar. A total of 150 pre-assessed eligible participants who were diagnosed with schizophrenia or an affective disorder with psychotic symptoms and who had heard auditory hallucinations during the past 12 months were assigned to avatar therapy or supportive counselling. The clients were then assessed at 12 and 24 weeks by masked assessors who were unfamiliar with the mode of therapy that had been offered. The avatar therapy showed a large effective size and a reduction in persistent auditory verbal hallucinations at 12 weeks compared to supportive counselling (mean difference −3·82 [SE 1·47], 95% CI −6·70 to −0·94; p<0·0093) with no adverse effects noted from either treatment. At 12 weeks there was more improvement in the participants assigned to avatar therapy; then at 24 weeks there was no significant difference. The authors concluded that although the supportive counselling delivered in the trial was less rapidly effective than the avatar therapy, it appeared probably to be beneficial for the treatment of auditory hallucinations. "Supportive counselling is a control condition with non-specific factors that, compared with no treatment, can be effective in its own right." (Craig et al, 2018).

1.8.8 Contemporary and Third Wave Therapies

As well as Avatar therapy, other contemporary Third wave Therapies for psychosis have been recently developing with influences from spiritual philosophies such as Buddhism (Rundle 2017a, 2017b) These newer therapies are sometimes integrating more elements that link to person-centred theory. Mindfulness approaches (Chadwick, Hughes., Russell, Russell, & Dagnan, 2009) and person-based cognitive therapy (Chadwick, 2006) incorporate a strong focus on relationship and highlight the critical nature of alliance in relation to client outcome.

Gumley developed RCTs of CBT relating to the prevention of relapse in people experiencing psychosis (e.g. Gumley et al 2003) and he has since taken a central role in developing and piloting third wave interventions for psychosis.

This includes Compassion Focused Therapy (e.g. Gumley et al., 2010; Braehler et al, 2012.,). which showed promise in terms of increasing self-compassion and reducing shame and self- criticism, as reported in Leaviss and Uttley's systematic review (2015). Acceptance and Commitment Therapy show positive outcomes in mood and other areas in early pilot trials and other trials (e.g. Gumley et al, 2017). Wakefield, Roebuck and Boyden's (2018) systematic review more recently reported positive outcomes including reduced hospitalisation and other positive outcomes with the hope of gaining more long-term data in the future.

Voice Dialoguing is also an important approach which is growing in recognition and seen as complimentary to PCT approaches (Corstens, Longden and May,2012). Different strands of therapies continue to emerging and increased research base and awareness of the importance and positive outcomes relating to relationship.

1.9 Summary of Literature review

In summary, research in this area suggests that HEPs and person-centred ways of working with clients can be helpful with rapidly developing theoretical constructions and developments in practice as well as growing respect for the approach as a result of favourable results recent comparative trials and meta-analyses. Outcomes can include increased social skills, reality contact and reduction in "psychopathological" symptoms, and some trials show similar outcomes and effect sizes to NHS recommended CBT treatments and other therapies.

It can be difficult to assess research in this complex area, where many clients are in inpatient or outpatient contexts with multiple treatments and severe and varied acute or chronicity of presentation. Literature suggesting that alliance may be more fundamental, both with general client populations and those with psychotic process, may be more significant in the debates regarding which modality is most effective. We need to then consider what does this mean in relation to specific treatments which may be based on the foundation of positive therapy alliance but additionally impact upon the client in different ways. More large scale and complementary rich qualitative research is clearly needed to further explore outcomes and changes.

The aim of the present study was to partially address this need to develop further understanding of contemporary person-centred therapists' views of their practice with clients who experience psychotic process and to investigate the change experiences and therapeutic process from the client's perspective, with a client case study to provide further insight. This was a realistic goal, given the limited scale of the project as a PhD study with no external funding source. I hoped to gain further awareness of change processes in clients and what appears to be useful practice; to compare the results to previous studies; and perhaps to encourage further research.

The foundation of the research lay in relating to the person-centred ethos when working as a team with clients. I involved practitioners' perspectives of helpful practice and changes in study 1, then clients' perspectives in study 2. I followed this by involving service users and carers, as well as professionals as experts, in the final HSCED study, being transparent regarding my own personal motivations and totally open to scrutiny from a vulnerable participant population who may find trust challenging. This gave some power to the voice of service users to express their experiences in their own words, within a structure.

Chapter 2

Study 1: Helpful factors and outcomes in person-centred therapy with clients who experience psychotic processes: Therapists' perspectives

2.1 Introduction

This qualitative study explores person-centred practitioners' perceptions, firstly, of what may be helpful in their work with clients who experience psychotic processes and, secondly, of the impact that they believe this practice has on their clients and any changes they have perceived or observed in clients. In-depth semi-structured interviews with 20 British person-centred practitioners focused on how the practitioners worked therapeutically with clients who experienced psychotic process, what they perceived as helpful practice, and how they believed these practices helped their clients. Analyses used a grounded theory approach.

Special Note

I conducted this client study in the earlier part of my doctoral research studies at the University of Strathclyde whilst supervised by Professor Mick Cooper (who is now based at the University of Roehampton) and I was then additionally supervised by Professor Robert Elliott who then became my sole supervisor to completion. I conducted a literature review, designed this research, collected and analysed data for this study, supervised by this team, and Mick and Robert audited and co-authored a published paper with me, based on the outcomes (Traynor, Elliott & Cooper, 2011) which is in part expanded and integrated into this section with full acknowledgement of their contributions to the completion and dissemination of this study. I later published a book chapter (Traynor, 2014) with reference to both this study and my entire project in its very early stages of analysis and tentative results.

2.2 Method

2.2.1 Procedure and sample

Following ethical approval from the University of Strathclyde (see appendices A.1 and A.2), according to the research protocols. Participants were recruited via national counselling journals, person-centred journals, person-centred websites, organisations and groups, and word of mouth. The sample consisted of participants in the role of counsellor, psychologist or psychotherapist. Other participants were practising in an exclusively client-centred way in the context of other roles such as support worker or mental health practitioner. The sample consisted of 20 UK-based person-centred practitioners (14 females, 6 males) who had worked with at least one client in a psychotic process. Fifteen participants had completed a Diploma or equivalent in person-centred counselling. Other participants had substantial training in the person-centred approach or had attended extensive Rogerian courses or creative expressive person-centred training. All practitioners described the way they worked with “psychotic process” as person-centred and most referenced literature and additional training beyond their Diploma or core training. The descriptions provided a picture of how the therapy proceeded and these all matched components of the claimed modality, warranting inclusion.

Unstructured interviews were conducted with prompts relating to the key research questions. These involved participants being asked to:

- describe their training and any additional short courses or influences
- describe their background and work context
- describe their experience of working with clients in psychotic process
- describe the practice they offered to clients who experienced psychotic processes and any differences between this and usual practice
- discuss any particular aspects of practice that seemed particularly helpful to clients
- describe client changes they had perceived and say how they came to this view (e.g., evaluation tools, observations or client feedback)
- describe their perceptions of unhelpful practice and any possible negative outcomes
- discuss any additional issues they felt were important.

2.2.2 Theory and process of method

The research method was developed within the epistemological context of Hermeneutic phenomenology, with a reflexive relational focus and assumptions that meanings arise from contexts (Finlay, 2011, p.165)

I considered whether to use structured, semi-structured or unstructured interviews. Unstructured interviews are a qualitative method that can be recommended for phenomena that is new or where there is little information (Barker, Pistrang & Elliott, 2015). In this case a body of texts was slowly emerging in the subject area but there was very limited research regarding current practice in the UK or larger scale studies. I therefore aimed to approach the area with an open mind and exploratory perspective as much as possible, with the aim of seeing what practices or outcomes emerged, allowing participants to talk freely around the central topics and wondering whether areas would emerge beyond what I might naturally have considered. I was open to using a more structured approach in later studies after establishing some basic knowledge in relation to this area. Questions can arise with this method in terms of reliability; or, in other words, if another person duplicated my approach, would they arrive at the same or a similar position?

Robson & McCartan (2016). discussed the advantages and disadvantages of interviewing. They described the advantages of the method in that it is flexible and allows the line of enquiry to be modified. They further explained that this method as needs a major time allowance, as well as skill; pointing out that half an hour may provide insufficient data while anything over an hour could be an unrealistic commitment for the researcher and too demanding for the participant, with the risk of under-recruiting. I therefore planned my interviews to last for about an hour although some practitioners spoke for a little less than this or longer if they chose to. The time and the use of the room were flexible for both parties. I was glad that this was possible when several practitioners revealed topics that were emotionally loaded for them and this flexibility allowed time for pacing, a potential grounding period or debriefing where it was needed. Several participants spoke at length regarding the difficult contextual politics of PCT practice for them and the barriers they had faced. This was a digression from the core research questions but, was enlightening and warrants comment, despite falling outside of the scope of this analysis.

This open timing was not recommended by Robson et al (2016), who suggested that the researcher should terminate the interview after a specific maximum time-frame, relying on closure skills (p. 273). I realised from this note of caution that I would be committing more time to transcribing any particularly lengthy interviews but was open to following process in this sensitive political climate. Many practitioners also mentioned personal links to the subject in relation to themselves or people close to them, which may have motivated their practice, and at times discussed difficult personal material.

2.2.3. Ethical considerations in process

My own position as a practitioner would inevitably impact on results somewhat, as well as the fact that some participants emerged from my wider networks, although others were entirely new to me. Contamination regarding this was a concern but a prior relationship, despite its possible negative or contaminating issues, could be advantageous in other ways: having a basis of trust would encourage openness, although participants wanting to please me might also be a factor. The wider sample were mainly not within my core networks and, over 20 interviews, enough data could be generated to allow for these factors and still hopefully generate significant findings of interest or relevant to practitioners in the field.

Twenty participants were the minimum data set discussed with my supervisory team to ensure there was adequate data and saturation (e.g. Strauss & Corbyn,1998; Charmaz, 2006; Aldiabat, & Navenec, 2018) and it took some time to recruit the sample. As I conducted the recruitment and research itself, I gained a heightened awareness of why such recruitment may have been challenging in a sensitive UK climate of practitioners operating without a strong underpinning foundation of proven efficacy (as discussed in Chapter 1, literature review). In addition to this, it was a time of economic decline and there were often concerns regarding job security and an increased need for agency accountability to fund holders in relation to ethics and outcomes. In fact, two of the practitioners interviewed, despite seeing positive outcomes in clients, had decided to cease practice due to experiencing insufficient support and understanding within the service setting.

2.2.4 Recruitment and data gathering

I treated the interview with the first candidate as a pilot study and transcribed it and received feedback and advice from my supervisor before proceeding to interview the second candidate. I was advised that I could place more attention and focus on the key research topic, bringing the dialogue back to topic if it wandered and be more careful to limit expressing my own views.

I then proceeded to conduct the remaining interviews, during which I worked to stay focused. I did manage to gather more data in relation to the central research questions but still found the emotional content of the discussions and distress of some of the participants who were working in difficult contexts quite challenging. There were moments of possible collusion on my part and sometimes the discussion went off on a tangent, although it would then continue back on track. I could identify with some of the participants and had to push myself to be as pragmatic as possible in gathering the data, while also being genuine and sensitive in terms of maintaining ethics and my own integrity, and safeguarding the wellbeing of the participants, which was of paramount importance. This then led to a rich set of data, but data that were also inevitably somewhat impacted by the above factors.

Williamson (1996) discussed the place of emotions and human contact in research. He suggested that the researcher may lack the power to change complex situations described in the research and how maintaining focus and timing may be difficult, as topics raised may be more powerful than the research question itself. He went on to suggest that the researcher’s own emotions may spill out or, alternatively, the researcher may feel self-denial. He questioned whether the emotional investment of researchers into substantial outcomes could lead them to become deluded and this could impact on the research process and outcomes in many ways. He also felt that it may not be easy for researchers to admit they are having difficulties. He went on to state that “admission of this emotional dimension lies uncomfortably with the social scientific and systematic paradigm” and suggested the need to reconsider social research that provides findings derived from emotional investment and commitment. Williams felt that it might be unrealistic for researchers to suspend their emotions and that emotions are not incompatible with academic rigor. He expressed the view that people are not laboratory rats and that “empathy, openness and honesty” in the research process can still result in data and reports that will “attract curiosity and interest”. Williamson’s points encapsulate the dilemma which I frequently faced. For example, several of the practitioners who were interviewed discussed challenging contextual issues and I found it hard to contain my own reactions as I felt deep empathic responses to their distress and isolation.

The contract between myself as the researcher and the participants (see Appendix A2) included the option of debriefing as needed. Of the 20 interviews, 15 were conducted face to face and 5 were conducted by telephone using a digital recorder, with the participant's consent. Nineteen interviews were taped and transcribed (except where a participant objected, in which case notes were taken and later verified with the participant). The 20 practitioner participants discussed a total of more than 40 clients within the 20 research interviews.

2.2.5 Data analysis

The data were analysed and audited using the principles of grounded theory (Glaser & Strauss, 1965,1967), as interpreted by Rennie, Phillips & Quartaro, 1988), allowing themes to emerge from the data. Grounded theory has its roots in sociology and has developed into different schools such as constructivist grounded theory, first developed by Charmaz (2000), which was not used in this study and is criticised by Glaser (2012). This approach is promoted by Fassinger (2005) in terms of adaptability and ability to bridge paradigmatically between postpositivist, interpretive/constructivist, and post structural or critical approaches.

Whilst following the original principles of this method I was aware that it was far from an exact science and I relied on a certain rigor, experience, instinct and supervisory support to complete the process. The limitations of approach be been widely reported

(e.g. Bryant, 2013., Flynn & Korkuska, 2015) but the method seemed most suited to this study in it being true to the data itself and seemed to marry well with the person-centred ethos.

The analysis involved immersion in the data. Results were grouped into categories and subcategories as themes recurred, with extensive use of written memos that helped to clarify the subject of sections of transcripts and identify tentative themes (Powers and Knapp,1990). The data and process leading towards final domains, subdomains and lower categories within the structure were fully audited with the University of Strathclyde research clinic by two professors of counselling and psychotherapy.

For example, I considered specific emerging topics, such as power, and what the topic included, the meaning of the theme (if indeed there was only one theme) and how this conceptually fitted with the other emerging headings, resulting in its final place within the structure.

The categories and arrangement of data needed to make sense within the context and to show the interrelationships between groups. Themes were then finalised.

I found this process challenging. The final arrangement of data consisted of three distinct topics relating to the research question regarding what practitioners did, the perceived changes in clients and possible contraindications or referral issues. The data and themes were carefully considered, with notes and memos and underwent multiple phases and drafts with minor changes to form two domains for the practice-related themes and four domains of subheadings relating to changes. The third heading emerged which related to contraindications but on reflection and deeper analysis this became part of domain 2 and then later was reformed into domain 3 for the final alignment, after much consideration. Although the third higher level heading contained only a small number of meaning units I finally concluded that it for ethical reasons it should stand alone as it contained important and distinctive data relating to negative outcomes that I felt should be transparent and exposed a possible design flaw in the interviews extracting less explicit information in this area and possibly in the analysis if there was positive bias. This was issue was remedied in study 2 (as described in Chapter 3) by using a more structured approach and is also mentioned in the final discussion in chapter 5. All research designs have both obvious and unforeseen advantages and vulnerabilities. In this case I arrived at a set of data which was rich in content due to the relatively open interview format but possibly lacking focus or further prompting in some areas.

2.2.6 Demographics

Of the participant practitioners, 13 were female and 7 were male; and 16 were in England, 3 in Scotland and 1 in Wales. Table 2.1 shows the self-reported training and modality of the 20 participating practitioners.

Table 2.1

Training and modality of the participating practitioners (self-reported)

Practitioner	Professional PC Therapy Training	Additional training	Role therapist/other
1	Diploma in *person-centred therapy*	Occupational therapist, no specific training re psychotic process in early practice -later influences-Warner plus other	Therapist
2	Diploma in *person-centred therapy*	Additional training re person-centred approach.	Therapist
3	Diploma in *person-centred therapy*	N/A	Therapist
4	Diploma in *person-centred therapy*	Original TA training, art therapy diploma-now PCT-later short courses re psychotic process-of person-centred	Therapist
5	Diploma in *person-centred therapy*	Later reading re pre-therapy and short courses re psychotic process	Support worker and Registered mental nurse (RMN)
6	Diploma in *person-centred therapy*	Co-counselling, person-centred creative therapy training	Therapist
7	Not formal PCT training	PC practice via various routes-not formal training	Psychologist
8	Diploma in *person-centred therapy*	N/A	Therapist
9	Diploma in *person-centred therapy*	Later some pre-therapy training plus earlier social work training	Therapist

10	Diploma in *person-centred therapy*	N/A	Therapist
11	Diploma in *person-centred therapy*	Later Hearing Voices Network (HVN) links	Therapist
12	Early Rogerian training (before existence of professional courses)	Psychology degree	Therapist
13	Diploma in *person-centred therapy*	Registered Mental Nurse	Therapist
14	Certificate in *person-centred therapy skills*	Professional Gestalt Training then additional PCT training	Therapist
15	Diploma in *person-centred therapy* and Cert *counselling skills*	N/A	Therapist
16	Certificate in counselling skills	Diploma in psychiatric social work	Social Worker using counselling skills
17	Diploma in *person-centred therapy*	Additional training in another model	Therapist
18	Diploma in *person-centred therapy*	N/A	Therapist
19	Diploma in *person-centred therapy*	N/A	Therapist
20	Diploma in *person-centred therapy and MA*	Additional training in mental health, psychotic process and pre-therapy and post qualifying PCT training plus HVN training	Therapist

2.3 Results

2.3.1 Organisation of results

The results of this study are described below under headings and subheadings which relate to the three data domains and their corresponding subdomains shown in tables 2,3 and 4 (in the text in this section) in order to assist the reader to navigate both the data content and structure.

Most practitioners described more than one client who had presented with psychotic process within the therapy, and practice often changed to incorporate pre-therapy or other enhanced practice. Most practitioners initially used basic PCT and then developed their practice, incorporating pre-therapy or other practices as they became more experienced and skilled. Results are therefore more accurately reflected by reporting incidents or meaning units rather than number of practitioners.

2.3.2 Structure of sub-domains

All data described in this results section refer to perceptions of helpful practice and changes described by PCT practitioners. After these data were extensively processed and audited they naturally fell under three main headings, represented in Tables 2, and 3 and 4, one referring to practice, the second to perceived changes in clients and a final domain with a small amount of data distinctly related to possible contra-indications. This final category was absorbed into another domain at one point but then later re-ordered to a third domain but still could warrant further attention if further re-analysis ensued. The final resting place for this category for this dissertation was decided with ethics most in mind to avoid the possibility burying any negative data and instead leaving this transparently available.

These themes and their underlying detail are described below, including examples that illustrate the nature of this data and bring the experiences to life, with a particularly focus on the most frequently occurring themes. This section aims to illustrate both the thematic nature of the data and its conceptual relationship. It provides some of the rich examples that were often emotionally expressed by practitioner participants as they described how they practiced, self-cared, developed, adapted and sought to try to support clients who presented with complex processes, as well as the wider contexts impacting on this. This often-needed enormous resilience and creativity but produced inspiring outcomes as well as difficult experiences and learning opportunities.

2.3.3 Categories of data with content descriptions

Domain 1 Helpful factors (practices)

This domain describes a wide range of helpful practice themes, firstly in terms of overall strategy and secondly regarding specific themes.

The category structure referring to this first domain of helpful practice factors are presented in Table 2.2. The figures in the table are numbers of incidents or meaning units rather than the number of practitioners reporting an experience (unless explicitly stated). A minority of 3 of the sample of 20 practitioners reported that they used *the core person-centred approach only* and felt that their practice with clients who experience psychotic processes did not vary from usual practice. The remaining 17 practitioners reported that, having begun in earlier practice with a more core person-centred approach, they later came to work differently after accessing workshops and reading, especially in relation to pre-therapy and contact reflections (see Table 2.2). Each practitioner discussed one or more clients, thus some of the later clients discussed may have experienced different person-centred practice such as pre-therapy.

Table 2.2: Domain 1

Helpful Factors

Category	No. of practitioners
I. Overall approach	
A Core PCT approach only	3
B Incorporated other PCT approaches	17

	Number of responses (meaning units)
B.1.1 Contact work	6
B.1.2 Pre-Therapy /Pre-Therapy contact work	11
B.1.3 Other practices re specific theory (e.g., Warner)	4
II. Specific themes	
A. Building a PCT relationship	54
A.1. Person-centred values	27
A.1.1 Genuine care	8
A.1.2 Relational depth	7
A.1.3 Being real/use of self	6
A.1.4 Minimising power dynamic	6
A.2. Core conditions	31
A.2.1 Unconditional positive regard especially important	15
A.2.2 Important to be more congruent	2
A.2.3 Important to be less congruence	2
A.2.4 Congruence individually adjusted	4
A.2.5 Empathy especially important	8
B. Working with psychotic content	14
B.1. Owning own reality (whilst accepting client's)	3
B.2 Accepting/entering client's reality	3

B.3 Staying in client frame3 whilst holding private sense of what’s “not true”	3
B.4. Therapist dealing with own reaction to psychotic content	5
C. Adapting therapeutic parameters	20
C.1 Flexible use of space	4
C.2 Boundaries and contracting	16
D. Other specific strategies	16
D.1 Getting beyond labels and illness	10
D.2 Supporting educative/coping strategies	6
E. Exercise particular care and attention	15
E.1 Multidisciplinary support	7
E.2. Risk management	6
E.3. Sensitivity	2

Domain 1, (continued)

Sub-Domain I: Overall approach

The overall approach used by practitioners consisted of three categories consisting firstly of core PCT practice as well as two further categories of practitioners who incorporated pre-therapy and a category of other PC approaches.

Category I.A Core PCT only

Three practitioners gave accounts of using a classical person-centred approach. For example, practitioner 12 commented that they just “just stuck to basic PCT”. Practitioner

12 described how at the time they underwent person-centred training, which included two clinical placements, resources were very limited compared to the contemporary UK training context. The only texts that they were able to access were those by Carl Rogers.

This practitioner described their person-centred stance to practice as follows:

> I didn’t know there was a different way… and two… the ideology of my practice was that there was only one way of working anyway. So, it was – two things conspired... one was my ignorance and the other was that I didn’t think that it was appropriate to work in any different way and I wouldn’t have known how to anyway. (Practitioner 12, lines 178–182)

Category I.B Incorporating other PCT approaches

Category B.1.1 Contact work

Six practitioners explained general ways in which they attempted to make contact with clients. One practitioner discussed observing and gently feeding back an invitation, while another described checking out whether clients were in contact with them.

Category B.1.2 Pre-Therapy /Pre-Therapy contact work

Eleven therapists sometimes specifically used pre-therapy as a way of working; all found this effective. Practitioners frequently mentioned Prouty and other pre-therapy authors, trainers and practitioners such as van Werde and Pörtner were also sometimes discussed and cited as strong practice influences. For some practitioners the discovery of pre-therapy and Prouty’s work was a revelation and changed their practice, confidence and, they believed, the outcome. Pre-therapy was discussed by one person as helping to link a client to reality, while others discussed using contact reflections and two talked of working closely to “Garry’s book”. Some practitioners had attended short courses in pre-therapy and applied this learning.

One practitioner described how they worked with clients in a psychiatric inpatient setting and gave an example of how they used this approach with a specific client:

> The Garry Prouty reflections were useful in trying to establish a connection between both of us – working in the here and now and reinforcing the reality of the moment. (Practitioner 13, lines 95–99)

Another practitioner described how they integrated pre-therapy work into their practice and found that reading Garry Prouty’s work in “a lot of detail” was “really affirming”. The practitioner gave examples of how they had used contact reflections with a specific client with sensitive “checking out” with the client to see if they were in contact at that time, and described how they noticed changes in the client’s responses, body language or eye movements:

> I will actually talk about my process with the person – you know, just sort of what I’ve observed. “I’ve noticed that, erm…”, I’ll be saying; or, “I’ve noticed that we haven’t said very much for a long time”; or, “I’ve noticed that… um… I’ve been wondering what – you know – what might have been happening for you… um, well, while you were all hunched up on the chair… um…”. (Practitioner 14, lines 352–356)

This practitioner also described making observations about posters on the wall to a client who was experiencing times out of psychological contact. The practitioner's thinking around this was that they were tentatively offering an invitation to the client, acknowledging both their own process and the client's, to see if the client wanted to connect.

Category B.1.3: Other practices

Other practices informed by specific PC theory were also mentioned. For example, four practitioners discussed the value of Margaret Warner's work on difficult client processes, and practitioner 17 followed her fragile process paper with a client, staying close to the client's words.

Sub-domain II: Specific themes

A category emerged containing specific practice themes which broke down into four areas of focus involving building a PCT therapy relationship, including PCT relational qualities and values, followed by categories which encompassed ways of working with the psychotic content, adapting therapeutic parameters, other specific strategies with a final category in this group involving exercising care and attention which included possible contraindications.

Category II.A Building a PCT relationship

The theme of building a PCT relationship emerged with 54 meaning units, demonstrating its importance as a theme for practitioners. This category included firstly person-centred values of genuine care, relational depth, being real and minimising the power dynamic. This was followed by a category which focused on the importance and application of specific core conditions.

Category II.A.1 Person-centred values

Person-centred values were frequently discussed and occurred in 27 meaning units and are described in the four categories below.

Category II.A.1.1 Genuine care

Eight practitioners named genuine care as an important issue (e.g., showing warmth, compassion and non-romantic love). One therapist stated that they felt that a number of clients sensed that they cared and were not just providing empathic responses. Another therapist spoke of how both they and the client experienced a close connection: “Our last session together felt very powerful, she cried and so did I” (Practitioner 4, line 107)

Another practitioner described their work with a client:

> He told me that he valued the support. The relationship was close, and we were both moved to tears at times. I cared about him deeply and he clearly realized this and valued it. Often, he was very low, and we would sit together, both understanding this. (Practitioner 20, lines 186–189)

II.A.1.2 Relational depth

Seven practitioners discussed relational depth. For example, one practitioner described the therapeutic relationship as “empowered” and “deep”. One practitioner discussed her relationship with a client, saying that there were “those moments where you meet eye to eye, and something happens… special moments… soul moments… as if a barrier has gone – a spiritual connection.”. Practitioners described feeling emotionally close to the client. For example, practitioner 7, commenting on how they saw their relationship with their client, said they had told the client, “I can’t do anything to change it, but I’ll walk close to you” and added, “I know I did this” (Practitioner 7, line 92)

II.A.1.3 Being real/use of self

More than a quarter of practitioners explicitly referred to being real, striving to be real or use of self. Comments included practitioners’ feeling that being themselves was important. One practitioner noted that it is the relationship itself that *is* the therapy. They felt that this therapeutic relationship is crucial where people have been stigmatised and provides conditions for the growth of self-acceptance and self-integration in the client (Practitioner 13, lines 412–427)

Practitioner 20 commented that they were mindful of the levels of congruence in the work with the clients they had seen who were in “psychotic processes”. This practitioner felt that an emphasis on being in congruence and being in a therapeutic relationship that was as real as possible was more important than any other relationship, because they considered that such clients needed a lot more reality-checking (Practitioner 10, lines 49–52).

II.A.1.4 Minimising the power dynamic

Six therapists discussed issues around minimising the power dynamic, such as sharing power and promoting client empowerment. This included trying to help clients to have active control in sessions where possible, supporting clients to say what they needed to say and asking the client how they wanted the therapist to be. One therapist discussed taking the position of negotiator and another practitioner discussed how not being an expert was important.

Practitioner 18 described how a client who experienced hallucinations and paranoid ideas improved in functioning, seemed happier and brought fewer issues to sessions. One day the client asked the counsellor if they thought this should be their last session, but the counsellor left it up to the client to decide when to end the therapy.

Power was often described in terms of the dynamics within the therapy relationship as well as being extended to the wider context of care and societal structures. There were examples of clients increasing in self-value, power and assertiveness through the counselling, which acted as a foundation for them to feel more powerful and allowed them to test this out in other relationships or contexts. They sometimes faced barriers. For example, Participant 13 commented:

> …I think when clients start taking their own power and managing their own mental health – that can be very challenging to… um… systems that inadvertently encourage dependency upon them. (Participant 13, lines 217–227)

II.A.2 Core conditions

Person-centred therapeutic core conditions were discussed in 31 instances and are described in the next three sections.

II.A.2.1 Unconditional positive regard especially important

This was an important category with three quarters of the interviewed practitioners discussing the particular importance of unconditional positive regard (UPR). Themes included offering the prizing or valuing of the client, holding an accepting attitude, accepting all parts of the client including the psychotic parts, avoiding making assumptions or judging, embracing what is part of the person rather than focusing on trying to "make them better" and allowing the client to "be". Data suggested that this, at times, could be unsettling for practitioners with less experience of psychotic processes or dramatic presentations of some clients, but practitioners often described becoming more grounded in familiarity with the client and process in order to accept the client more readily without judgement and acknowledged the helpfulness and importance of relevant training and support to sustain them.

Practitioner 20 described supporting a vulnerable woman in her own home. The young woman, who had a diagnosis of schizophrenia, was troubled by voices and sometimes saw Hitler's face superimposed on other people's faces. The practitioner explained that after an initial reaction, they were able to adjust, familiarise themselves with the client's situation and stay in a non-judgemental frame with the client, even in the face of challenge. This practitioner once visited the client for an appointment, accompanied by a co-worker for safeguarding reasons. The young woman was very "high" and was naked apart from a "bra" (brassiere). Since their previous visit the practitioner also noticed that the young woman had written bizarre messages all over the walls of her living room. The practitioner warmly suggested that she might consider putting on some additional clothing (to maintain appropriate boundaries), which she did. The young woman then sat by a large pet snake in a tank in her living room. At times she was more connected than others. The practitioner used PCT and counselling skills with her (prior to any awareness of pre-therapy). The practitioner remained very calm and focused on acceptance and trying to stay as much as they could in the client's frame of reference (Practitioner 20, lines 270–282).

Practitioner 14 described the importance of her UPR in working with a client who experienced very angry figures following her around and how they felt punished, blamed and ashamed. This practitioner commented that clients who experience psychotic process often feel guilt, shame or rejection, so UPR is crucial and is part of accepting that unusual experiences. Practitioner 14 commented that however bizarre they may seem in some contexts such experiences are actually a normal human phenomenon and an informative part of who the client is, embracing part of the person. (practitioner 14, 164-184)

The following three categories refer to congruence but were not also joined into a higher status data category as they each seemed distinctly different, although this could be debated. Eight therapists identified particular issues around care in the use of congruence. Congruence was clearly an area that required particular thought, with some variation in how practitioners approached it.

Category A.2.2 *Important to be more congruent*

Two practitioners felt that clients in psychotic process could be more sensitive to incongruence and that being congruent was therefore of particular importance.

Category A.2.3 Important to be less congruent

However, several other practitioners were less congruent with clients in psychotic process. They felt that there needed to be less edge-of-awareness work or more negotiating with sensitive or fragile clients regarding what was safe to "name".

Category A.2.4 Congruence individually adjusted

Four practitioners were particularly sensitive in the use of congruence and varied their stance according to perceived individual client needs and processes.

Practitioner 13 elaborated on their careful use of congruence. They felt that use of congruence was always risky but with this client group there may be more risk of misinterpretation. They also raised the issue of the practitioner congruently stating their reality, which could be challenging for certain clients in some contexts. They felt that a lot more sensitivity was required in the use of congruence with this client group, requiring the necessity of sometimes withholding:

> P: …and I think as well as kind of responding to the person and not the hallucination – you know it's difficult to assess…
>
> R: I'm not sure if you could give an example of what that might mean in a session – in terms of responding to a person and not the hallucination
>
> P: I think what I mean is if, when somebody's actively hallucinating – and they are maybe being very negative towards you because the voices are telling them [yes] you are there to harm them [yes] – it would be… my immediate reaction would be perhaps to react to the threat rather than stay with the person [yes] and respond to the person – so I think that's what I'm trying to say – to almost

> experience the person beneath… beneath the behaviour [sure] – which you would do with any client really.
>
> R: Yeah, that makes sense.
>
> P: In that type of relationship it can be a lot more florid, if you see what I mean.
>
> (Practitioner 13, lines 193–213)

Category A.2.5 The particular importance of empathy

Eight practitioners discussed the particular importance of empathy, with several emphasising the need for deep empathy and staying close to clients. Practitioner 13 described finding that individuals who were in acute psychosis "responded very well to empathy and respect". These clients gave feedback stating that they couldn't respond to the practitioner "in the here and now, where they were" and that they were experiencing quite a different reality. They were aware of the practitioner's presence but were unable to verbally communicate in an appropriate way (Practitioner 13, lines 47–53).

Practitioner 10 described how entering high levels of empathy with clients who may be experiencing delusions or experiencing a different reality to them required particular attention to self-care and grounding with colleagues after sessions (Practitioner 10, lines 61–69).

II.B Specific* strategies *Working with psychotic content

Fourteen practitioners specifically described working with the psychotic content within the four categories below.

II.B.1 Owning their own, different reality from the client's while accepting the client's reality

Three of the practitioners who worked with the psychotic content described staying with "the client's frame" and owning their own, different reality from the client.

One therapist commented on their initial experiences with a client with a history of trauma who was the therapist's "second ever private client" and explains their initial experience and reaction:

> Yeah – so the early sessions would be – the first time she came she just came and made this dreadful, dreadful, dreadful howling noise – I had no idea what was going on. I stayed with it. Then… she – in the early session – she talked about a bereavement… that had apparently sparked off a whole psychosis.
>
> (Practitioner 1, lines 42–45).

This therapist described how over time they became more used to the client's process and how to work with her through episodes of extreme fear of events that could not actually happen, and of her feeling very emotionally raw. The practitioner stayed with the client's fear and congruently acknowledged their own different position in terms of their experience of reality, which the client said that she experienced as helpful:

> What was useful for her was if I got into her frame of reference enough to understand why she thought these things were going to happen – but also saying, "I don't think that's going to happen" (Practitioner 1, lines 83–90).

This practitioner often found that the client's content did make sense as well as not being in the shared reality. The practitioner would also go through periods when they were not sure whether the content of the client's disclosures was really happening or not and would need to remain open minded (Practitioner 1, lines 76–92).

II.B.2 Accepting/entering the client's reality

Three practitioners discussed entering the client's reality or accepting the client's reality, for example staying with a client's world to the extent that it involved understanding the responsibility and associated emotions of being both a religious leader and a specific celebrity. Practitioner 13 commented, "and you would share that reality for a few moments – a few minutes". This practitioner described how, when they entered a shared reality with one particular client, they were at first scared and found this threatening but over time found it became easier for them and safer for the client, who then went on to really let the practitioner into his world and talk more openly. At first the client's persecutory delusions seemed to cause him to fear the practitioner but over time this changed (Practitioner 13, lines 62–81).

II.B.3 Staying in the client's frame whilst holding one's own sense of what is "not true"

Three practitioners discussed staying in the client's frame whilst privately holding their own sense of what was "not true". Some practitioners sometimes felt distracted when holding two realities; for example, one practitioner reflected that they had no idea what was true, and it was not their job to judge. Nevertheless, they were aware that their own reality was different from the client's and tried to put the thought aside and understand what the client believed (Participant 7, lines 18–37).

II.B.4 Practitioners dealing with their own reaction to "psychotic" content

A quarter of all practitioners discussed how they dealt with their own reactions to psychotic content in sessions. Some practitioners tried to avoid distraction or panic when confronted with "psychotic content" and tended to grow increasingly comfortable with such material, often processing it in supervision. Typically, participants described their increasing familiarity with psychotic material enabling them "to stay with" the client. A quarter of all participating practitioners described dealing with their own feelings and reactions to psychotic content, such as initial fear or shock, and some revealed this to the client. This helped the therapist and client to enter deeper relationship. Practitioners mentioned the need for self-care in order to stay with the client and deal with sometimes horrific material, describing a need to ground themselves both during and after sessions.

Practitioner 12 described how they were at first shocked and unsettled by some client's unusual experiences such as one client's "delusional" beliefs about them as a practitioner. The client received messages from the practitioner that they did not send to the client, but the practitioner found themselves feeling more at ease as they felt an increased understanding of the client and their world (12/246-12/258).

Practitioner 15 described being "unnerved", scared and insecure at first when working with a client who was experiencing auditory and visual hallucinating and acting as if they were being attacked, with a great deal of dramatic and emotionally intense responses. The therapist found it hard to tell when the client was responding to them and when they were responding to their own experiences and said that this work tested their acceptance but that they strove to understand the client (15/54-15/92).

Category II.C Adapting the therapeutic parameters

Eight therapists discussed issues regarding adapting parameters to accommodate client needs, with 20 responses on this theme.

Category II.C.1 Flexible use of space

Four responses referred to the use of space. For example, working in a large space was necessary for some clients, and the need to respect the physical distance or closeness needed by individual clients as needs changed was discussed.

Category II.C.2 Boundaries and contracting

Practitioners also thought that attention to boundaries and contracting was important, with 16 responses regarding this theme. Examples included the need for flexibility regarding client telephone calls, missed sessions or the length of sessions. Other issues included the importance of having a contract the client understood and having some firm or clear boundaries as a foundation but with some flexibility in certain areas. Practitioner 13 commented:

> I think with working with that client group – their boundaries are very distorted or can be very distorted so I think as a therapist I need to have very firm boundaries [mmm] – but not rigid [no] – in the fact that clients are not able to

> miss sessions or not able to get up and leave sessions if they need to – [yes] – it's a kind of balance. (Practitioner 13, 156–177)

Category II.D Other specific strategies

Sixteen meaning units referred to other specific strategies which consisted of the two themes below.

Category II.D.1 Getting beyond the labels and illness

Half of the practitioners discussed the importance of getting beyond labels and illness, for example by focusing on the person rather than the "illness". Practitioner 12 elaborated on this and discussed positive feedback from clients, suggesting the importance of not being judged or labelled and instead being understood. This practitioner commented:

> Well the thing that stands out most from all the work I've done with people who might have a psychiatric diagnosis or might be in psychotic process is that it's the individual qualities of the person that were more important than anything else – and that… it's really difficult to lump them together in any way whatsoever. (Practitioner 12, lines 162–166)

> Practitioner 17 discussed the challenges on working within a PCT model in a medical environment and where both they and their clients were sometimes subject to negative judgements challenge from medical staff. She explained that

> “on the ward it was very medical model—very looking at the symptoms [mmm hmmm] rather than looking at the person—"” and later expanded this comment to explain that
>
> “whereas my view—my attitude was that you know –this is a person and I want to engage with this person—and understand and I think when you asked me about what did I do differently to other people –what else I did--I think often it was about the attitude really—"
>
> (Practitioner 17, lines 174 to 207)

Category II. D.2. Supporting educative or Coping strategies

Six practitioners discussed supporting coping strategies or educational elements (offered to the client within the multidisciplinary context of care). Some therapists supported clients to understand what was happening to them but avoided giving advice.

Practitioner 14 described how during a break from their therapy a client did some work with a clinical psychologist that was then naturally incorporated into the person-centred sessions when they resumed with the client’s lead and explained:

“She went and did some work with a clinical psychologist and did some work there in terms of self- awareness, management of her voices ,[yep]some um—she showed it me all on paper—coping strategies—sort of self- monitoring—yeh—and that work was actually really useful to her in being able to then work with me because we were able to discuss her strategies and her coping mechanisms um so that she was able to integrate those [yeh] into the work that we were doing together—[yeh—that makes sense] and that worked really quite well—"

(Practitioner 14, lines 547-555)

This example was typical of the data in this category where examples were given where discussions regarding coping strategy enhancement were often initiated by clients themselves or sought from other resources or services and developed as themes by the client.

Practitioner 13 described how some of their therapy clients in psychotic processes sometimes found that talking about “voices” would often result in them becoming quitter or easier to manage. They described examples of how clients would use therapy to help top cope with their reality and gain awareness of unusual experiences and often reacting less to hostile voices. She explained that rather than being symptom focused the therapy was often helpful in managing the client’s whole life and could involve the therapist helping the person to understand what was happening which would alleviate fear and on prompting confirmed that they absolutely agreed that part of their role could be educative (Practitioner 13, 243-269).

Category II.E Exercising particular care and attention

Fifteen responses referred to examples of exercising particular care and attention. This category was redefined several times, firstly integrating the data which finally made up domain 3 and then excluding it whilst re -analysing data and remains somewhat complex. This category includes the three groups of data, describing practice themes of multidisciplinary support, risk management and sensitivity.

Category II.E.1 Multidisciplinary support

Seven practitioners discussed their views that a multi-disciplinary approach was important for vulnerable clients and to help the practitioner to stay with the client, knowing that a team approach was in place. Several participants wanted or needed more than one therapist in the room or to have co-therapists. One participant explained that this was to hold the process and for therapists to be able to look after each other in demanding situations.

Category II.E.2 Risk management

Six practitioners discussed the issue of supporting the client to manage risks to self and others.

Category II.E.3 Sensitivity

Two practitioners felt that a sensitive approach was important. Practitioner 14 emphasised the need to be very sensitive in checking out what could be happening for a client or what they may be needing, and in being aware of any incongruences, approaching these gently.

Practitioner 15 described their attempts to work tentatively and sensitively with a specific client with a dramatic psychotic process who often expressed great anger.

“—at first—I was just trying to take a back seat --- checking out what was going on--- and perhaps—some part of that was a slight fear of how to engage—it felt like a huge responsibility I think---I was very careful of how I engaged—[yeh]” (practitioner 15 116

Domain 2: Perceived changes in clients

I More Connected

Domain 2, described below, shows the wide range of changes which were observed in clients by practitioners as shown in table 2.3. This data shows themes important which could be compared later to client self- reported changes in studies 2 and 3. Unless specifically stated otherwise the findings are grouped and described with regard to number of meaning units. Themes raised included reduced distress and increases personal or emotional growth.

Category I.A More connected to reality

Out of 40 clients who were discussed, 30 appeared to be ***more connected*** following therapy. Nine practitioners referred to increased contact with reality being achieved. One practitioner explained that they and the client began to have intermittent contact where they would share that reality for a few moments or a few minutes. One participant commented on “seeing someone, for want of a better word, come out of a psychosis, become more connected within a relationship and less distressed”.

One practitioner described working with a client in an acute mental health residential service setting. This practitioner had training in and experience of pre-therapy, which they were able to use, using contact reflections with this client. The practitioner described using counselling skills and pre-therapy, using the person-centred model, and

Table 2.3: Domain 2

Perceived Changes

Category	Number of meaning units)
I. More Connected	***33***
A. More connected to reality	9
B. Improvement in social interaction/relationships	24
B.1 Improved social skills/relationships	13
B.2 More connected/socially oriented	9
B.3 Better relationship with therapist	2
II. Decreased difficulties with problematic experiences	**31**
A. Less need for psychiatric treatment	2
B. Less trouble with voices/hallucinations	10
B.1 Better management of voices/hallucinations	4
B.2 Reduction in voices/hallucinations/delusions	2
B.3 Client more accepting of voices, etc	4
C. Affective changes in mood/anxiety	10
C.1 Positive change in mood	6
C.2 Less anxiety	4
D. Decreased risk	9
D.1 Less harm to self	7
D.2 Less harm to others	2
III. ***Improvements in sense of self***	24
A. Feeling more accepted/less judged	3

B. Increase in self-acceptance/self-confidence	3
C. More sense of control/empowered	6
D. Self-integration	12
D.1 Increase in client insight/self-awareness	7
D.2 More integrated/stable identity	5
IV. Improvements in quality of life	15
A. Increase in resilience/coping	9
B. General improvement	6

establishing a good relationship with the client. The client became more connected to the practitioner and the world, as well as with another client in the room, following pre-therapy responses. He was initially sitting alone in a large side room, talking out loud about things that the practitioner found difficult to understand. There was bizarre content in his speech, which was disjointed and distressed. The practitioner sat at the same table but gave the client space and started to use pre-therapy skills:

> “I began during a quiet moment reflecting on the environment around us. I also started to do some art. Eventually he joined in and made more eye contact plus spoke with less bizarre content, less fragmented language and was more present and responsive. Another man entered the room and joined us, and we all spoke. The client seemed relieved and more relaxed. He talked about difficult issues in

> his life regarding relationships. Eventually he said, "I've been here in this place for two weeks and you are the first person who has really spoken to me". (Practitioner 20, lines 53–58)

Category I.B Improvement in social interactions/relationships

Twenty-four meaning units related to outcomes associated specifically with improved social skills and ability to be with and relate to others. This was the most frequently mentioned outcome. This category consisted of three sub- categories as described below.

Category I.B.1 Improved social skills/relationships

Socialising was described as easier for many of the clients discussed, with 13 meaning units in this category. One client, who was described as initially very isolated and withdrawn, and went for days without saying anything other than "hello" to anybody, moved to "striking up conversations with people and… striking up almost friendships" within about 20 weeks (Practitioner 12, lines 270–289).

Data category I.B.2 More connected/socially orientated

This category contained nine meaning units relating to observed increased social connection or orientation of clients. Practitioner 17 spoke about involving pre-therapy in their work with a client who was initially "disconnected" most of the time. He was a psychiatric inpatient with a diagnosis of schizophrenia and others tended to leave him alone because he was "locked into his own world" and would stand in the same position for long periods, not engaging with others or responding. The practitioner began visiting him and using pre-therapy reflections, and the man would sometimes give minimal eye responses. The practitioner felt awkward at first but continued contact reflections with no pressure on the client and the man began to respond. Over two visits he began to engage more and speak at times and fetched his artwork to show the practitioner. He then withdrew again. The progress over several weeks was dramatic and the client became able to attend groups and actively participate in activities (Practitioner 17, lines 25–57)

Category I.B.3 Better relationship with therapist

Two meaning units referred to the relationship improving between the client and the therapist were discussed with implications of this being a starting point in helping to improve other relationships.

Category II Decreased difficulties with problematic experiences

Thirty-one meaning units emerged which referred to clients reporting or displaying decreased difficulties with problematic experiences, suggesting that this was a significant category which was composed of four sub-categories as described below.

Category II.A Less need for psychiatric treatment

Two practitioners reported clients having less need for treatment. One client was able to withdraw from antipsychotic medication.

Category II.B Less trouble with voices/hallucinations

Ten meaning units described experiences involving the client experiencing less difficulties with unusual experiences such as hallucinations or unusual ideas. This category consists of three subcategories as described below.

Category II.B.1 Better management of voices/hallucinations

Four practitioners identified the client's improved ability to manage voices or hallucinations. Typical comments referred to clients accepting their voices, learning to cope more effectively with voices or other hallucinations, and becoming less likely to act on them if they were instructional. This was true of a client described by Practitioner 20, who was supported by a multidisciplinary mental health team including the counsellor and a psychiatrist. The man had a diagnosis of schizophrenia and was tortured by voices. The practitioner had not at that point received pre-therapy training so used standard PCT and often supported the client to use metaphors, which the client initiated. He often felt terrified and as if he was being pursued. He explored issues relating to guilt and remorse for real acts which seemed to feature in his voices. He frequently told the therapist that he felt understood in the therapy. He reported that the sessions helped him to feel better, cope with the voices and reduce risk of harm, as well as become more able to be with others (Practitioner 20, lines 95–125).

Category **II.B.2** *Reduction in voices/hallucinations*

Two comments referred to occasions where voices or hallucinations were reduced. One client reported to their therapist that the voices became quieter. Another client recognised alcohol as a trigger to worsen hallucinations and consequently stopped drinking.

Data category II.B.3 Client more accepting of voices/hallucinations

Four practitioners described clients being more accepting of their hallucinations.

Practitioner 20 described examples of clients embracing their unusual experiences and developing a stronger sense of self whilst practitioner 17 described a client who attended a therapy group starting to relax and be open about their experiences with aliens.

Category II.C Affective changes in mood/anxiety

There were 10 meaning units referring to improvement in mood or anxiety levels in clients. These were composed of two subcategories which are described below.

Data category **II.C.1** *Positive changes in mood*

Six examples of improvement in mood were discussed. One practitioner saw all three of their clients' mood improve. Practitioner 15 saw clients become more able to be in relationship with others and reported a reduction in distress after experiencing pre-therapy (Practitioner 15, lines 294–302).

Data category **II.C.2**-*Less anxiety*

There were four examples where a client's anxiety was seen to decrease. Practitioner 2 described the change in one client, stating "When she came, she was very anxious and upset-almost distraught—and then at the end of the counselling she was kind of—ok—I can handle this!"

Category **II.D** ***Decreased risk***

There were nine meaning units relating to reports of reduction in risk of harm to self or others which fell into two sub-categories as described below.

Data category II.D.1 Less harm to self

Seven instances of less risk to self were discussed.

Category II.D.2 Less harm to others

Two examples of reduction in risk of harm to others were discussed. One client, who previously talked about delusional beliefs regarding his family, felt that the sessions helped him to process feelings such as anger and hatred, and to feel fewer urges to hurt others.

Another practitioner described their work with a vulnerable client where risk issues were seen to reduce as well as many other areas of improvement. Their client was a young man who had “bizarre” ideas. Others had been frightened of his behaviour, which they had perceived as threatening, and he had invaded boundaries, acting inappropriately. The young man expressed suicidal ideas and self-injured. He verbally responded only very minimally at first but attended therapy regularly and seemed fully committed to the relationship:

> I used creative methods and standard PCT to engage him plus Margaret Warner’s fragile process paper was an excellent help as he was very sensitised. I saw him for about two years. He was at first very vulnerable and dependent like a young

> child and clung to sessions, sometimes lying in the foetal position. He had psychiatric admissions during the relationship, and I visited him on the ward, which seemed important. He painted and used poetry plus said a little in sessions. He eventually discussed abuse and issues regarding identity, He became less suicidal, self-harmed less often, and showed more appropriate behaviour with me and others. He got into a few unsuccessful relationships, which did not work and left him very hurt, but then a successful long-term relationship and was on track to a professional career. (Practitioner 20, lines 241–250)

Category III Improvements in sense of self

Significant data composed of twenty-four meaning units referred to improvements in sense of self. These were grouped into four sub-categories, described below.

Category **III.A** *Feeling more accepted/less judged*

Three practitioners reported that their clients said they felt more accepted/less judged.

Category **III.B** *Increase in self-acceptance/self-confidence*

Three clients were described as showing change in self-acceptance/confidence and one practitioner reported that the client felt accepted and became more self-accepting and more accepting of others.

Category **III.C** *More sense of control/empowered*

Six clients were described as feeling more in control/empowered. One practitioner discussed her work with an 18-year-old client who appeared to have been traumatised when young. The client heard voices and saw people who might be “dead people”, embracing these experiences over time. She became calmer and increased her sense of control as well as reducing the frequency of occurrence of loss of contact (Practitioner 2, lines 125–140).

Practitioner 17 found that many of the clients who were experiencing psychotic or unusual process were quite damaged. This practitioner’s experience was often that people “control stuff for” the clients, leaving them with little control or power over themselves. The practitioner found that the client’s experience of feeling accepted, being more themselves and having someone just be with them provided a different experience and gave them the courage to reflect and re-establish their own power (Practitioner 17, lines 253–260).

Data category III.D Self-integration

Self-integration was the subject of twelve meaning units in this category which naturally fell into two sub-categories as described below:

Category III.D.1 Increased insight/self-awareness

Seven clients were described as showing an increase in insight or self-awareness, and five as becoming more integrated. Practitioner 3 described working on emotional issues with a client who initially regularly self-harmed, cutting their face but during the second of two phases of therapy the client became more stable and integrated and psychotic process was no longer evident (3/7-3/35). Practitioner 13 also saw growing self-awareness in clients and increased ownership of self and emotional wellbeing (13/243-13/249)

Category III.D.2 More integrated/stable identity

Three situations involved clients who explored issues around sexual identity and one moved from confusion to entering a sexual relationship at the end of therapy.

Category IV Improvements in quality of life

Three quarters of all participants discussed improvements in the quality of life which consist of two groups described below.

IV.A Increase in resilience/coping

Nine clients were reported as experiencing increased resilience. This included examples of clients being more able to cope with life and stressful situations.

Practitioner 19 described supporting a client to experience emotions which were frightening for her but through this she found strength and resilience.19/137-19/151

IV.B General improvement

Six practitioners also reported general improvement in general wellbeing and functioning.

Domain 3: Contraindications/referral issues

The small but important and distinct data in this domain with three meaning units is listed in table 2.4 below, describing negative effects or the need to refer clients to alternative treatment pathways if PCT was considered unsuited to those individuals and links to issues discussed in Domain I.2.E in relation to exercising particular care and attention.

Table 2.4

DOMAIN 3: Contraindications/referral issues

Category	**No of meaning units**
Contraindications/referral issues	3

Whilst in the practice data it was clear that practitioners worked with care to avoid overwhelming clients there were three meaning units in this domain which more specifically referred to possible contraindications or referral issues where at times practitioners and clients questioned the suitability of the therapy at that time and were open to breaks or referral to other resources. Practitioner 14 felt that one client who decided to discontinue the therapy may have experienced the therapist as too intense. The therapist learnt from this experience to modify their practice, being more sensitive of the emotional distance needed by some clients and added “it’s really important to look for triggers to make sure that I’m not exacerbating someone’s mental health” (14/577-14/57) and had supported another client to access CBT as they had not wanted to work in an emotional level. Practitioner 20 gave a further example of a client’s uncertainty regarding the suitability of the PC therapy due to the risk of being with the therapist reinforcing feelings of being alone after the sessions.

2.4 Study 1: Interim discussion

In this section, I will make sense of the main findings of this study and reflect briefly on the implications. The collective findings from all three studies, including this one, will be extensively explored in chapter 5.

2.4.1 Overall practice

Most of the practitioners integrated pre-therapy into their practice, together with other elements acquired through post-qualifying training in addition to standard PCT. Most practitioners used pre-therapy either as part of formal therapeutic work or in the form of pre-therapy contact work in the context of a supportive relationship, following related reading and training workshops. Results therefore showed the impact on practice style of more recent developments in person-centred practice. Furthermore, the application of Prouty's work on practice was reported to influence very positive and sometimes surprising changes in clients (see also Dekeyser, Prouty & Elliott, 2008). Practitioners found that using pre-therapy or pre-therapy contact work as part of person-centred therapeutic practice resulted in them being more able to make psychological contact with vulnerable "out of contact" clients, leading to perceived positive outcomes. Several practitioners were also influenced by Margaret Warner 's (2000) writing on psychotic process.

2.4.2 Important elements of practice

Practitioners generally identified UPR as the most important therapeutic condition for clients with psychotic processes, which is consistent with Sommerbeck (2005). Prouty's suggestion that labels can be oppressive and lead to judgement and stigma was also supported by these informants' views. Individuals with psychotic processes are often socially rejected and labelled by lay people and mental health professionals alike. PCT, however, may contribute to the reduction in social exclusion by providing individuals with a sense of being truly seen and accepted as people, a view highly consistent with the writings of Laing (1965) and others (Davidson & Stayner, 1997; Davidson, 2016) on work with clients with psychosis.

Findings indicated that practitioners approached psychotic content in a variety of ways and that it could sometimes be distracting or unsettling for them. Therefore, practitioners particularly valued short courses, supervision and other input that provided them with ways of staying grounded and working productively with these processes. Some important themes regarding person-centred practitioners' perceptions of their practice are apparent from the data. Emerging themes in perceived useful practice included "getting beyond labels and illness" and "working with particular care and attention."

Paralleling Warner (2001a, 2001b) and Mearns (2003), the results suggest that responsible practice when working with psychotic processes may involve sensitive and appropriate adjustment of therapeutic parameters. Informants noted the need for supervision and careful reflection to enable them to discern when to either extend or tighten boundaries. For example, in some situations it might be valuable to conduct part of the session outside the therapy room (e.g., when the client is reacting negatively to the space). In contrast, it might sometimes be important for the practitioner to keep explicit time boundaries, have clear risk management contingencies and carefully observe the limits of their competence (e.g. referring the client on if they may need a higher level of care to stay safe). This may reduce the risk of practitioner burnout and supports client safety and continuity of care. Explicit contracting with clients appears to be very important because of the risk that clients may misunderstand or later reframe remembered events in unpredictable ways. The experience of these practitioners suggests a value in being explicit about the limits of what they can offer and taking great care when they consider extending boundaries.

Results suggest the importance of specific therapeutic conditions, especially unconditional positive regard. The perceived therapeutic change most often described was increased social adjustment. Some clients were also perceived by therapists as showing lessened risk of harm to self or others and improvement in self-awareness, mood, resilience and other areas.

The most significant finding in this study may be the role of PCT in enhancing clients' social and interpersonal skills. Given the degree of social isolation and interpersonal avoidance in this population, this kind of change is essential for helping clients improve their quality of life (Davidson & Stayner, 1997; Harding, 1987). Although this is consistent with the results of the Wisconsin (Rogers et al., 1967) and Essen studies (Teusch, 1990), this point has not been emphasised in the literature. Thus, in PCT, including pre-therapy (and other forms of therapy for psychotic processes), the therapist strives to provide an opportunity for the client to form a therapeutic relationship that may then provide a model for other fulfilling relationships:

> *The* task of psychotherapy is to help the person achieve, through a special relationship with the therapist, good communication within himself. Once this is achieved he can communicate more freely and more effectively with others. (Rogers, 1961a, p. 330)

The finding that the therapy relationship seemed to enhance the client's sense of self and ability to be around other people links to results from a study by Lysaker, Buck, and Roe (2007) of narrative integrative psychotherapy, conducted by 8 therapists with 30 clients with a diagnosis of schizophrenia. The study demonstrated how a non-hierarchical therapy relationship appeared to enhance social worth, an integrated sense of self and experience, and symptom reduction.

Many clients were reported to have improved mood and decreased "symptoms". Indeed, Bentall (2009) recently reviewed research supporting the idea that the therapeutic alliance (in both CBT and Rogerian psychotherapy) is causal in improving both mood and "symptoms" in clients with psychosis.

In addition, the results suggest the need for practitioners to consider tempering the intensity of the relationship to prevent negative effects on clients. This fits with theories of high expressed emotion, in which high levels of critical comments, hostility or over-involvement were significant factors in client relapse (Vaughn & Leff, 1976). This may involve helping clients to find the best working distance (neither overwhelmed nor cut off from difficult experiences), as suggested by Gendlin (1984). Davidson and Stayner

(1997) describe how people diagnosed with schizophrenia may have magnified sensitivities, which may influence social withdrawal, and how establishing meaningful social contact can pose a major challenge. This observation is echoed by Warner (2014, 2016, 2017). The results of this study suggest that PCT may be an approach suited to this type of clinical presentation because it is less intrusive than many other approaches and matches the pace of the client, so they can process experiences and connect without pressure.

Contextual factors suggest that it may be important to manage complex client issues by working within competences, receiving support from managers and high levels of clinical supervision, operating within a multi-disciplinary team and promoting the obtaining of support by the client from a variety of sources. For optimal practice, the therapist may need to use more flexible ways to help clients manage risk and support the client's emotional containment i.e. ability to stay with emotions, helping the client to learn to improve coping between sessions. This may involve greater directivity than many PCT therapists are used to. For example, at the end of sessions clients may need to be assessed for disorientation and intention to harm; when these are present, it is important for the therapist to support the client to be safe and to reduce risk.

The two main limitations of this study were the small sample and the fact that client perceptions were not assessed in addition to therapist views. In addition, other factors may have affected client outcomes. PCT therapists are also likely to be biased in evaluating their own work as well as positive bias in researchers. Luborsky, Diguer, Seligman, Rosenthal, Krause, Johnson et al (1999) and Dragioti, Dimoliatis, & Evangelou (2015). demonstrated the potential for such bias in their meta-analyses which both concluded that as much as two thirds of variance could be due to researcher allegiance factors. Furthermore, such factors in psychotherapy trials were often not declared or taken into account.

This study was inevitably impacted by such issues, but nevertheless, was a realistic way to identify emerging trends and areas for further inquiry. The study could help to inform to the development of a basic pilot resource manual for participant practitioners. This study also laid the foundations for Study 2 which is a qualitative interview study of PCT with clients experiencing psychotic processes, described in Chapter 3.

Chapter 3

Study 2: Mid and post therapy change experiences in person-centred and experiential psychotherapy with clients who hear voices or have other unusual thoughts or experiences or psychotic processes

3.1 Introduction

Following the completion of Study 1, which focused on practitioners' perception of change, Study 2 was designed to involve client participants. Studying clients as participants brought a new dimension to the research. Specific challenges were involved in researching and safeguarding a vulnerable client population and gathering data in a sensitive political climate. Study 1 had already focused on practitioners' accounts of perceived client post-therapy changes and perceived helpful or unhelpful practice and had brought some useful insights. Study 2 aimed to build on this foundation by directly asking therapy clients in this specific population about their process of change and experiences of therapy.

3.1.1. Goals of study

This study consisted of Structured Change Interviews with 20 clients who had unusual experiences such as hearing voices, hallucinations, paranoia, unusual ideas or psychotic processes, and who had also received person-centred/experiential psychotherapy. I widened the remit of study as part of a strategy to ensure sufficient data was gathered, but in practice this was not necessary as all participants reported receiving PCT.

The aim of the study was to discover how these client participants experienced therapeutic change and to explore factors influencing the process of change. The study also investigated helpful and unhelpful aspects of the therapy process and factors that directly or indirectly impacted upon the client, such as the qualities of the client and therapist and contextual parameters surrounding the therapy. Each client participant was interviewed by researchers who were not the client's therapist, and data were analysed using grounded theory.

3.1.2 Background and study context

Study 2 complements the study 1 practitioner study by focusing on the client's experience of therapy. Clients who had had psychotic experiences and PCT were asked directly about their therapy journeys. My original intention had been to interview or study clients but my original academic supervisory team and other academic consultants within the University advised me to commence my research project by first focusing on obtaining practitioner data. I was informed that I needed to complete a practitioner study with appropriate data, to increase the likelihood that I would gain ethical approval for a client study of this specific vulnerable population in the current UK practice context, given the lack of previous research that showed efficacy in this area. Having completed this initial preparatory practitioner study and gathered some insight into UK practice, I embarked on study 2.

Study 2 was originally designed and ethically approved by the UK National Health Service (NHS) and the University of Strathclyde ethics committee as an open clinical trial with a battery of measures to be applied during therapy with participating and consenting clients. The initial trial form of study 2 began on schedule, with one initial client participant; but further recruitment then proved extremely difficult. The study began at a time of comparative economic difficulty where many services were being closely scrutinised with possible scheduled financial cuts. Within this pressured climate there was a focus on promoting evidence-based practice, and for psychosis the NICE guidelines recommended Cognitive Behavioural Therapy and Family Therapy. PCT was allegedly insufficiently evidenced to warrant inclusion in UK care pathways although the cited studies did not actually support this (Elliott, 2013). Changes in NICE guidelines contributed towards already sensitive politics in a difficult economic climate in the UK. This created enormous barriers to recruiting additional participants, and several gatekeeper parties withdrew.

As noted earlier in this dissertation, evidence-based practice and care pathways for psychosis recommended by NICE (2009, 2011) had been updated, and new guidance was introduced that more firmly suggested medical intervention and CBT as first lines of treatment. This was based on the supposed gold standard evidence from RCTs, although the guidelines have since come under scrutiny as closer inspection of trials revealed smaller efficacy differences than implied by the resulting recommendations. The guidelines specifically contraindicated "supportive counselling" unless there was a lack of other available resources or the treatment was initiated by patient choice.

Study 1 had shown some covert practice or difficulty in practising PCT in some sectors due to the wider political climate. Information regarding the wider context continued to emerge as the entire research project developed. During the time within which my study evolved, the context in which I was conducting my study shifted. Strict adherence to

NICE guidelines increased my dependence on gaining data from private practice and third sector agencies who were less reliant on NHS funding and thus the guidance. Third sector and private agencies traditionally had more autonomy with more room for independent thought and radical and innovative practice, but at the same time such agencies were becoming more dependent on statutory finding and guidance and their practices needed to be accountable and ethical.

Services were frequently located in contexts in which they were competing for funding. A few nervous practitioners who were gatekeepers to suitable practice and potential participants were quietly practising in services that they were worried could come under threat if they were highlighted, even though there was no robust evidence of the practice being negative.

It was therefore necessary to completely redesign the client study. The new Study 2 design considered what seemed realistically achievable in this complex and changing climate of UK mental health research and practice. I was able to retrain the data from the first client seen in the original design for Study 2, as there was a common measure in the revised design, which involved individual client interviews using the Change Interview protocol. Amendments were formally ethically approved (see appendix A3 to A12 for complete process). NHS and University amendments also allowed participants to respond from a wider range of services and user groups as the complex climate was clearly limiting data collection. A specific University amendment allowed international recruitment via international mental health groups.

3.1.3 Researcher process

As chief investigator, I was a trained and experienced counsellor with more than 20 years of experience. I had worked extensively with this client group, as a counsellor and in other roles, and therefore had familiarity with issues and multi-sector service care pathways. I had received regular training in safeguarding and risk assessment and was aware of how referral and support services operate to assist any clients in seeking help if they were not receiving support and were at risk. My experience also meant that I was comfortable with the kind of material that was likely to be disclosed, was able to support and able to help containment, and was aware of issues that may arise.

I was closely supervised within the University of Strathclyde Counselling Unit by a Professor and a research supervisor who was also a trained mental health clinician, trainer and clinical supervisor with extensive experience of working with vulnerable populations from a PCEP modality perspective. I could seek advice when needed.

I was initially disappointed to be amending my design as I was concerned that it could result in less robust data in terms of evidence-based practice. However, this feeling shifted and I was eventually glad that I embarked on the revised design, as it produced a rich and intriguing data set.

I commenced Study 2 with an awareness of the findings of the practitioner-generated data from Study 1. I then tried to distance myself from the Study 1 outcomes and to proceed with an open mind. I was curious to discover how the data from clients would compare or contrast with the practitioner data. The practitioner and client studies were each approached differently and were not designed to be directly comparable. However, each group of participants – first practitioners and then clients – was studied with a focus on client change. I wondered whether there would be significant similarities or differences in practitioner and client reports of what might constitute changes and helpful or unhelpful practices and other related factors. I was interested to see what the independent and combined data from the studies might imply in terms of practice considerations.

3.1.4 Modification in the use of language

I somewhat modified the use of language in this study. I was aware that the term psychotic process was used in for person-centred experiential psychotherapy (PCEP) by Warner (2014) and was adopted by some clients. The fact that the roots of the term lie in the medical model produces tensions and discomfort in me, due to the power implications and the lack of scientific basis for the diagnosis, (as I discussed in the main Introduction and Chapter 1). The tension I was experiencing increased and I was worried about the issue. I therefore modified the language for the purposes of this study, using what felt like a clumsier and yet more ethical and PCT-ethos-driven language. I began to adopt definitions such as “people who hear voices or have unusual experiences”, which I could then justify in more detail if asked. This posed its own problems in terms of both clumsy language and lack of precision in terms of sample criteria and I was concerned that it might impact on outcome quality. Ethics and staying within a person-centred ethos were the most critical foundation of the study and terms based on models of differential diagnosis that were more medical and have no scientific basis did not sit well with a person-centred framework. Similarly, it made sense for me to use language that was more diverse and flexible. Clients were consulted at each stage to allow them to give verbal feedback regarding the evolving design and the use of language, and they gave mixed views regarding medical or alternative descriptions of psychotic process.

3.2 Method

3.2.1 The research protocol and process

This study involved the Change Interview v.5 2008 (Elliott; see Elliott, Slatick & Urman, 2001) being conducted with 20 participant clients who reported hearing voices or having other unusual experiences or psychotic processes and who had completed person-centred and experiential psychotherapy (see Appendix B.5). I conducted majority of interviews (15) and two other researchers who were qualified therapists approved by the NHS ethic committee) conducted the remaining 5 with my own clients to ensure that the Change Interview researcher was not the same as the therapist.

It was not assumed that the unusual experiences themselves were necessarily a problem, that they had been the subject of referral or a focus of therapy, or that the clients had any agenda to change these experiences. I was interested to learn how clients who have psychotic experiences experience and use therapy, what is helpful or unhelpful and the wider context of their developmental journey. The study was simply focusing on self-selecting clients' actual experiences of therapy, regardless of whether the clients had specific presenting issues or an unknown therapy agenda. It was approached with an open mind to see how therapy might be experienced and to assess any perceived outcomes. This fits with a person-centred/experiential model of therapy where a therapeutic agenda or diagnosis is not necessary to embark on a therapeutic journey with potential benefits. Person-centred experiential psychotherapy (PCEP) is ethos- and process-orientated, with the power being centred with the client as much as possible. While acknowledging that a power differential in the relationship is inevitable, it is minimised by the real relationship and the lead of the client. The study recognised that PCEP is wide, encompassing many "tribes" (Sanders, 2004, 2012). Practice may, for example, be based on more classical models or from a more pluralistic perspective (e.g. Cooper & McLeod, 2007).

The inclusion criteria for therapy were that the therapy was to be humanistic person-centred or experiential, and non-directive. This was noted via the reports of client participants rather than monitored manualised therapy (adhering to a treatment manual to support delivery of a consistent approach), which was therefore an imprecise way to deduce it. However, to compensate for this somewhat, the reports comprised clients' detailed accounts of their therapy journeys, describing how the therapist worked and, most importantly, what seemed helpful or hindering, what changes occurred and contextual parameters. This procedure gave the potential for substantial data generation and insight into therapy process and style.

Therefore, although there was not a neat way of selecting or monitoring either client's process or therapeutic treatment the power, ethics and person-centred parameters were respected and the study method, in my view, was no more flawed than the perhaps false sense of security which may have been generated by a trial with simpler and less rich and informative data and based on medical criteria that had no real basis. I was simply proceeding in a way that made sense within the specific research context rather than it fitting a hierarchy of superior or inferior styles.

In this study the client participants gave descriptions of their personal and therapy experiences. Their experiences were framed by the focus of the questions they were asked in the Change Interview Protocol. Within this specific, structured, audio-recorded interview, client participants provided information relating to how the journey of therapy operated, their own difficulties and strengths, and wider contextual factors.

3.2.2 Ethics and risk management

During the development of the research design my academic and clinical supervisors understood that the risks were minimal, as I was really measuring what research trial language may refer to as “treatment as usual”. It was not anticipated that my design would put the participants under any more pressure than simply answering the questions if they chose to do so. In addition, the participants were to be offered debriefing and links to resources if difficult material was raised, as appropriate.

The research protocol allowed for the exclusion of clients where there were known vulnerabilities and immediate safeguarding concerns. The interviews were all conducted by researchers who were based in Europe and were qualified psychotherapists or psychologists, trained to conduct this research. UK researchers who fell within the UK ethical approval process submitted their curriculum vitae to the research investigator to send to the NHS ethics committee for approval. All UK researchers were members of the British Association of Counselling and Psychotherapy and worked within the BACP ethical framework (BACP, 2002, 2007, 2009, 2010). One non-UK researcher in Europe was a member of a known PCEP international body and was a registered psychologist in a statutory mental health service and had permission from their service context to conduct the Change Interview with a participating client in a specific service setting. During the ethical approval process I was aware that the PCEP approach had a limited research base and known efficacy (see the literature review in Chapter 1), which motivated me to pursue the research to further this knowledge but warranted concern from the NHS committee, which, on meeting me for the original core approval understandably asked me detailed questions relating to risk. All researchers were trained experienced practitioners who were members of ethical bodies and experienced in working with vulnerable individuals and following safeguarding protocols. All were able to contact general practitioners or emergency services as per participant contracts and breach confidentiality if any concern arose regarding significant risk to self or others regarding the candidate. Researchers were also able to assist signposting to a general practitioner or other services if needed or requested. However, no major issues occurred, as the volunteering participants who chose to participate had already received support, had moved forward in their recovery journeys and were aware of local resources. The original study design was approved by the NHS and thus approval was accepted by the University of Strathclyde to proceed with advertising, participant recruitment and data collection (see Vol 2 appendices A3, A4, A5, A6 ,A7, A8, A9, A10, A11 and A12 to illustrate the lengthy and robust process involved in formally seeking amendments and gaining approval in a challenging context .)

3.2.3 The context of change process: research and selection of measures

In this study my goal was to study clients’ experiences and any changes they perceived to have occurred in themselves, the related therapy processes, and personal and contextual factors; and to consider their interrelationship and possible clinical implications when considering any common components or points in striving to offer optimal practice. Greenberg and Newman (1996, pp. 435–436) discussed the challenging issue of attempting to study scientifically the process of change in states of mind through therapeutic process. Greenberg examined the opportunity of viewing the individual client as described by Jantsch (1980), who viewed the individual as a complex self-organising system with complex character.

The Change Interview v5.5 (Elliott, Slatick & Urman, 2001) was selected for this CPR study to address the above goals and considerations. I had previous experience of using diverse batteries of measures in clinical roles as well as unstructured and semi-structured interviews and saw this measure as a more specific focused tool to obtain the data needed as well as allow for other idiosyncratic expression.

I rejected the idea of structured or unstructured interviews developed specifically for this purpose as I wanted to develop a more consistent and focused study of specific elements of the change process and allow future comparison to other studies that may also use the same widely available and free measure.

The Change Interview has been described by Elliott, Slatick and Urman (2001). I chose this measure as it offers a balance between a relevant structure in relation to my research questions and an openness to participants' own additional material. The structured Change Interview asks the clients at the end of therapy to consider how they regard their experiences of the therapy, any positive or changes that may have occurred and various aspects of what they considered helpful and unhelpful therapy processes. The Change Interview also requires that the researcher ask the client to describe their experiences of therapy, any helpful but difficult factors and impacting factors that may be contextual or related to others, and to describe any helpful or hindering personal qualities or attributes. Therefore, the interview not only focuses on therapy processes and any changes but also considers other factors, including self-help or treatments that may have had an impact.

Client changes are also listed as part of this interview and rated by clients in relation to how surprising the changes were, how likely they were to have occurred without the therapy and how important the client considered the change to be.

In this study I used a revised version of the Change Interview (Elliott, 2006), developed from the original version (Elliott, 1999) as included in appendix B.4 .This version of the interview protocol asked additional questions relating to the clients' use of personal resources, and personal strengths or limitations that may have impacted on their wellbeing and use of therapy.

The Change Interview v5.5 also required clients to be asked about what it was like to be involved in the research, including what had been helpful or less helpful about the research. In this study the small amount of data regarding the research itself was not placed with the main body of the research outcomes but was processed separately to the main body of the data as it had an entirely different emphasis relating to the study process itself.

The Change Interviews were, in each case, conducted mid- or post-therapy by a researcher who was not the therapist and who had been trained in the use of the measure. I was the researcher in the case of fourteen of the interviews and two co-researchers conducted five change interviews where I was the therapist and a third co-researcher conducted one interview with a further client. Researchers were therapists with a variety of core trainings, including person-centred, CBT, narrative therapy and life coaching. They may have held allegiances to particular approaches, with a mixture of orientations, helping to somewhat mitigate against inevitable non-conscious researcher bias, as discussed by Luborsky, Singer and Luborsky (1975) and other authors (Cooper, 2008; Leykin & De Rubeis, 2009; Wampold, 2001, 2015).

The study that is known in this dissertation as Study 2 was ethically approved as a substantial amendment as a level 3 of 3 levels of client participation (as previously fully explained in the introduction chapter) but was amended when United Kingdom clinical pathways changed. The original approved study consisted of an open clinical trial in multiple sites. After amendments the client study also included previously gathered data from one client which was analysed as to a systematic case study (see Chapter 4) with measures previously approved; in the revised study additional data was collected directly from clients both from independent contacts and via service settings and user groups.

The study (as a simplified modification of an earlier design, as explained earlier and illustrated in appendix A11) was submitted for ethical approval and was approved by both the University of Strathclyde ethics committee and the United Kingdom National Health Service ethics committee. The University of Strathclyde ethics committee supported the entire multi-stage National Research Ethics Committee (NRES) approval (e.g. see Appendix A3). Whilst the NHS required the chief investigator of the study to be the research student, the University of Strathclyde ethics committee needs clashed with this, and required the chief investigator to be the supervisor and so an additional form was completed by my supervisor to resolve this issue and an additional insurance form was completed by my supervisor to ensure full compliance with all parties (see Vol 2, Appendix A.6).

3.2.5 Participant recruitment

Participants were recruited in Europe by myself as chief investigator. I advertised in person-centred and experiential groups and networks, mental health organisations and on noticeboards (see Appendix A9, A10 and A12). Where participants were interviewed in the context of particular organisations, I ensured that any service gatekeepers were approached directly and that all parties agreed to any contextual boundaries or conditions. For example, some interviews were conducted in an organisational context where specific multi-sector referral protocols and safeguarding requirements were met. Additional data was collected at a later directly from clients, both from independent contact and via websites. If a participant raised safeguarding concerns (such as immediate risk of harm to self or others) in such a context there was an organisational response, whereas in independent interviews (as approved by a later ethical amendment to generate both adequate quantity and quality of data) the person could be signposted or referred to other services or their GP contacted if appropriate.

The adverts asked for participants who were self-defined in terms of fitting the research criteria, having responded to the advert and having received the participant information sheet and consent form.

It seems important that this was the process for individuals who had often been diagnosed by a medical model framework. Although this approach clearly poses problems in comparison to other studies where more precise criteria is used, the individuals described their issues and solutions in their own language and participated on their own terms, giving full commitment and movingly honest accounts of their therapy journeys. These included, for example, accounts of incidents where they "played the game", felt unhappy with practice but were afraid to challenge it or failed to disclose certain issues. Such disclosures presented by participants, who showed emotional responses and considered reflection as they responded to interview questions, gave a sense of authenticity of information given rather than just compliant pleasing of the researcher. Accounts of positive therapy experiences were discussed, as well as information relating to therapy experiences that were perceived as unhelpful or even damaging. I was interested that as a researcher I did not feel a pull to censor the negative outcomes; as the entire three-study research project progressed, I became more pragmatic in my position of neutral enquirer. I became more respectful of the data and less defensive of specific practice modalities and lost the desire to prove particular outcomes that had been apparent when I first wrote my PhD proposal in a climate of criticism of PCEP for complex process.

I have already discussed language issues in Chapter 1. Further to this, I did not adopt medical model terminology in adverts but used wider definitions for patients to self-describe their process. The American Psychiatric Association's (2013) definition of psychosis is widely used and accepted by some clients but has little scientific validity

The Change Interview protocol (appendix B4) advises that, ideally, participants should be given the interview a week in advance but although individuals and organisations received information prior to the interviews it was not always possible to disseminate information directly to participants. As a result, most interviews were conducted without the participant having received the Change Interview beforehand.

As this is a vulnerable client group who were not to be financially disadvantaged by taking part in the study, a small financial allowance to a maximum of £10 per participant (which was ethically approved) was available for their travel expenses if required. People who hear voices or have other unusual experiences may be more likely to be economically disadvantaged due to their experiences and may find some modes of transport challenging. One participant found it hard to use the bus at times as crowded places sometimes triggered distress and thoughts of harm to others.

3.2.6 Demographics

Eleven of the twenty participant clients described their gender as female and nine described their gender as male. There were no other gender descriptions given. In terms of the age of participants, this was an adult study where all participants were aged between 19 and 68. In terms of location, all participants were in Europe: seventeen based in England, one residing in Scotland, one located in Wales and one from Belgium. Participants represented a number of different nationalities.

Some participants chose to be interviewed face to face and others by phone. Some participants described experiences with different therapists and where this was the case the therapists were labelled as A and B or AB if non- specific so in interview 14 the data 14B would refer to therapist B.

Some of the participants had experienced psychiatric treatments; in some cases, they were taking medication at the time of the therapy. Participants also had varying levels of formal or informal support. These factors were discussed by participants in their interviews. It was difficult to know how other treatments may have impacted and participants often gave their own strong views about treatments and how they felt affected by them. Many of the participants had experienced great difficulties in life including trauma and the interviews were paced with breaks given and de-briefing and signposting offered if needed.

The sample of 20 was large enough to gather sufficient data to uncover emerging themes in relation to the therapy in the context of wider influences, and to raise questions for further study.

3.2.7 The process of interviewing volunteering client participants

The Change Interview was completed at mid or post therapy or after complete phase of therapy by a trained researcher who was not the psychotherapist. The researcher conducted Change Interview as single measure. Each researcher who conducted the Change Interview was required to adhere to all relevant agency legal requirements, The specific British Association for Counselling and psychotherapy (BACP) ethical framework in place at the time of the study phase as well as respecting research protocols and internal policies if any issues arose. De-briefing and signposting were offered to each participant, if required.

The researchers tried to maintain a position of neutrality and limit bias in asking questions and responding to participant’s comments. As a counsellor with more than 20 years of work with clients with complex process, I was used to the balance between being genuine and offering containment and boundaries. However, given the powerful and often emotionally charged nature of the material disclosed and the vulnerability of this client group it was, perhaps, inevitable that some bias would creep in, even in my mildest reactions or ways that may be beyond my awareness.

I was aware from personal dialogue with academic researchers that I was in the company of many other researchers in facing both the advantages and disadvantages of researching a subject that was “close to my heart” and encountered research supervisees who were at times emotionally overwhelmed by their data which had often been a result of studies rooted in their own passions and vulnerabilities and sometimes, furthermore, they were frightened by the unfolding political consequences of research results as they hit the public domain and were under scrutiny or robustly challenging current practices. I therefore embraced this aspect of my research journey as normative but took great care of myself emotionally throughout.

If participants enquired or the topic arose, I told them that I had supported people with complex processes who were close to me as well as on a professional level, and I disclosed some of my own personal history that had motivated me to conduct the research. My own transparency seemed important in gaining the trust of some vulnerable participants. They sometimes indicated the need for openness due to being let down by others or sometimes experiencing paranoia or other complex processes. If I expected participants to trust me with such vulnerable issues it felt critical to both limit the extent of my own disclosures and be grounded enough to hold them, while still being openly transparent regarding aspects of my own professional and personal history and motivations. At times I feared that participants might at worst feel like vulnerable guinea pigs being researched by an inquisitive and ruthless voyeur of hallucinations. So it was important to me, not just as a researcher but for my integrity as a human being and as a member of BACP adhering to its ethical framework, to consider my position and ensure I avoided exploitation either by overloading clients with my own experiences or by withholding in an overly-defensive position. Thus, a delicate balance was achieved. I accepted any further bias that this might load onto the study and resolved to embark on the project with this awareness while hoping still to gain valuable data.

Despite their best efforts the researchers did not always stick exactly to the script, but all interviews were transcribed and show that the Change Interview protocol script was followed in the main. There were some minor variations in researcher style; and some clients found it difficult to approach the interview in the order laid out, preferred not to rate changes or moved onto topics that were not central to the protocol. In each case the researcher made decisions to extract data while being simultaneously supportive to the participant's needs, including their need to follow their own creative style and their limits; they were offered breaks if helpful and debriefing if required. Participants knew that they could withdraw at any stage of the study.

The data from interviews conducted by myself and the other three other interviewers (who conducted 4 of the 20 interviews, including with 3 cases where I was the therapist) showed some minimal evidence of encouraging and supportive responses and bias, which was considered when data was analysed and audited at each stage. Where the candidate might have given ambiguous answers after encouragement, the data was carefully scrutinised to unpick, where feasible, those responses where the participant used their own words and gave answers they had considered or strongly expressed with clarity. This does not rule out researcher influence but does mitigate it somewhat.

I did not like the word “symptoms” at the top of the Change Interview sheet; this clashed with my non-medical position in collecting data and I did not use this part of the interview. Instead, the researcher asked the participants during the interviews and on additional forms to disclose basic demographic information and whether they were taking medication, if they wished to disclose this. Participants varied in terms of disclosure of difficulties or unusual experiences.

Some participants understandably scrutinised me before volunteering and indicated that they were more able to talk to me with ease and honesty because of my comfort with the subject and my own history. This therefore generated rich data. Three participants were members of a support service where they accessed counselling and other support and I was in an email dialogue with the group and their coordinator for about a year before they decided to participate in the study. During this time, I was transparent in stating my own position as well as describing the research process. I was at times in awe of the resilience of participants and their creativity and strength to survive often extreme hurdles and still progress. I found the research process profound, enriching and inspiring, and this resulted in my reflecting deeply about the research question, my own clinical practice and myself as a person, as I philosophically processed stories of individuals pushing forward.

Despite these biases a rich body of data was gathered with clear indications of trends in the data that raise points for discussion in relation to therapy practised, process and outcome, all of which may warrant further future research.

3.2.8 Research protocol and interview process

All interviews were conducted face to face or by phone, at the preference of the individual. Most clients were interviewed in the service setting where they accessed therapy, but three were interviewed in a neutral setting and two chose a phone interview. Where participants were interviewed by phone, I used a two-way digital recorder that recorded both sides of the conversation and I affirmed the contract explicitly regarding this before the interview and at the start of the interview, with the participant. I only proceeded if they were in full agreement with this. The interviews were arranged for the convenience and comfort of participants, to ensure they had maximum power in the process in line with a person-centred ethos and to take account of participant vulnerability. Some participants said they felt more comfortable or safer meeting face to face, some preferred to be interviewed in their own home and one chose to be interviewed in their therapist’s home with the therapist available in another room if needed. In this case the client was offered a break, so they could check in with their therapist, and this client chose for the transcript to be given to them via the therapist, so they could check it. All other participants were in direct contact with me or via organisations where they accessed therapy and could ask for a transcript if they wanted to do so.

3.4 Data analysis

3.4.1 Overview of study 2 data analysis

The grounded theory approach adopted in this study, and its basis, are described in Chapter 2 as I used the same analysis method for Study 1 (the practitioner study). This systematic inductive method was also applied to this study (Study 2) and the rationale for its application and actual process is described below.

In this section I will describe further detail specific to the process in the analysis method for Study 2 (client study). The data here were in a different format and approached slightly differently from the treatment of data in Study 1, but in both cases classic grounded theory stages were followed. In the analysis in Study 2 I had the advantage of having more experience of the method.

In Study 2, I was confronted with an adventure comprising a large, rich and somewhat complex data set, covering a wider range of related topics than Study 1. I coded and sourced each small distinct piece of information in the original transcripts to manage such a large amount of data.

The data were analysed and audited using the basic systematic principles of grounded theory originally discussed by Glaser & Strauss (1967) and interpreted by Rennie, Phillips & Quartaro (1988). I also considered more recently discussed ideas relating to the process and researcher experiences, as knowledge has developed without deviating from the basic principles (but not, allowing themes to emerge from the data, preferring a more descriptive-interpretive approach to a strictly constructivist approach (Charmaz, 20014; McLeod, 2014). Holton and Walsh (2017, pp. 10–11) explained how grounded theory is a “process of conceptual abstraction” where the relationship between concepts and their relative importance is uncovered. Charmaz (2008) also discussed her view that the positioning of grounded theory within the construct of social constructionism, supporting research to be “broadened” and “deepened”.

In a conference keynote address in 1999, Glaser commented that “grounded theory is used in part or in whole by researchers” and is adaptable, but also goes on to comment on the difficulty of contamination of the original method. Glaser described how a grounded theory researcher needs to have the characteristics of being able to conceptualise data, tolerate some confusion and tolerate regression. He felt that such attributes are essential for the researcher to be able to make conceptual sense of the data and can be a natural choice. As I embarked on the analytic process, I tried to minimise what Glaser and Strauss describe as “logical speculation”; having time between data gathering and analysis, and some distance, helped this process (Glaser & Strauss, 1965). Glaser and Strauss and other key authors developed their own positions regarding grounded theory as the approach developed. (see Holton et al, 2017).

Glaser (1999) felt that researcher development takes time and that it may take several studies to fully comprehend the grounded theory approach.

I felt naturally drawn to the grounded theory method of analysis, as raised in study 1. I felt that allowing the data to speak fitted with notions of the PCT ethos and trying to stay true to the data and the participant’s voice, despite inevitable interpretative processes. I am also a creative person with a background in both the arts and archaeology and thrived on the adventure of wading through complexity and multi-layered concepts and processes and the discovery involved.

An approach of openness and allowing a fast, spontaneous process to catalyse thinking is important when embarking on such a style of analysis (Charmaz 2006; 2014). The analysis involved immersion in the data. Results were grouped into categories and subcategories as themes recurred.

As the data was gathered in the form of audio recordings and notes, the transcripts were each coded according to a classic grounded theory approach. This method of analysis initially involved coding which consisted of both categorising and summarising each piece of data with codes which remain close to the data itself (Charmaz, 2006). Each distinct piece of information was given a code to represent the participant and the number of the piece of information so that the code enabled any piece of data extracted from the script to be accurately located in terms of its origin. The first part of code identified the participant and transcript number and the second part identified the piece of information ("meaning unit") in the script. For example, 5/13 means transcript 5 and meaning unit 13. Memos were written to help to encapsulate the essence of the data content and where data categories were emerging, these helped to begin the process of the formation of early tentative categories. This approach was advised by Charmaz (2006).

A substantial amount of time elapsed between data gathering and cross-analysis and then final analysis. Although the disadvantage of this was that it took time to regain momentum and immersion in and familiarity with data, there was the advantage of approaching the material afresh with less bias in terms of interpreting it, as the memory of the process was somewhat diminished. This caused me to look more at the actual words of the participants and rely less on any assumptions that may have occurred in the interviews that I personally conducted (15 of the total of 20). However, I was fully aware that some bias and preconceived ideas in data gathering and analysis were inevitable.

Bryant (2017) has discussed the fallacy of being able to have no preconceptions and how the researcher should engage in their "distinctive roles and forms of participation, engagement and positionality". Bryant explained how grounded theory accounts often ignore the motivation and rationale for research and how Glaser continued to promote a "no preconceptions" dictum, which Glaser described in detail in the *Grounded Theory Review* (2012). Bryant felt that this dictum had uses but is limited. Bryant asserted that demanding no preconceptions was overplayed by Glaser and Strauss and that their stance had been too literally interpreted by others. Bryant also highlighted the potential of cultural norms bias. Nonetheless, Bryant took the view that "GMT is a robust and adaptable method if it is used with intelligence and insight", discussed suspending preconceptions and encouraged transparency of explicit process rather than simply attributing method to a particular model.

I hoped at best to limit the impact of my own bias and was pleased that data and analysis audits were conducted to ensure correct process and helped to point out any discrepancies or biases, with an acceptance that all processes will have biases and limitations.

Whatever preconceptions existed, this method required allowing findings and meanings to emerge from the data as much as possible.

3.4.2 Preliminary Analyses

Prior to the final analysis, three processes were carried out to gather a sense of all the data. This consisted of, first, a cross-analysis to establish emerging themes and check for data saturation, secondly, an examination of the change ratings scales and finally a full analysis from the complete data set.

First, a cross-analysis was conducted of four of the first 15 Change Interviews, chosen at random. This showed early themes. Second, the final five Change Interviews were conducted after a period of additional recruiting, in order to successfully complete the planned sample size. After all the Change Interviews were completed and analysed, the additional data was added and the process of modifying fine tuning categories continued. Third, qualitative data from the Change Interview was also combined with full versions of the outcomes of the ratings section. For example, if a participant rated a change as extremely unlikely without the therapy and gave a numerical score as well as stating this, the sentences explaining this were incorporated in the main data set.

The cross-analysis of four transcripts was conducted before all participant interviews had been completed. This enabled the initial domains, subdomains and data headings to tentatively emerge before the final analysis of data from all 20 transcripts, as data from the remaining 16 transcripts were added in a later process. The original categories were modified according to the newly added data.

During the initial cross-analysis (as well as at later stages), memos were added to transcripts to aid the process, which is a suggested strategy in grounded theory (Charmaz ,2006). This involved taking each piece of data from the four transcripts and placing it in a new document, where it was gradually moved around as themes arose from the data, while simultaneously producing and amending a document of tentatively developed headings and subheadings, which were continually adjusted. Strauss and Corbyn (1990) discussed the idea of core categories being arrived at as a "central phenomenon", which integrates with surrounding categories. Glaser (2007) described how a core category has generalisability and appears repeatedly in a natural way that stands out to the researcher, while Charmaz (2006) placed less emphasis on this idea in more recent texts, favouring a wider perspective rather than a focus on core categories.

Where it was not clear whether a piece of data belonged within one of two or more headings it was duplicated to be in all of them, with openness to later deleting some of these copies as a result of further processing and consideration of the data and categories. This simultaneous working on the domains and sub-domains and subheadings, as well as rearranging and making sense of the data, fits with the process described by Charmaz (2006, p 48). Gradually themes emerged from the data and were revised to eventually form possible headings and subheadings. I also looked at a summary of all the completed listed and rated changes, whilst acknowledging that many other changes were embedded in the wider transcripts, before embarking on the final analysis.

3.4.3 Final analysis

The final analysis enabled processes that led to the arrival at categories and subcategories. This final analysis was arrived at by adding the remaining data to the cross-analyses data within its headings and subheadings, and adjusting these as I went along, as well as further modifying the separate distinct document with these headings and categories to arrive at a final list of domains and sub-domains. The cyclical process of interaction between early coding stages and data sampling was more complex than the earlier stage's linear process and has been referred to as advanced coding (Birk & Mills, 2011). This stage involves the formation of higher- level concepts, which form part of classic grounded theory analysis. The process progresses through critical questioning of categories in relation to the data, to the arrival at final categories. Bryant and Charmaz (2010, 2012) discussed the transition from coding to categories and concepts, and their interrelationship.

Auditing of data and headings (or in formal terms, researching the domains, sub-domains and subheadings) occurred periodically at the stage of initial coding, cross-analysis and final analysis, where all data, processes and drafts were audited by the main supervisor of the research. This auditing process reinforced data integrity and reduced potential researcher practitioner bias. At this stage I was fully immersed in the data and a fresh perspective was welcome from someone who was not previously familiar with data content.

Appendix C.1 shows the entire final list of domains, sub-domains and detailed subcategories that emerged from entire data set of twenty interviews the data.

It was somewhat reassuring to see that – despite some reorganisation, minor additions and additional detailed subcategories reflecting nuances of these lower level categories – the final domains, sub-domains and categories did not substantially change in basic character and structure from the initial cross-analysis. This suggests that even though this is a limited study with a small number of participants (n=20), a saturation of rich data enabled a stable set of outcomes to emerge, as for a study of this nature 20 interviews is actually quite large. This saturation process was described by Strauss and Corbyn (1998) and Charmaz (2000). Debates exist in relation to what constitutes saturation and the potential relationship between this and data quality, with some conflicts in the literature. Bowen (2008) states that saturation claims should be supported by the steps to arrive at this point. However, other authors such as Frances et al., (2010) discussed conducting around 13–15 interviews as sufficient until no new categories data are generated, while Guest, Bunce and Johnson (2006) stated that 12 is sufficient. Charmaz (2006) stated that a small study with modest claims may consider itself at saturation point earlier than a large-scale study with grand aims. Overall it seems that rich data is needed to reach the point where no new categories emerge. Whilst there is no clear consensus, the decision to mark this point needs to be accountably justified on an individual basis in that specific process.

As I analysed the data I became immersed in the data and was often moved to tears or excited by the intensity of experience expressed, the stories of growth, and my own learning in relation to how therapy and life can impact on individuals and how they move forward; there was as well “heart-sink” data indicating unwanted therapy processes, which was also a learning.

As the data was arranged in the order that naturally arose, a sense of meaning and the interrelationship between the data content became more apparent as themes repeated and linked to other areas or made sense. After the full data set of relevant pieces of information was positioned within the final categories, the finer detail of the data was then thoroughly considered in terms of content and quantity. During each stage and on the final draft of the data analysis, memos were added to the pieces of data in the categories to help to make sense of them, as even within the lowest level headings many repeated themes emerged, which are described in the results. There were some pieces of data that moved around, and some uncertainty remained regarding their rightful place, but this process has no certainty. There came a point, after final adjustments and a second audit process (in which the data analysis process was rigorously checked by the auditor), where the data arrangement did not change substantially and seemed as ordered as was possible within the time structures allowed for the project. There were still some elements that could have fitted differently but considered decisions were made within the time-frame. Some meaning units were repeated where it clearly belonged in more than one place.

Some participants described their experiences with more than one therapist (labelled in the data as “A”, “B”, etc). For example, participant 7 was on an NHS waiting list for 15 months then the therapy was terminated on disclosure of abuse. The participant was left unsatisfied with the NHS treatment so sought a private therapist and had a much better experience and made substantial progress.

The final data categories were influenced by the emerging themes and the way that changes and contextual issues were framed and, in some instances, influenced by the structure of the Change Interview questions. Rated answers from the sections of the Change Interview protocol that required this approach were transformed into sentences to enable the content to be integrated with the entire data set. Qualitative data of the Change Interview was combined with full versions of the outcomes of the ratings section. For example, if a participant rated a change as extremely unlikely without the therapy and gave a numerical score as well as stating this, the sentences explaining this were incorporated in the main data set.

The categories and the data within them are described in the results section below. I have mainly paid attention to higher level categories and themes that occurred in 3 or more of the 20 clients interviewed and in certain other cases to clarify specific findings. This was because if a theme occurred for 3 or more individual participants it was likely to have been more than random or coincidental in terms of establishing its existence as a distinct and recurring client experience. If 18 participants experienced a phenomenon, I classed this as “most”. I will use typical examples to illustrate the most frequently occurring themes.

3.4.4 Overview of Change Ratings

Independently of this process of analysing the transcripts I took all the Change Interview rating tables where the clients had named and rated their key changes and listed them, taking the first 15 interviews and then later adding the final five (see Appendix C.3) resulting in a total of 17 rated interviews, with a further three clients having chosen to omitting this part of the interview. If there was any ambiguity in a score, I rated “down” rather than “up” so, for example, where a researcher described the highest rating in error and the client enthusiastically said that it should be the highest rating I rated “very” and not “extremely” to stay with the client’s description and allow for positive bias. Not all clients wanted to use the rating scale part of the Change Interview, participants 11, 15 and 17 preferring to describe their changes. In some cases, those who did use ratings omitted specific items where they found it difficult to translate their experiences to the ratings.

All 20 clients, including the seventeen clients who used the ratings scale section described changes and other aspects of their therapy and developmental process within the full Change Interview, which provided qualitative data for the full analysis. The change charts from the 17 client participants who used the rating scale gave a flavour of the diversity of data before all data from the Change Interviews were analysed and incorporated with this ratings data as it was translated into a narrative format. Rich data with other changes and nuances emerged from the complete data set as participants more fully explained their perceptions of change and therapy processes within the entire interview.

3.4.5 Participants’ experiences of the research

All participants expressed positive comments relating to the research. No participants requested debriefing or disclosed any negative effects, either at the time of the interview or after it but, of course, there could have been an unknown element of wanting to please the researcher. In terms of suggestions to improve research process there were several comments. One person felt that the Change Interview was rather repetitive and could be modified.

3.5 Results

3.5.1 Overview of findings

3.5.1.1 Change ratings overview

The ratings charts data is listed in Appendix C3. Seventeen clients interviewed post-therapy rated 93 positive changes. Of those rated changes, 72% were rated as unlikely or somewhat unlikely to have occurred without the therapy. The mean ratings give further clarity.

For the question regarding how surprising the change was, the mean rating was 3.58, which implies that the average client is slightly surprised by the change. The question relating to how likely or unlikely the change would have been without the therapy the mean rating was 1.94, which implies that on average clients felt that the change was between very and somewhat unlikely without the therapy. The mean importance rating was 4.32, which indicates that the change was very to extremely important. Therefore, the average client was slightly surprised by important or extremely important change that they attributed to the therapy to some degree.

These change rating data provided an initial picture that tentatively demonstrated that clients were in many cases attributing changes to the therapy and gave a flavour of the range of the changes that would more fully manifest in the complete qualitative data set incorporating the full interviews. These ratings are the changes that clients themselves thought of immediately, which suggests some degree of authenticity to the data even if some biases exist. No negative changes were named or rated in this section, but these do arise later in the wider data set.

The emerging data formed a structure with three distinct domains and subheadings, with lower-order categories under them.

The full list of all the key higher-level categories arising from the data can be seen in the tables in the text with the full structure and details of all categories located in Appendix C1. Appendix C2 shows the three domains and how the data were distributed with the main headings, subheadings and lower level headings. Each domain, with lower level categories, is described in detail later in this chapter with in text tables to support this.

3.5.1.2 Structure of analysis

The aim of this study was to discover the 20 clients' perceptions of changes and helpful/hindering factors in therapy. The study set out to explore clients' processes of change and experiences of helpful and unhelpful therapy processes, attributes and contexts, using the Change Interview to gather the data. I have already described the process of analysis. Full transcripts are not included in the text or appendices in order to protect the identity of individuals, as contracted with them, but extracts from the audited data are provided and sourced to the number of participant and number of responses. For example, (6/17) refers to the 17th piece of data (meaning unit) provided by participant 6.

While all categories and numbers of affected participants are listed in tables, in the text and as a comprehensive list in appendices, the analysis focuses on descriptions beneath first, second and third tier headings to ease navigation of findings within the tables in text, in order to show finer detail of data distribution. Any categories or occurrences within a category with more than three respondents are described and examples are used to illustrate the findings. Usually I have used two brief examples or one detailed example, due to limited space. Occasionally more examples are used where these are needed to clearly illustrate the findings, in order to ensure that the data are meaningfully explained. I have chosen examples that showcase typical responses and illustrate the category content.

Domain 1: Changes (mid- and post-therapy)

Domain 1 contains categories of data relating to changes which were described by clients at mid or post therapy and is the largest body of data in this study. These categories, encapsulate clients' recognition of changes and descriptions of these, staying close to their own words, wherever possible.

Sub-domain 1.1: Positive changes (improvements, getting better)

Positive global changes are divided into two categories, as shown in Table 3.1 together with the number of participants who gave responses in this category. Some respondents gave multiple responses referring to this category, reinforcing their position that in their opinion therapy caused global change. These changes are general non-specific changes or feelings of improvement described by clients, either noted by themselves (in the case of 13 of the 20 respondents) or described by them as having been noted by others (in one instance).

Table 3.1
Domain 1.0: Changes (mid- and post-therapy). For detail see Appendix C.1

1.1 Positive changes (improvements, getting better)
1.1.1 Positive global change
1.1.2. Internal/self-related changes
1.1.3 Increased positive external connection
1.1.4 Reduction in risky experiences/behaviours
1.1.5 Physiological improvement
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

1.3. No change/missing changes

1.3.1 Client wanted to be 100% better

1.3.2. Client wanted change to be faster

Category 1.1.1: Positive global change

As illustrated in table 3.1, more than three quarters of the participants discussed generally feeling better in non-specific ways such as being more able to get on with life or saying that the therapy had “worked” (20/6). Participant 3 said, “I came here to get it sorted out and I got it sorted out” (3/18). Participant 19 revealed that with the therapy they found it “easier to deal with things” (19/1).

A theme that arose within this category for seven participants involved the sense of the therapy being transformational and therapy integrating with the participant themselves and their lives. Participants used expressions such as “transformative” (14/37–38), “recovery”, “not being the same person” (12/24) and “waking up” (13/6). Participant 10 said that the therapy “felt really life changing for me” (10/41). One person described their counsellor as “brilliant” and explained that the service had totally changed their life (17/11b). This participant said, “I never thought I would be at the stage that I am at” (17/52). Participant 12 captured the joint sense of achievement of therapist and client and spoke of her therapist being “proud for her” as they had come “an awful long way” (12/35).

Three clients within this group expressed the general view that the therapy helped them to stay alive or to live. This was separate from any data relating to reduction in self-harm ideation. Participant 10 said that the therapy was "really, really, important" and that they needed it "to be able to live, really" (10/18). Participant 20 described finding a way to live with negative things and that originally life at the start of the therapy was "not liveable" (20/17e).

Category 1.1.2: Internal/self-related changes

In this section relating to internal self-related changes there was a high volume of and wide range of data which I have detailed in lower headings below in order to describe it effectively.

Category 1.1.2.1

Most participants experienced positive internal self-related changes. Over three quarters (16) of all participants reported a reduction in specific problematic internal experiences (excluding self-harm-related experiences).The responses of nine of these clients related to reduction in unusual experiences These included a reduction in frequency or intensity of hallucinations, unusual experiences, distressing thoughts or increase in connection to reality, even if they did not necessarily see the unusual experiences as problematic. Four of these eight participants specifically reported a change in their voices or hallucinations. For example, participant 11 described hearing voices that were multiplied versions of a voice relating to a specific adult who had violently beaten the participant as a child. The voices repeated the original words of the perpetrator of the abuse. The participant said that the voices became less problematic, less intense and less frequent (11/1–11/5). Participant 14 did not perceive their voices to be a problem but noticed a reduction in frequency of voices during the therapy and commented:

> It happened accidently through my need to go to therapy (participant pauses to reflect) but after having the therapy the voices became very rare – I didn’t have them every day or anything. (14B/96)

This participant went on to explain:

> D: So, I didn’t go to therapy for the voices. (14B/99)
>
> R: But you noticed a change in them.
>
> D: Yeah – because I had greater wellbeing – and I was more tuned in and it was about being more tuned in and connected – connected with my emotions and my needs. (14B/100).

Some participants reported a reduction in other unusual experiences. One reported that “very scary stuff in my peripheral vision went away” (10/5a–10/6).

Three participants discussed experiencing a reduction in unusual or distressing thoughts (category 1.1.2.1.1.2). For example, participant 7 reported a reduction in feelings of being contaminated from her abuse (7/17.3–7/17.4) and two other participants described less unusual thoughts (4/3 and 8/4). Three participants discussed a reduction in feeling that things were unreal: participant 20 described “always hearing and seeing things” but not losing reality (20/21). Participant 9 explained that they felt more connected to reality and said it was like coming out the other side within a process of post-traumatic growth, preferring to frame their process in this way rather than psychiatric diagnosis or medical model terminology (9B/109).

Five client participants experienced normalisation of their unusual experiences and a reduction in feelings of self-stigma (category 1.1.2.1.2). Participant 6 described “Feeling less weird, less different and more self-accepting" (6/6). One participant explained that the therapy left them feeling that "It's alright – these things happen, it's okay to talk about – it made it like you are not a total freak" (10/30f). It is interesting to note that although these five clients all placed great importance on the role of the counselling in this process, being specific about this in their explanations, three of them felt that what they saw as an important change may have occurred anyway, perhaps suggesting that they saw this process as something that could potentially also happen in other non-therapeutic contexts.

More than half of client participants described improvements in their mood or emotional states (category 1.1.2.1.3). Four of these clients felt less depressed or happier. Participant 17 commented, "No, I wouldn't say it's been easy [the therapy] but it's been well worth it. I'm much happier" (17/68). Participant 10 described how before the therapy they were so depressed they felt that it was debilitating, and they were unable to walk to work or attend work but reported that their depression improved (10/3a). 333Four clients experienced a reduction in anxiety, stress or panic. Participant 6 found it easier to relax. They described this change as very much expected, very unlikely without the therapy and extremely important. They explained:

> C: Coming here [therapy] every week relaxes you.
>
> R: Are you saying it's been easier to relax after the therapy?
>
> C: Yeah, yeah.
>
> C: You've emptied all your kind of bad stuff out, right – and it's – you just know you've got this every week and it's like… (6/25–6/26)

Participant 7 described how their therapist talked to them during panic attacks, which eventually stopped:

> C: Used to get dead panicky and have panic attacks. (7/126/)
>
> C: Eventually I would have to get to a certain point where I knew he’d get me through it. (7/128)
>
> R: You knew he’d get you through it.
>
> C: He was talking to me to help calm me down? (7/129/)
>
> R: So, he was just talking to you and that was helping.
>
> R: Is there anything you think was difficult or painful about the therapy that maybe now might be ok? It sounds like you had panics at the beginning.
>
> C: Yeah, I don’t have them anymore. (7/132)

Five clients reported a reduction in anger or agitation or improvement in anger control (category 1.1.1.3.4). Participant 6 reported experiencing less build-up of their anger. They felt that this change was very much expected, very unlikely without therapy and moderately important (6/1). Participant 15 commented, “I think I’ve become less angry” (15/28a) “and more insightful” (15/28b).

Category 1.1.2.2

Over three quarters of the participants reported improvements in their experience of self. This included improvements in self-evaluation, increased self-awareness, more connection with feelings, increased hope and positivity and greater ability to deal with loss or trauma issues. Nine of the 16 participants raised themes linked to improvements in self-evaluation including increased maturity, self-value and respect. Five of these nine participants experienced an increase in self-confidence. Participant 17 described a "*huge* increase in confidence" (17/12) and participant 14 reported being much more confident (14B–24/). Five of the participants expressed an increase in self-value or self-acceptance. Participant 10 said that they became less judgemental and more accepting of both themselves and others and expressed an increase in self-value and became able to spend time and money on self (10/31).

Half of the participants in this study reported an increase in self-awareness or self-depth (category 1.1.2.2.2). This included reports of changes such as increased patience with self and increased connection with feelings. All 10 of these participants reported improvement in connection with themselves. Participant 9 said that therapy solidified ideas that they already had about themselves in a spiritual connection (9/67). A further example involved participant 12, who commented, "I became more fully me – I'd never *been* me. Change was very surprising, somewhat unlikely without the therapy and extremely important" (12/5). A quarter of the sample (1.1.2.2.5) said that they felt less fragile, less vulnerable or more resilient. For example, participant 14 said that even in the face of challenge they felt more solid and whole and as if they had extra depth (14B/27–14B/29). Participant 12 described feeling stronger as a person in identity, and more self-confident. They said that the change was very surprising, somewhat unlikely without the therapy and extremely important (12/4).

More than a quarter of the participants/sample described an increase in perspective (category 1.1.2.2.7). Participant 13 explained that their perspective shifted, and they became more realistic. This change was rated as very much expected, very unlikely without the therapy and moderately important (13/5). Participant 2 said that in the therapy they found it difficult to discuss a relationship, but the process changed their perspective regarding their relationship with an abusive person and realised that they were not at fault (2/21a–2/21b).

Category 1.1.3: Increased positive external connection

Most participants reported an increase in their positive external connection in terms of self-care, coping and connecting with others (as opposed to harmful actions towards themselves or others). Specifically, more than three quarters of participants experienced an increased positive connection to the external world (category 1.1.3.1). Within this category, more than a third of participants revealed that they had noted an increase in their ability to cope. Four of those seven participants discussed general coping; and four of the seven participants who experienced an increase in coping abilities reported improved self-care. For example, participant 4 noted their increase in attention to appearance and added that this change was very surprising, very unlikely without the therapy and very important for them (4/11). Participant 13 gave a similar report, saying, “I look after myself more”. This change was rated as somewhat surprising, very unlikely without the therapy and extremely important (13/4a). Four participants became able to achieve educationally, all completing courses and all feeling that this was somewhat or more unlikely (one participant) or very or extremely unlikely (three participants) without the therapy. Participant 4 completed a degree. Participant 12 explained, “Finishing the course was a huge change for me – I never finished anything” (12/42). One became able to work and one was more able to access other resources.

More than half of all participants saw improvements in their interpersonal connections (category 1.1.3.2). Three of these participants experienced fewer difficulties or conflict with others or were more respectful or less judgemental of others. Participant 10 reported that they were more able to say “sorry” and that this change was very surprising, very unlikely without the therapy and very important (10/11a). Participant 15 also found a reduction in conflict and felt that they had become a better person, treating others more respectfully and understanding them more; they linked this change to a realisation that “no one is perfect” (15/31–15/32).

> Almost half of the participants noted improvements in specific groups of individuals: friends, family and intimate others. Four respondents spoke of improvements specifically with family members. Participant 6 developed a “better relationship with mum”, finding this change very surprising and very unlikely without the therapy (6/4). Participant 12 said that they felt bad that they were ill and did not feel that they were themselves while their children were growing up but that the relationships had improved, and they now had a good relationship with all their children (12/100, 12/101). Four participants experienced improvements in relationships with partners or intimate others. Participant 5 had started a positive relationship with someone they described as “wonderful” and stated “I did need quite a bit of help in my therapy with getting in not so positive relationships and so that’s changed since my therapy”. (5/13) Participant 4 saw a healthier relationship develop with their current partner and found the change very surprising, very unlikely without the therapy and extremely important (4/1).

Half of the 20 participants observed improvements in their interpersonal abilities (category 1.1.3.3). Six of these participants became more able to connect with or trust others. Participant 16 commented, “Yes, I think I learnt more how to have relationships, how to be in relationships and how to manage difficult emotions in relationships really” (16/48a) and found this change extremely important. Participant 7 echoed this position and explained how they had learnt to trust the therapist after a history of trust being difficult. (7/30).

Five participants became more able to complain/be assertive. Participant 12 described how she was in a relationship with a man who was quite aggressive. As she became more assertive, he accepted her as more empowered and the whole relationship dynamic shifted. She said that she progressed from being afraid of him to feeling more equal and “I can give as good as I get – and it seems less necessary” (12/26c). Another participant expressed an ability to speak out more. They described being more able to express their needs and found the change very surprising, somewhat unlikely without the therapy and very important (10/2).

Category 1.1.4: Reduction in risky experiences/behaviours

More than a third of participants reported a reduction in participating in risky behaviours. Five of these participants experienced a reduction in internal sources of risky behaviours and five participants specifically reported fewer ideas of harm to themselves or others. Participant 7 had a history of sexual abuse. She explained that this personal history and its impact on her led to ideas of self-harm and to her trying to get rid of her feelings of contamination from the abuse. She reported reductions in thoughts, firstly of a specific type of self-harm and secondly of suicide, and felt that both changes were extremely important and very unlikely without the therapy:

> C: I guess I don’t feel as suicidal as much as I used to
>
> R: Don’t you? So, is that quite a big change for you?
>
> C: Yes. I used to wash myself in bleach because I was dirty.
>
> R: And are you doing that less?
>
> C: Yes, I don’t do it at all now.
>
> R: So, when you first started seeing N [counsellor] were you feeling very suicidal then?
>
> C: Yes.
>
> R: Was it something you were thinking about quite a lot?
>
> C: Yes. (7/14-7/16)

A fifth of participants experienced a reduction in external risky behaviours (category 1.1.4.2). This included reduction in harm to self or others (behaviour) and reduction in risky lifestyle. Participant 13 described a reduction in risky lifestyle. He explained that four sessions into the therapy he broke a pattern of alcohol addiction and stopped drinking, being able to do this out of commitment to the therapy and because the therapist was accepting of his choices and committed to the work with the client. The participant wanted to honour the commitment and seemed to imply a context of mutuality being important to him within the therapeutic relationship. He stayed awake at night the day after session 4, drank the two cans of alcohol which were in the fridge and never drank alcohol again after that (13/16–13/21). This change was rated as very surprising, very unlikely without the therapy and extremely important (13/1). This participant said, “I know myself a lot better – it would have been a miracle to see this change and without therapy I would’ve ended up dead”. They described the change as somewhat surprising, very unlikely without the therapy and extremely important (13/3). A similar position was adopted by participant 11, who commented, “If I hadn’t had therapy and if I hadn’t seen counsellors – I wouldn’t be here” (11/23).

Category 1.1.5: Physiological improvement

Three participants reported physical improvement. They all reported an increase in energy, with one of them enjoying beginning dance classes. Participant 10 explained, “My energy improved so much through the therapy [after being debilitated with depression] that I took up dance classes” (10/27a). This participant described how the belly-dancing involved doing something for herself that made her feel good and, as she made progress and returned to work on a phased basis, she ended the therapy and replaced the therapy sessions with dance classes (10/27c).

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

A quarter of participants gave examples of therapy episodes where they noted some negative changes. For some of these clients this was their only experience of therapy.

Category 1.2.1: Negative global change: Things got worse/felt worse

Three of the five clients who noted negative changes reported global or general negative changes. Some of these clients also had some positive experiences or changes in the same therapy episode, sometimes showing a complex picture of mixed experiences and outcomes.

Participant 15 experienced both global and specific negative deterioration. They felt that the therapy was too infrequent and that there was insufficient time “to fit things in”. They stated that they would have preferred several sessions each week instead of one. This participant client had mixed experiences of the therapy, with some negatives and positives. They explained that they had more than one issue and felt that they deteriorated and “ruminated more”, generally spiralling downwards (15/9–15/12c).

Category 1.2.2: Negative specific change

Four of the five clients who described negative changes experienced specific negative changes, which in some cases supplemented reports of negative global change. Participant 9 had experiences fitting both categories. Negative specific changes were the temporary loss of faith in the PCT approach; reduction in intimacy with a partner; increased suspicion; and increased ruminations. Participant 9 described negative and positive aspects of two therapy experiences. In one therapy they experienced both global and specific negative changes. They said that they felt judged by the therapist and this resulted in the participant losing faith in the person-centred approach (9A–183). This participant described “therapy A” as “bloody awful” and went on to say, “in fact I’ll be honest with you, I felt worse coming out after 20 sessions than how I felt going in” (9A–179); and, “well, a damn site worse… just totally… loads worse, judging me – totally judging me” (9A–186).

Sub-domain 1.3: No change/missing changes

Four client participants experienced either no changes (one client) or missing or insufficient changes to satisfy them. Of these, two participants wanted to experience a complete recovery (category 1.3.1), while wo participants wanted the change to happen more quickly *(category 1.3.2)*.

Domain 2: Helpful aspects

Domain 2 consisted of helpful aspects of the therapy, including client, therapist and contextual aspects (see Table 3.2)

Table 3.2

Domain 2.0: Helpful aspects (for details see Appendix D1)

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

2.1.1 Helpful client personal attributes

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

2.1.3 Helpful client circumstances/situation (situational resources)

2.2. Helpful therapy contributions

2.2.1 Helpful contextual therapeutic parameters

2.2.2 Positive in-session/therapy processes

2.2.3. Positive immediate within-therapy effects

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

2.3.1 Helpful CBT

2.3.2 Helpful dreamwork

2.3.3 Helpful groupwork

2.4 Difficult/painful but okay/helpful aspects of therapy

Sub-domain 2.1: Helpful client contributions (outside of therapy or brought into therapy)

Most participants discussed helpful contributions that were brought into the therapy, such as qualities of the client, self-help activities taking place in the wider context of the client's life, or support from other people or resources.

Category 2.1.1: Helpful client personal attributes

More than half of the 17 client participants who named helpful client contributions described personal attributes of their own, which had been helpful to them. This included flexibility, belief systems, openness and maturity. The client's own determination, stability and positive attitude were also discussed as helpful to them. A few discussed the positive impact of their own self-awareness and self-reflection; participant 8 said, "I'm very analytical and think things through and it helped the first two changes" (8/71).

Over a quarter of participants discussed determination or perseverance as a helpful client attribute (category 2.1.1.5). Participant 13 described how they showed determination, commenting, "The PCT therapists have both made me realise I've got qualities and how determined I am" (13/38). They went on to describe their commitment to work hard, face the challenge and be real in the therapy: "You can't be cardboard cut-out. A therapist is not going to wipe your arse for you – it's hard emotional work" (13/50). This participant felt that if the client gave "bullshit" then it was pointless (13/51).

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

Eight clients reported self-initiated self-help activities or coping strategies, which included singing, writing a journal and mindfulness techniques. Participant 9 developed techniques for helping themselves to manage problematic voices in their head:

> C: I can't quite remember if it tied in with that. I can remember walking down the street and having like voices in my head – as part of my subconscious – saying "kill that person over there".
>
> R: Like instructional voices.
>
> C: Yeah – very unpleasant.
>
> R: Yeah – sounds very unpleasant.
>
> C: I tried to block it out like, thinking, for fuck's sake – this is ridiculous.
>
> R: So, there was another part of you rationalising it—trying to block it.
>
> C: Yes, rationalising it – and sort of like – being on the ball like that, you know?
>
> R: Yeah. So, you were like fighting it really.
>
> C: You are bloody right. I developed this technique and it was like yoga – and it was like putting a carpet under my foot.
>
> R: Mm m.
>
> C: It was almost like – you get these mindfulness techniques. (9/38-9/39)

Category 2.1.3: Helpful client circumstances/situation (situational resources)

Eight clients discussed helpful situations, contexts such as housing, or other people. A few reported that family members were helpful. Participant 7 felt that both their family and husband helped them (7/91). Several clients found that their links and support networks in the wider community were helpful. Examples included help from a spiritual network and help from a work setting. Participant 3 said that their job was “stopping the other problems getting through” (3/14b).

Sub-domain 2.2: Helpful therapy contributions

Three quarters of participants discussed helpful contributions such as contextual therapeutic parameters, therapy processes within sessions and positive immediate within-therapy effects.

Category 2.2.1: Helpful contextual therapeutic parameters

Seven participant clients disclosed examples of helpful contextual parameters. This included perceived therapist similarities to the client in terms of culture or unusual experiences, holding boundaries, using the space or time in helpful ways and being treated sensitively when “bumping into” the therapist outside of therapy. Several participants commented on their experiences of the therapist’s helpful use of time or organisation of sessions. Participant 7 said that organising the extension of the length of some sessions had been very important to them as prior to this arrangement they had found it very difficult to begin to talk about issues of abuse until the very end of a standard-length session. Therefore, more therapeutic work was possible with the longer sessions until the participant was more used to talking about this difficult material.

Category 2.2.2: Helpful in-session/therapy processes

Three quarters of all participants reported helpful in-session therapy processes such as being able to discuss traumatic events. Four of these participants discussed global helpfulness within the therapy relationship, including the relationship quality and atmosphere.

Almost half reported helpful relational aspects they experienced within the therapy (category 2.2.2.2). This included their perceptions of there being a strong alliance, and the therapist being warm and sympathetic. Seven participants within this category described the non-judgemental and accepting attitude of the therapist as helpful, and examples of this included not being interpreted, labelled or diagnosed and being open and “themselves”. Of those seven participants, four spoke explicitly of the therapist’s acceptance. Participant 10 described how the therapist accepted their unusual experiences and the client’s fear of them.:

> C: Just having that – being accepted – the total lack of judgement… (10/20a)
>
> R: Hmm mm.
>
> C: …was really, important. (10/20b)

The participant later went on to describe the impact of this.

> C: And it became an environment where I could talk about anything. (10/22)
>
> R: So, it sounds like it was very liberating.
>
> C: Uh huh.

C: And supportive as well. (10/23)

R: Yeah.

Participant 12 spoke of the impact of acceptance on them.

C: It *was* healing. (12/39a)

C: The healing part was the complete acceptance. (12/39b)

R: You felt completely accepted [by the therapist].

C: Absolutely. (12/40)

More than a third of participants described positive in-session therapist qualities including feeling valued, feeling attended to, positive commitment, genuineness and empathy (category 2.2.2.5). Three of these seven participants described their positive experience of feeling that the therapist cared about them. For example, participant 13 reported that they felt that they mattered to the therapist, unlike their experience of a psychoanalytical therapist where they felt like it was “business”. They said that feeling that they mattered led them to feel for the first time that they wanted to reciprocate and were committed to making a change in breaking an addiction to alcohol, which they followed through successfully (13/36–13/37). Participant 13 disclosed that the therapist being real, authentic or genuine in the relationship was important or helpful. They said that there was “no room for bullshit” (13/32).

Participant 10 shared their experience of noticing a change in her therapist’s body and posture, wondering if she was pregnant and asking her. The participant had worried about this because they had been ignored after making a personal remark to a previous psychodynamic therapist; but the PCE therapist was apologetic about not naming this previously as there were now “three people in the room”. The participant felt that the therapist revealed herself as human and not fake, and that it was a meaningful experience as the therapist was real and open about her possible misjudgement. This participant commented, “It was – it was like she was an actual *person* – not just a counsellor” (10/46).

Half of the participants reported helpful therapist actions such as pacing, tracking and reflecting and referral (category 2.2.2.6). Four of the ten participants in this group found that the therapist not pressurising them, and not pushing them to move forward or discuss traumatic topics until they were ready was helpful. Participant 6 commented, “This [the counselling service] is one of the few places where there won’t be pressure” (6/31). Participant 5 also mentioned this:

> R: What do you think has caused the various changes? And it can be in therapy and it can be out of therapy.
>
> C: Being given the time and the space – I’ve been doing this because I’ve wanted to, and it’s been at my pace – which makes it lot easier to do.
>
> R: Your own pace.
>
> C: It’s not like there are expectations on me to be achieving certain things by a certain time – I think particularly because it is relatively open-ended. It’s not like six weeks and you are done. You don’t feel under pressure to achieve getting better. You can just get stuff out on the table and kind of shift around a bit and then go out if you don’t feel well and come back and stuff. (5/20–5/21)

Three clients discussed the therapist's openness or use of art, creative process, symbolism or metaphor (category 2.2.2.7). Participant 10 described how the therapist picked up a map analogy that she was using, reflecting back:

> C: Yeah, and because of that it helped me to make sense of things and it helped me to normalise the absolute pit of depression that I ended up in.
>
> R: Mmm.
>
> C: Because I could place it on a map and consider it like charting unknown territory.
>
> R: Sounded like you were on a kind of voyage.
>
> C: And it was like referencing maps and making maps – helped me to be okay with this awful depression – it was like using a language and talking to me in a way that made a lot of sense to me and that was – I still remember it really well. (10/53)

Category 2.2.3: Positive immediate within-therapy effects

Eight participants described immediate within-therapy effects including feeling understood and being able to release stress. Four participants in this group specifically discussed improved coping with stress in the moment or stress relief or releasing stress in sessions. Participant 6 explained that, "every Tuesday I come to therapy and I can unload a bit" (6/14). Participant 7 described how the therapist would be with them while they experienced panic attacks in the sessions and talk to them and stay with them, and it helped her to calm down (7/129–7/130).

Sub-domain 2.3 Other helpful treatments/other helpful therapy (non PCE)

Several participants reported experiences of other helpful treatments such as CBT, dreamwork and groupwork**.** Thus, two participants described helpful experiences of CBT, for example, participant 8 simply commented "CBT really worked for me" (8/55) and participant 15 found that both PCT and CBT were helpful in helping them to reach their own solutions. On the other hand, later categories (3.4.1) also showed less helpful experiences of CBT. One participant found dreamwork helpful but did not explain further. Participant 8 described the benefits they experienced from attending group therapy. They commented, "Looking back, I was quite keen on killing myself and I realised other people had problems". This participant said that their perspective and their understanding of the human experience shifted, and their suicidal feelings reduced (8/67).

Sub-domain 2.4: Difficult/painful but okay/helpful aspects of therapy

Half of the client participants described aspects of therapy that were both helpful and painful.

Participant 2 said that they found the therapist exhausting (2/5). They explained that they had had a relationship with an abusive man and although it was very difficult to talk about in therapy, the therapist helped them to see that the abuse wasn't their fault. Eventually the participant could talk about those difficult experiences without pain (2/21b–2/23). Participant 5 discussed their experiences of painful but helpful therapy:

R: What things were difficult or painful about the therapy but are now okay? (5/35)

C: It was difficult to have all the different parts of me come out – in the room – and just to be. (5/36)

R: They're okay now?

C: Yes.

Domain 3: Unhelpful aspects

Domain 3 which is displayed in table 3.3 contains data relating to client participants specific experiences of therapy which they viewed as unhelpful.

(for details see appendices C1 and C2 in Volume 2)

Table 3.3. Domain 3.0: Unhelpful aspects

3.1 Client negative contributions (interfering factors)

3.1.1 Client personal attributes with negative effect

3.1.2 Unhelpful client circumstances/situation/others

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

3.2.3 Unhelpful immediate within-therapy negative effects

3.3 Missing aspects/processes of therapy

3.3.1 Missing information about therapy

3.3.2 Wanted structure/goals/progress tracking

3.3.3. Missing relational qualities

3.3.4 Wanting other additional treatment/links

3.4 Other unhelpful treatments

3.4.1 Unhelpful other therapy (non PCE)

3.4.2 Unhelpful medication or psychiatric treatment

Sub-domain 3.1: Client negative contributions (interfering factors)

This category involved 60% of all client participants (12), who reported negative client contributions to the therapy such as hindering personal attributes, unhelpful situations or unhelpful others. This data was composed of two lower level categories which are explored below.

Category 3.1.1: Client personal attributes with negative effect

Eight of the client participants who mentioned negative client contributions specifically discussed client personal attributes that included worry or fear, lack of perspective, over-confidence, difficulty achieving safety with others, guilt, suicidal or self-harming feelings or behaviours, and seeking unnecessary resources. Each of these items was described by just one or two participants.

For example, participant 6 described how their “overthinking”, “hyper analysing” and jumping between issues rather than retaining a focus impeded their progress whilst participants 8 and 2 fought feelings of guilt around accessing support.

Participant 7 described how they had become a “loner” and that trust was a huge barrier to engagement in therapy as they had learnt that they could only depend on themselves, but they did eventually build trust in the therapist. (7/60-7/69).

Category 3.1.2: Unhelpful client circumstances/situation/others

Seven clients described global or specific life circumstances such as poor finances, stressful job or lack of support from others, generally or specifically family or friends.

Three of these participants discussed unhelpful experiences with friends, which included issues such as lack of support, presence or understanding, or pressure to conform to expectations. Participant 1 commented that “friends being judgemental or horrible if I do not do things makes it harder”. This participant explained that if they said they did not want to go somewhere with friends (due to being emotionally unwell), they did not understand, and they made remarks such as “don’t be stupid” (1.1/25a). Participant 13 reported that they felt raw at times, and without the support of friends who the participant felt were waiting for him to fail (13/43–13/44). A few participants discussed the absence of support or unsupportive behaviour from others in their wider networks beyond family and friends. Participant 2 discussed the impact of stigma on the lack of support they received generally from others and commented, “some people treat you differently [negatively]; some don’t care [re: bipolar]” (2/15). Participant 13 felt that the lack of support from others slowed down their progress with issues of anger [13/44].

Sub-domain 3.2: Unwanted/unhelpful therapist contributions

Seven participants discussed unhelpful counsellor contributions; no participants discussed negative client contributions.

Category 3.2.1: Unhelpful contextual therapeutic parameters (e.g. room, spacing, timing, service)

The named negative therapist contributions included unhelpful contextual parameters such as use of time or setting, in-session process events and unhelpful actions or processes initiated by therapists, and unhelpful processes or actions initiated by clients. This issue was raised by two participants.

Category 3.2.2: Unhelpful in-session/therapy processes

Five participants discussed unhelpful in-session therapy processes. These included general unhelpfulness and a deteriorating quality in therapeutic relationship. The largest subset of this group comprised the four participants who reported unwanted therapist actions such as judgement or criticism, and all four of the participants in this group reported unwanted therapist directivity. The unwanted directivity described included areas such as the therapist over-focusing on emotions, putting pressure on the client to connect to painful feelings, imposing expectations, exerting power, stating the obvious or introducing an unwanted activity. For example, Participant 10 discussed examples of what she experienced as unhelpful perceived power being exerted by the therapist. She went on to explain how she experienced the therapist exerting power:

> C: Okay – there were things that were not spoken about – little things– that I never mentioned, and that the therapist never mentioned.
>
> R: So, are you saying there were things kind of there – present but unnamed?
>
> C: Well they were for me—I don’t know if they were for her.
>
> R: But you had a sense.
>
> C: Yeah, to be a little bit specific I remember there was once or twice where I misjudged time and turned up a few minutes late.
>
> R: Hmm.
>
> C: And she never saw me immediately.
>
> R: Right.

C: And I wondered – is this a *thing*?

R: Right.

C: Is this like a power thing or is it that she is just not ready for me? I was never brave enough to ask.

R: Yeah – whether she was giving you a message…

C: Yes. (10/51)

Category 3.2.3: Unhelpful immediate within-therapy negative effects

Just one participant discussed unhelpful immediate within-therapy negative effects.

Participant 15 described how the therapy was painful and made them realise how empty their life was. They regretted continuing with that specific therapy and commented

“I got as low as I could get, and I should have put in building blocks” (15/19)

Sub-domain 3.3: Missing aspects/processes of therapy

Six participants reported aspects of the therapy that they felt were missing. The responses fell into three groups, focused on: missing information about therapy; wanting a structure or to work to goals and the wish for additional other treatment.

Category 3.3.1 Missing information about therapy

Several participants felt that there were missing aspects to their therapy. The named missing aspects included wanting the therapist to reveal their theoretical modality and qualifications, to be given a contact card and signposting to other resources. Participant 9 commented that they wished that the therapist had explained their approach to them: “More helpful – I’d say – for both orientations for the therapist from the very beginning to explain from the onset and make it known to the client (i.e. myself) what the therapy is about – even if they explain it, ‘you might not catch everything I’ve said but do feel free to ask me a bit later on’ – if you’re not certain about the approach or anything” (9–220/). Participant 13 found it problematic that they could not contact their therapist after the therapy ended. They had access to a helpline but had no network and thought that the therapist might not have been aware of this (13/58–13/59).

Category 3.3.2: Wanted structure/goals/progress tracking

Three participants wanted more structure, planning or tracking of change (progress or deterioration of the client’s distress). Participant 5 described how they wanted an agenda:

> R: Has anything been missing from your therapy; so, in other words, what would’ve made your therapy more helpful/more effective?
>
> C: I’d like to say structure – some kind of idea of where it’s going – I don’t know if that’s… or not. (5/37)
>
> R: Can you just give me a little bit more on that?
>
> C: Having it down clearly – what would we be doing – what would we be working on.’ (5/38)

Category 3.3.3: Missing relational qualities

Two participants discussed five examples of missing relational qualities such as wanting the therapist to offer more challenge and perspective, and to be more "in tune" (9/91) with the client.

Category 3.3.4: Wanting other additional treatment/links

One participant wanted other additional treatment/links and wanted a rest in an "asylum".

Sub-domain 3.4: Other unhelpful treatments

Seven participants discussed other treatments (aside from the PCEP therapy of focus) that they found unhelpful. This category included other unhelpful therapeutic treatments and medical interventions or medication.

Category 3.4.1: Unhelpful other therapy (non PCE)

Four participants reported unhelpful other therapy. Participant 16 recalled two sessions of psychodynamic therapy, which they experienced as a blank-screen approach and found unhelpful. They said that they felt particularly anxious and not relieved. This participant commented on how they experienced the therapist and the unhelpful power dynamic:

> C: I remember when I first saw her (the psychodynamic therapist), I said, "Hi, how are you?" just as a…
>
> R: Yeah.

C: …thing that everyone tends to say – and she didn’t answer me.

R: Right.

C: She didn’t respond at all and I felt really small. (16/11–16/12)

Participant 13 described their experience of psychodynamic therapy as “the most destructive – like playing games – like mothers and fathers” and reported that it didn’t work for them. They recalled how the therapist would write letters to which the client participant didn’t have access until they requested them later, and the participant felt that the therapist had a set path regarding how therapy would run, despite how the client was (13/20).

Category 3.4.2 Unhelpful medication or psychiatric treatment

Four participants highlighted unhelpful medical interventions, such as withdrawal symptoms from antidepressants, suicidal ideation as a side effect of medication and distress triggered by pressure to conform to drug treatment from medical professionals. For example, Participant 6 criticised the mental health system and commented, “the psychiatrist was like a robot – horrible people, scary people” (6/21). Participant 17 described how psychotic process reduced as they proceeded with therapy and reduced their medication (17/7–17/10).

3.10 Study 2: Interim discussion

I will now consider prominent features of client experiences which are apparent in the qualitative and quantitative data and consider how they may relate to the literature in terms of research and theory. I will also consider possible implications for practice.

These themes will be integrated into the final discussion and conclusion in Chapter 5 where the findings of all three studies will be explored and compared.

Domain 1: Changes

Most clients reported positive change, either generally or in terms of specific changes. Three quarters of client participants experienced a reduction in specific problematic internal experiences (excluding self-harm-related experiences). Nine of the participants saw a reduction in unusual experiences, such as positive change in hallucinations, unusual experiences or distressing thoughts, or an increase in their connection to reality, regardless of whether they viewed the unusual experiences as problematic, whether they told the therapist about these experiences, or whether they worked on them in the therapy. This links with a theme which emerged in Rundle’s (2017b) doctoral research which involved a study of adults who heard voices experiencing PCT and produced a data thread entitled "it’s not all about the voices” (i.e. not symptom focused). The therapeutic journeys of participants with such experiences were often described as focusing on deeper underlying issues – such as trauma relating to abuse – but nonetheless in what they described as a good therapeutic relationship they saw changes in such experiences, as well as other positive changes such as an increase in sense of self or self-integration. This is a particularly interesting finding as it links to studies such as Read, Rudegeair & Farrelley (2006) and Reiff, Castille, Muenzenmaier & Link (2011) which suggest that voices and other unusual experiences are often linked to early traumatic life events and that real relationships can be helpful.

PCE therapy typically focuses on the therapeutic conditions and real alliance rather than being problem-focused or symptom-focused, other than where the client takes the journey.

A quarter of clients mentioned reduced self-stigma and less fear of “being mad”, which also arose in the practitioner study (Study1). This raises the importance of the wider context of clients with psychotic processes and how therapy may support the reduction in internalised judgements from society, where there still exists a fear of mental health issues and media stereotypes of “madness” that, for example associate it with dangerousness. The supportive and accepting therapy relationship that normalises unusual experiences as human experiences rather than seeing them as symptoms, but does not minimise them, and that accepts the person even if such experiences are not raised in the therapy, may be helpful in the person’s self-acceptance. (These findings seem to compliment literature explored earlier including Rogers theories as well as more recent reflections by Shlien, (2003) and ideas explored earlier in the literature search regarding normalisation and de-stigmatisation, as well as Mearns and Thorne’s (2000b) theoretical position regarding configurations of self.

Thirteen of the client participants noticed improvement in their emotional state. In this category a quarter of all participants in the study saw improvements in coping with anger or agitation.

Over three quarters of participants saw improvements in general experience of self. This was therefore a key finding in this study. In self-evaluation, eight of the 16 participants in this group reported increased self-confidence (affecting a quarter of all participants), increased self-value (a quarter of all participants), increased self-respect and higher values. Half of the entire sample increased in self-awareness or depth, including almost half of the sample feeling more self-connection. A quarter of participants felt less fragile and more than a quarter of all participants experienced an increase in perspective.

Increased positive external connection was experienced by over three quarters of participants which shows similarities to study 1 where this was also a strong feature of the data. In study 2 this category included self-care and the ability to engage with work and education, with a third showing increased coping, suggesting examples of changes leading to increased independence. More than half of the participants showed increased interpersonal connection, including several who engaged in less conflict. Almost half of all participants improved connection with specific groups and around a third of participants reported increased social skills, with a quarter more able to be with or trust others. Considering the difficulties of trust which were often disclosed by vulnerable clients who had often experienced being let down or violated, it is interesting that trust became more possible for some clients either with the therapist or others, which feels like a hopeful outcome and part of a recovery journey.

Literature in Chapter 1 referred to Rogers' position (e.g.1951) that the real relationship with the client in therapy is a model of both self-expression and a positive relationship and interpersonal connection with others and that despite inevitable barriers in connecting clients in this study saw real improvements in self-connection and social skills.

Four fifths of all participants experienced a reduction in internal or internal risk-related behaviours and thoughts, including lifestyle risk as well as ideas or actions related to self-harm or suicide.

Domain 2: Helpful aspects

The issue of clients being active in their own change process was frequently discussed.

Most client participants recognised helpful contributions that they brought into the therapy or while they were active outside of the sessions, with over half of all participants naming helpful attributes such as being flexible or belief systems. Determination was named by a quarter of participants, self-help strategies by eight, and contextual issues or situational resources including people or services by eight.

Three quarters of all clients discussed helpful therapy contributions, with a third stating that contextual factors were helpful, such as the way sessions were organised which links to outcomes in Study1. Three quarters of all participants named helpful therapy processes, with almost a quarter naming global helpfulness and almost half reporting positive relational aspects. Person-centred values and Rogers' conditions featured strongly in this data set, with almost half of clients naming positive relational qualities offered by the therapist. UPR was reported as the most frequently named helpful core condition (by over one third of client participants), linking to Rogers' conditions for therapeutic change (1957,1959).

Half of all participant clients found aspects of the therapy painful but helpful and were able to discuss traumatic or difficult issues with benefit.

Domain 3: Unhelpful aspects

When asked to describe any unhelpful aspects of therapy, more than half of the client participants described client factors that had negatively impacted them. Eight of these unhelpful client factors consisted of interfering personal attributes, such as fear, guilt or overthinking. More than a third of participants felt that unhelpful life circumstances such as poor housing, financial issues or lack of support affected them negatively.

Unwanted or unhelpful therapist contributions were reported by over a third of participants. A quarter of participants mentioned unhelpful in-session processes such as poor alliance, and a fifth of participants named unhelpful therapist actions such as directivity, exertion of power or expectations of the therapist.

Over a quarter of all participants reported what they felt to be missing aspects or processes of therapy. There were various responses, with several clients wanting more information about the therapy and several wanting more structure and tracking. This latter point is interesting as it can be common for PCEP therapists to feel reluctant to work within structure; but with the growth of outcome climates, client satisfaction surveys and pluralistic approaches (Cooper & McLeod,2007) an element of structure may help to focus the therapy as the client would wish.

Over a third of client participants discussed unhelpful treatments, including other therapeutic models such as CBT or psychodynamic therapy, with four participants having difficulties with medication itself or pressure to comply with medication as treatment.

Clients evidently viewed themselves as quite active in the process of therapy. We could consider whether this was a typical sample of clients with psychotic process. The sample of clients were active research volunteers, so this raises the question of whether this mean they were more likely than on average to commit to actively working or if this is this a typical outcome for this client group.

Limitations

This study has limitations such as the fact that clients in the study chose to participate in the study (self-selection) and so probably were a biased sample. A further limitation involves study’s reliance 3on the accounts of participants during and after the therapy sessions or episodes rather than using measures within the therapy process itself. Participants may also have wanted to please the researcher or have been compliant in some ways, affecting their reporting.

This was a small-scale study with variation in client presentation and treatment. There may have been researcher bias, as previously discussed and placebo effect of psychotherapy (Grünbaum, 1981,1986; Jopling, 2011; Blease, 2018) as well as other factors impacting change. Despite these limitations a sample of twenty clients was sufficient to produce rich data and show some interesting outcomes.

Concluding Comments regarding interim discussion

In conclusion it appears that the most significant findings in this study (study 2) were where clients widely reported positive global change, improvement in self -coping with problematic experiences, improvements in social interactions and full awareness of their active role in both contributing actively to the therapy as well as recognising their own barriers. Clients often highlighted person-centred values in their comments. Comments relating to helpful practice included the need for a flexible approach where they felt heard by a therapist who was genuine and present. Data showed that clients wanted to work at their own pace, deciding how close to connect with upsetting or traumatic material and only disclosing material if they felt ready. Exploration of painful material could be helpful if not initiated under pressure.

Chapter 4

Study 3: Person-centred experiential therapy for hearing voices, unusual experiences and psychotic process: A hermeneutic single-case efficacy design study

4.1 Introduction

4.1.1 Background and Overview

The type of case study design which was used in this case is the Hermeneutic single case efficacy design (HSCED). HSCED is a mixed method case study design that is based on a legalistic framework. The HSCED method has been modified since its original form and is still being developed. This HSCED study is of a person-centred experiential therapy with a client (pseudonym of "Becky") who was experiencing psychotic process. The study follows standard HSCED goals of evaluating pre–post client change, the possible causal role of the therapy and the processes of change.

Becky was a woman aged 19 years with psychotic process who received 22 sessions of PCT and is the subject of this study (Study Three) which is a case study. Becky was a vulnerable young woman with complex difficulties and issues around loss and challenging family dynamics. On presentation she was sometimes hearing voices, noises and other unusual ideas and perceptions. She described feeling unreal as well as having thoughts of suicide and harm to herself and others. These experiences were in themselves both frightening and distressing for Becky as well as triggering other difficulties for her and causing her to withdraw from social engagement. Such experiences can be acute or chronic and cause problems in multiple areas of functioning as well as being traumatic. Social functioning may be compromised, and, as previously discussed in Chapter 1, social stigma exists that may be a barrier to seeking help. In Becky's case there had been increasing difficulties for years but at referral she was at a point of crisis and referred to therapy by her family.

The HSCED process involved a set of procedures which over time have been refined. A case was constructed around a Rich Case Record, Affirmative Brief, Sceptic Brief, and Affirmative and Sceptic Rebuttals. These documents were examined and systematically evaluated by five judges. The judges reached conclusions regarding whether the client had changed, whether the therapy had impacted or caused the change, and the degree of change.

Change processes due to the PCE therapy and the client's own resources may both be considered to impact significantly/other on overall change.

The research question posed in this HSCED is whether a client, "Becky", with complex needs including psychotic processes experienced change as a result of person-centred experiential psychotherapy and whether the change was substantial. The implications of the findings in relation to theory and research context and their possible implications for both practice and further study will be considered.

4.1.2 HSCED in the context of research design

HSCED is a recently developed type of single case study design, which sits within the wider context of the case study method. A case study is a strategy of empirical investigation that can focus on one or a few subjects or phenomena in a real-world context using multiple evidence sources (Robson & McCartan, 2016, p. 150). There should be consideration of the generalisation of findings to wider application. The focus of the case study may be a person, a setting, a process (such as the implementation of a policy in a specific context) or a specific subject (Robson & McCartan, 2016).The term case study has been used loosely with different meanings but has been redeveloped by Yin (2004, 2009) who has helped to build upon the understanding of the principles of rigorous case study design.

4.1.3 HSCED and context of evidence-based practice and research

In the current UK climate, emphasis is placed upon evidence-based practice (the systematic development of evidence). This approach is endorsed by key health care providers and supports the delivery of cost- effective treatment with “proven efficacy” to agreed standards. This is based on a sufficient amount of approved robust evidence, which is usually quantitative in nature. Qualitative research in psychotherapy has struggled to gain respect and weighting when compared to what may be deemed more robust studies.

Alongside a genuine need to develop and improve effective practice there has evolved a growing clinical context of defensive and fear-driven practice with a litigation culture and increased need for accountability. This rests in a UK model transposed from a medical treatment context, which may be somewhat clumsy when applied to counselling. Shean (2014) explains how RCTs do not reflect the “multi-faceted nature” of many mental health problems and the complexity of surrounding factors. Shean’s view is that RCTs present flaws with sampling and the presentation of outcomes in the form of uncomplicated symptoms. Stiles and Shapiro (1989,1994) reinforce this stance by highlighting the problematic position of conducting psychotherapy research as if it is a medication-based active ingredient treatment affecting client change. However, Silberschatz (1994) criticised the position taken by Stiles and Shapiro as well as the common perception of RCTs being misguided or naïve. Silberschatz felt that methodological advances would be better focused on developing more precise ways of measuring client progress in psychotherapy instead of more general outcome measures.

Respected evidence for health care in the UK, such as that approved as “gold standard evidence” by the National Institute for Health and Care Excellence (NICE) involves RCTs that can be replicated. Case studies are regarded as lower rated evidence, not producing reliable data that would impact on guidelines. The reputation of case study design has been problematic (McLeod, 2010); studies have been viewed as biased towards the model of therapy delivered or providing inadequate information (McLeod, 2013) and are viewed as limited and less robust than other RCT research designs.

Kazdin (1981) and Cook and Campbell (1979) influenced steps towards understanding case study design and what might be involved in more robust case study research. Kazdin (1981) unpicked the strengths and difficulties of case studies. For example, he pointed out that if only one or two instances are examined it may be difficult to infer that change is attributed to the treatment that is under scrutiny and that internal validity or reliability may be limited. Kazdin (1981) highlighted how in many instances it is the reliance on anecdotal evidence that is a key factor in rendering the case study method weak in terms of drawing conclusions or generalisability, and not the case study design itself. Attributing change to treatment rather than other factors can be very difficult to ascertain. Shadish, Cook, and Campbell (2002) stated that all causal relationships are not deterministic and are dependent on context, which raises the issue of limitations in the generalisation of treatments or effects (p.5). The definition of change in the context of psychotherapy is itself without consensus. Strupp (2013[1963]) discussed how exploring the idea of symptomatic recovery is feasible in research but that wider definitions of increased functionality such as “achievements of sufficient insight to handle ordinary psychological conflicts and reasonable reality stresses” may be more complex to capture in terms of data. Stiles (2013) explored the difficulty of operationalising outcome.

Bohart & Tallman (1999) pointed out that counselling itself does not “cause” clients to change. They used illustrative case examples and literature to explain how clients, as active agents, utilise therapeutic treatment opportunities to affect change themselves and may feel affirmed by the therapy supporting them to take charge of their own change process. They described how change is also affected by relationship, placebo, natural healing and other factors. Psychotherapy clients do not fit neatly within a medical model of treatment and outcome (as with some physical illness treatment paths) but rest within a more complex situation.

Kazdin (1981) explained that heterogeneity can influence strength of claims regarding the influence of treatment on change if several clients show different demographics or factors that may imply generalisability of outcome. Kazdin also considered the difficulty of establishing change when the course of an issue or its stability may be unknown. However, he concluded by emphasising the importance of case study research in developing hypotheses in relation to innovative treatments and urges that we should endeavour to increase their strength. This is exactly the kind of pathway that Elliott

(2001) has developed in terms of developing more robust case study designs and protocol.

This UK emphasis on the NICE minimum standard for robust evidence necessary to warrant impact on guidelines for specific difficulties in client populations may bring positive emphasis on ethics, safe practice and regulation. However, difficulties and limitations arise in endorsing new practices or where non-approved evidence of efficacy exists in the form of data from research other than approved RCTs. The paradox of protecting clients with robustly researched interventions as well as allowing room for the growth of new research relating to new or existing non-recommended approaches is a delicate balance. This issue has already been discussed in Chapter 1 in relation to all three studies presented here on PCT applied to psychotic process. A further debate exists around hierarchies of methodology and the justification of the relative weighting of these. The HSCED method was selected and applied within this context of critical responses to qualitative methods and case study approaches. HSCED is a more systematic way of gathering case study data than traditional psychotherapy case study methods and may be more robust to scrutiny.

Elliott (2002a), who has conducted trials and a wide range of research, has highlighted the limits of RCTs despite any merits. He referred to the RCT as a “blunt instrument” and as having “causal emptiness”. Elliott argued that RCTs do not investigate or demonstrate causal process. RCTs examine a data set as a whole and cannot claim causal inference for a single case. RCTs also have limitations in their ability to reflect or represent the complexity of the psychotherapy change process. This idea has been discussed by Bohart and Boyd (1997, p.3), who looked at the concept of hard causality with a “mechanistic linear causal relationship between the application of a technique and outcome” as expected from an RCT but point out that in psychotherapy a more complex process links intervention to outcome (“soft” causality).

Bohart and Boyd (1997) and Bohart and Humphreys (2000) explored the construction of more robust case study methods that involved legalistic processes and incorporated adjudication. These studies were a source of inspiration for the development of adopting a hermeneutic approach and more specifically the HSCED method. Quasi-judicial methods such as Miller’s (2011) Panel of Psychological Inquiry (PPI) was also influential in the development of the HSCED method.

4.1.4 Hermeneutics

McLeod (2010) explained that hermeneutics refers to the process of interpreting a complex text to make sense of it. Hermeneutic or interpretative methods have been applied in legal, historical and theology spheres and involve sensitive interpretation with an empathic understanding of the text within its context. McLeod explained how the method involves continual movement through a hermeneutic circle or cycle, involving sections of text being considered in the context of the entire situation and then interpreting the entire text. According to McLeod the hermeneutic process should be embarked upon with openness and may involve interpretive phenomenological analysis (IPA) or grounded theory as a method of text interpretation within this framework.

Rennie (1998) developed methodological hermeneutics as a potentially embodied experience with this approach enhancing the process of categorisation. This approach as interpreted by Rennie and Fergus (2006) integrated important influences which include

Gendlin (e.g. Gendlin,1991) whose focus was on how people consciously referred to embodied experiencing when symbolizing the usually pre-conceptual level of experiencing of their situations and Lakoff & Johnson (1999) whose idea of reality was linked to cognitive image schemata. Rennie and Ferguson concluded that "paying attention to embodied experiencing while conceptualizing the meanings of experiences of other individuals, as given in transcribed reports of them, prompts the emergence of such categories and seemingly helps to provide a sense of their adequacy" (p 495).

Elliott developed Hermeneutic Single Case Efficacy Design (HSCED) (Elliott 2001; 2002a) and built on this design with others as cases were completed. Modifications were added to improve the effectiveness of the method (Elliott et al., 2009; McLeod, Elliott & Rodgers, 2012; Stephen, Elliott & McLeod, 2011).

The HSCED method in its earliest form was a legalistic-like process that involved a therapist conducting the method in relation to their own client, to investigate if there was causal change and other impacting factors. Elliott told me that early in the process of developing the HSCED method he consulted his father who was an attorney. This consultation regarded the discussion of legal processes and the parallels being formed in the robust psychotherapy case study procedure that Elliott was developing in the HSCED method. The goal was to reach a point beyond reasonable doubt regarding the effectiveness of the therapy in relation to substantial outcome, as one would in a court process. The method not only encapsulates a structured legalistic structured approach to the case study method but also places the client's own experiences of process and change feedback at the centre of the approach, which can be considered empowering and links well to a person-centred experiential approach – the type of therapy offered in this

HSCED study. This results in a common ethos existing between research and therapy process as opposed to a research method where the client may be more objectified. The HSCED method can be adapted and applied creatively with some flexibility, whilst adhering to the necessary basic elements and standards. The method has been particularly endorsed (Elliott et al, 2009) in cases where the outcomes may not be clear.

Elliott and colleagues are still modifying and improving processes for the HSCED method (Stephen, Elliott & McLeod, 2011). This method, located within contemporary case study approaches (see McLeod, 2010, for a survey), seeks to approach case study research in a more pragmatic and systematic way than is allowed by more traditional methods, where data may be more anecdotal and limited (McLeod (2010) argued that the HSCED method and those methods that influenced it represent part of a contemporary development of the n=1 model to retain the fundamental question of whether the therapy has been effective. In their recent meta-analysis, Benelli, De Carlo, Biffi and McLeod (2015) have attempted to encapsulate the key essential features of what constitutes a robust HSCED-see paper, drawing particularly strongly upon Elliott's developments.

These shifts to new methods could be seen to bridge the gap between case study research and larger scale studies and provide an opportunity for robust single method study. Such new approaches fill an important gap in the range of available methods in single case design.

4.2. Method

4.2.1 HSCED: A brief overview of the method and its components

I will give a brief overview of the HSCED method here. I will then describe each HSCED stage and its recommended components in more depth. These explanations of method precede a description of the specific case of “Becky” through all stages of the HSCED and the outcomes and possible implications.

As has been explained, the HSCED is a case study research process and is constructed around a set of legalistic-like stages using supporting documents. First, a Rich Case Record introduces the case and treatment and incorporates relevant audited data pertinent to change. The rich case study is prepared and presented by the primary researcher and should be as neutrally weighted as possible rather than being biased towards either the affirmative or sceptic position.

An Affirmative Brief by the same author follows the rich case study, asserting that the client changed as a result of therapy and demonstrating explicit evidence of this in terms of outcomes and change process.

These two initial documents are followed by a Sceptic Brief compiled by a second researcher – an opposing party – after they have reviewed the initial two documents. This Sceptic Brief argues against the claims made in the Affirmative Brief. The sceptic researcher refers to their own specific points to support the case they bring and suggests other explanations for client change; or suggests that change did not occur or that it was more minimal than has been claimed.

A further document, known as an Affirmative Rebuttal, then follows. This is produced by the primary researcher who originally presented the Rich Case Record and Affirmative Case. The Affirmative Rebuttal challenges the points made in the Sceptic Case and reasserts claims of causal efficacy. A further Sceptic rebuttal is then produced, thus reinforcing the sceptic case.

Each party then assembles final summaries from the affirmative and sceptic perspectives. This completes the set of documents that are sent for judgement in the third phase of the HSCED, which is known as adjudication. These documents are examined by three judges using specific criteria and finally the judges' reports are transparently integrated by the primary researcher. This leads to final consensus of the level of causal inference within the therapy offered and the degree of change, including how these conclusions were reached.

Elliott (2002a) discussed the difficult issue of attempting to establish how change occurs in therapy and how it may be possible to identify whether the therapy led to substantial change. Here, Elliott highlighted authors such as Kazdin (1981), who supported this endeavour with checklists of possible components to consider in case research design to increase internal validity. Elliott (2002) proposed the HSCED method as a way of conducting such a critique of a therapy journey.

McLeod (2010) interpreted Elliott's position and explained that key research questions should establish the level of effectiveness of a specific therapeutic episode. HSCED involves the following questions for consideration (McLeod, 2010, pp.142):

"1. Did the client change?

2. Did the therapy make a substantial contribution to change?

3. Can causal links be established between the therapy process and eventual outcome?

4. What specific events or processes brought about the reported change?

5. How plausible are non-therapy explanations for the change that has been observed?”

4.2.2 The components of the HSCED process

4.2.2.1 Rich Case Record

The first essential requirement in the HSCED method is a rich, comprehensive range of information regarding the therapy of a specific client. This set of information consists of facts about the client and their presented concerns as well as details relating to the therapist and the therapeutic process, and data relating to the therapy process and therapy outcome from a range of sources or measures. Quantitative data collected from pre-, mid- and post-therapy outcome measures may identify any changes that occurred and the degree of change. Qualitative data may also be gathered.

Elliott (2002a,2002b) recommended the consideration of methods that regularly review the client’s goals. Outcomes are measured throughout the process of therapy, in order to track changes and evaluative feedback from the client. Elliott recommended that a third party should gather this data using a measure such as the Change Interview (Elliott, Slatick & Urman, 2001). When the measure is conducted by an independent researcher, it means that the client is more likely to be more open regarding any positive or negative comments regarding the therapy and its perceived impact, and practitioner bias is reduced.

The data is initially organised as evidence regarding client change and the possible role of therapy in this change in this specific case. The rich case study forms the basis of later debate regarding whether the assertions can be substantiated.

Elliot (2002) recommended that, ideally, therapy sessions are audio or video recorded and that Change Interviews are recorded with transcripts available to allow audit and data scrutiny. Some HSCED studies may have originated from research clinic data, where such data collection procedures are routine (e.g. Stephen et al., 2011). However, in practice I have found that this may be difficult when researching clients in settings where there may be restrictions. This could be due to local service protocols; and client consent may not be granted or feasible when working with vulnerable populations, protecting client identities and autonomy, of course, being paramount. These factors limit the data that can be made available.

There may be positive bias caused by the client wanting to please the researcher. Similarly, there may be negative impacts; Elliott (2002) refers to an HSCED of a client, “Paul”, who sometimes made negative comments about being “observed” by others during the research process in audio recorded sessions.

The next sections outline some useful data sources for the Rich Case Record (Elliott, 2002).

4.2.2.1.1 Pre-Post *Quantitative outcome measures*

Therapy outcome has both descriptive and/or qualitative elements that describe how the client has changed, and evaluative and/or quantitative elements that describe the degree of change in the client. Elliott (2002) explained that it is therefore valuable to choose to adopt quantitative outcome measures, including a minimum of one standard self-report measure of general clinical distress and one measure that is specific to the presenting problem or relevant to the theory. Measures should be given at the start and end of the therapy and periodically throughout the therapy (e.g. every 10 sessions).

4.2.2.1.2 Weekly outcome measures

Elliott recommended that the HSCED involves administering weekly measures that capture the client's main issues or goals. He explained that this process has two advantages. First, it provides a vehicle to link important therapy and life events to specific client changes. Second, the procedure ensures that some form of outcome data is generated and available if the client chooses to cease attendance and thus end the therapy before regular outcome measures can be administered. In my own experience, unplanned endings can be particularly common with vulnerable client groups and so building this awareness into data gathering is crucial.

Elliott (1999) and Elliott et al (2016) used the Personal Questionnaire (Elliott et al, 1999). This is a 10-item measure composed of problems on which the client chooses to work during the therapy.

4.2.2.1.3 Qualitative outcome assessment

In addition to quantitative outcomes, qualitative descriptive data is gathered. Elliott (2002) explained that it is not possible to measure all of the possible ways a client may change. It is therefore important to ask the client about their own perceptions of therapy, change processes and outcomes. Elliott went on to recommend that within the HSCED the minimum standard should include a post-therapy procedure of this nature but that optimally a regular process should occur regularly within the therapy. He suggested that, although such measures can be conducted by the therapist, they should ideally be conducted by a third party so that in the absence of the therapist the client may feel more freedom to be critical of their therapist if appropriate.

4.2.2.1.4 Qualitative information about significant events

Elliott (2002) recommended the collection of data relating to important events in the therapy as an important element. He stated that this is linked to therapeutic change occurring as "at least partly an intermittent discrete process". Elliott explained that collecting such information can sometimes be directly linked to client change, making them "signed causes" (Scriven, 1974). For example, a client may experience a therapeutic shift after a specific intervention. Questions about important therapy events can be included as part of a Change Interview (Elliott et al., 2006), or by using the Helpful Aspects of Therapy Form (Llewelyn, 1988). Stephen and Elliott (2011) pointed out how such elements in the transcript of the Change Interview, if available, can capture the voice of the client for all parties.

4.2.2.1.5 Assessment of client attributions for change

The client can be asked about their view regarding the sources of change using qualitative or quantitative data gathering methods (Elliott 2002; Elliott et al., 2006; Elliott et al., 2009). Elliott cautioned the researcher to ensure that care is taken to gain detailed information from the client regarding their experience of how their therapy process impacted on life changes. Details of such experiences are needed to provide adequate information for the HSCED process so that this data can be assessed and potentially accepted by the judges.

4.2.2.1.6 Direct information about therapy process

Elliott (2002 a) recommended recording all sessions as part of the HSCED process. He explained that this helps to capture the client narratives and interaction between the therapist and client. Detailed therapist process notes can be used to loosely navigate session content but are not in themselves seen as substantial or reliable evidence.

Sources of evidence may be linked together to show a correlation between outcomes and post-therapy ratings to track how therapeutic processes or specific instances are linked to extra-therapy change.

4.2.2.2 Compiling the Affirmative Brief

The second stage of the HSCED involves hermeneutic analysis. This analysis process involves critically debating aspects of the case in relation to clinical evidence and consideration of causal efficacy of therapy as well as other factors affecting change. This stage relies on a set of documents that are compiled as the process continues. Although both perspectives could be presented by one researcher, in many cases the two different and opposing standpoints are taken by two different members of the research team. As this stage progresses a debate emerges with two competing and conflicting standpoints to enable a wide range of analytical stances to emerge in order to reach a thoroughly considered result.

The Affirmative Brief is the second document required by the HSCED process and builds on the Rich Case Record. Elliott (2014) explained that the Affirmative Brief is composed of evidence that links the therapy process to positive client outcomes. The affirmative case should usually include information showing the following essential components: first, it should demonstrate that the client experienced changes in long-term problems during the therapy process; the client should explicitly link these post-therapy changes to the therapy; the client should describe helpful aspects in the therapy and directly link these to post therapy changes; and finally, weekly data that links in-therapy processes to significant events and shifts or changes should be presented.

Elliott (2001,2002) stipulated that two of five specific types of evidence must be presented to establish that change occurred as a result of the therapy. Benelli, De Carlo, Biffi and McLeod (2015) captured this essential component in their systematic review of HSCED standards drawn from Elliott (2001,2002). The five types of evidence are:

1. *Retrospective attribution*: consists of qualitative outcome data, such as the client's description of the importance of change and the likelihood of its occurrence in the absence of therapy
2. *Process-outcome mapping*: involves analysis of the correspondence between events within therapy, such as a client's self-report on a measure linking to an outcome rated on a post-therapy change measure
3. *Within-therapy process-outcome correlation*: involves analysis of the correlation between measured adherence to the therapy's principles and the variation in quantitative weekly measures of client issues
4. *Early change in stable problem*: involves evidenced change in a long-standing or chronic problem that was documented at the start of the therapy. A baseline measurement and post-therapy outcome measurement are needed
5. *Event-shift sequence*: involves analysis of the correspondence between a client-reported event within the therapy and a change in an issue or problem.

4.2.2.3 The Sceptic Brief

The Sceptic Brief, which is conducted by an independent researcher (one not offering treatment), takes a critical stance to the information presented in both the rich case study and the affirmative case Elliott's (2001,2002) recommendations were later adopted and discussed in other key texts on research methodology by (McLeod, 2010) and Benelli et al.'s (2015) systematic review of HSCED standards considered factors recommended by Elliott(2001,2002) that should be explored in the process of sceptic interpretation of a case, as follows:

"A. Change did not occur or was trivial:

a. Non-improvement should be considered in terms of alleged changes being trivial or negative and an absence of outcome data supporting change.
b. Statistical artefacts are scrutinised to see if apparent change reflects measurement error, outliers (atypical of main data) or regression to mean data.
c. Experimenter error in process of selecting data. The next category for consideration is of relational artefacts where changes that are claimed may be biased due to the client wanting to please the researcher.
d. Presentation of changes may be stereotyped and based on the hope of positive outcomes rather than fact.

B. Changes that occurred are due to factors other than the therapy:

a. Client self-correction of issues such as client-initiated self-help or limiting coping behaviours. This may include natural healing cycles.

b. Events outside of the therapy may have contributed towards the change. Examples of this could include receiving good news, a new friendship or moving to better standard accommodation.
c. Consider whether change involves the impact of psychobiological methods, medication, herbal treatments or medical illness.
d. The reactive effects of research may have influenced changes. This is where an individual's behaviour may change while they are aware that they are subject to observation; for example, the client might want to please the therapist or researcher in terms of relational impact."

4.2.2.4 Affirmative and Sceptical Rebuttals

The affirmative rebuttal addresses each point made in the Sceptic Brief and asserts its position, supporting the effectiveness of the therapy in leading to change.

The sceptic rebuttal then challenges the affirmative rebuttal, making key points in asserting that the therapy impact was not substantial.

4.2.2.5 Affirmative and Sceptic Case Summaries

Next, the first researcher (supporting the affirmative argument) and the second researcher (supporting the sceptic case) each write a final short statement or list of points supporting their opposing positions. In this case, a table can be used to present both views in summary.

4.2.2.6 Adjudication

The HSCED, as previously mentioned, is a relatively new method and is being continually developed. Elliott et al (2009) added a further stage involving adjudication to the HSCED process. This additional last stage, before reaching final conclusions, involves the judgement of evidence supporting and refuting causal change by a panel of independent therapy experts.

The judges are sent the set of documents that showcase the data and the arguments supporting and disputing causal impact of therapy in the context of any other factors. This set of documents consists of the Rich Case Study, Affirmative Brief, Sceptic Brief, Affirmative Rebuttal, Sceptic Rebuttal, and short summary of affirmative and sceptic argument clarifying key themes and evidence. The judges act independently in judging this material and are required to focus on the following three standard HSCED questions (e.g., Stephen, Elliott & McLeod, 2011; McLeod, Elliott & Rodgers, 2012; Elliott, Elliott et al, 2009):

1. Did the client change substantially over the course of therapy?
2. Is the change substantially due to the effect of the therapy?
3. What factors (including mediator or moderator variables) may be responsible for the change?

The HSCED method has being developed over time as new cases with their own nuances have been completed. As this process continues, tables are being developed and modified, and broken down into the key questions and evidence that may be adapted to provide a framework for the judges in supporting the assessments of the case.

Appendix D7 (in Volume 2) shows the judges' protocol form (Elliott & Widdowson, 2017) that was used in this instance. This form is populated by judges, after examination of evidence, to demonstrate the degree of change which they felt occurred, to what extent this was attributed to the therapy and other factors and how their decisions were influenced by the documents provided.

Conclusions can be reached by examining the judges' responses and a final verdict is reached as if in a courtroom, where all judgements are considered and integrated to form an opinion relating to whether the therapy showed causal efficacy.

4.2.3 Participants

4.2.3.1 The case of "Becky" and specific process

The client, known as "Becky", for the purposes of this study, was a white British female aged 19 who lived with her parents and was in casual employment. She was referred to the voluntary sector counselling service by a family member who was concerned that she was expressing suicidal ideas.

She was not receiving other support or therapy at that time, but the therapist referred her to other support in line with NICE guidelines and her presentation; this was because the therapist felt she would potentially benefit from and be safer with a package of care and could decide what was useful. Becky was independently assessed as "experiencing psychosis" by the EIP team as well as receiving more than 20 sessions of PCT from a qualified and experienced person-centred therapist in the counselling service.

Becky fitted the criteria for the study, did not fit any exclusion criteria and was happy to take part in the research. She was able to complete all the required measures in the protocol whilst experiencing PCT and fully consented to the research.

4.2.3.2 Therapist/HSCED investigator/affirmative researcher

The HSCED investigator was a qualified practitioner with specific training in PCE therapy (the therapy delivered). This person was also the therapist for this study and the principal investigator for this research. The therapy delivered to Becky was PCEP. The therapist, therefore, was also in the role of the HSCED investigator who led the affirmative case and conducted the study and analysis, assisted by other parties in the specific roles required for the process. The therapist had completed a diploma in PTC as well as further PCE post-qualification training. She had more than 15 years' experience of delivering PCEP training including creative person-centred expressive training and a mental health clinical certificate, and advanced PCT theory and postgraduate training. The therapist had received pre-therapy (Prouty,1990) training from a trainer recognised by the pre-therapy network. The therapist had awareness of psychosis, difficult process work and the wider context of care pathways, and extensive specific training in dissociation, psychosis and related areas.

The therapist/HSCED investigator was unsure whether the therapy could be helpful, so she took care not to offer false promises or hope to the client, evaluated weekly with the client and referred to other specialist services.

4.2.3.3 Researcher interviewer

The researcher interviewer was an experienced integrative practitioner with a diploma in person-centred counselling, who was pursuing post-qualification training (CAMHS Diploma including CBT training and practice) and was trained in a mental health setting in administering the specific measures used (the Positive and Negative Syndrome Scale [PANSS] and the Change Interview).

They did not report their expectations of the therapy or research.

4.2.3.4 Research supervisor and data auditor

The HSCED academic research supervisor, who was also data auditor, was an experienced practitioner and supervisor with competence in working with complex process. He was also an academic professor and the designer of the method.

He outlined his expectations of the outcome of the study:

> Based on the available research, I expected that Becky's therapy would probably be moderately successful, that is, she would show some degree of pre–post change (symptomatic and more broadly) and that this change could probably be linked to therapy. I expected relational factors to be key change processes.

He also summarised his background and expertise:

> [I have] 40 years of experience as a psychotherapy researcher, with broad expertise in qualitative and quantitative methods, including systematic single case research. I am the developer of the HSCED method. Originally trained as a clinical psychologist. Theoretical orientation: broadly: humanistic-experiential;

> specifically: emotion-focused therapy. Experience working with people with psychotic processes and specific interest in developing knowledge about the application of humanistic-experiential approaches with this client population.

4.2.3.5 The sceptic researcher

Dr Anna Robinson took on the role of the sceptic researcher for this study. She is a chartered psychologist and a member of the Counselling Psychology Division. She was a person-centred experiential therapist and a member of the British Association of Counselling & Psychotherapy (BACP) with a PhD in Counselling. She has conducted highly regarded research on the subject of *Emotion-Focused Therapy for People with Asperger's Syndrome.* The sceptic researcher’s expectation of the study’s outcomes was as follows:

> From the evidence presented I expected Becky would have some moderate gains that could be linked to the therapy she received. I expected the casual links to be stronger or for there to be stronger evidence. I expected the main benefit to be from the relational impact of the therapy and I thought the evidence seemed slightly stronger here.

4.2.3.6 Judges

Various people with relevant experience were invited to judge and a final set of five judges was recruited; two men and three women. It was important for me to try to recruit a mixture of professionals, experts by experience (mental health service users, ideally who had experienced psychotic processes themselves) and carers to allow different perspectives, particularly given that this research is centred within a person-centred ethos where issues around power and having the client at the centre of the process are crucial. (Mearns & McLeod,1984). I felt that this stance regarding the make- up of the judges' panel with a greater number of experts by experience and carers than mental health professionals somewhat reduced practitioner-client power bias and provided a diversity of views. Kara (2013) found that although service user research was become mainstream there was a lack of recognition of multiple roles and carers distinct contribution and so I have attempted to address this to some degree in this study.

I did also try to recruit a CBT therapist and a psychiatrist, with the intention of potentially providing more contrasting perspectives but all of the teams of people that I approached either did not have capacity at that time or did not respond to my invitations.

For the purposes of this study, judges were recruited by a literature search and networking to identify a range of individuals with relevant and diverse expertise. Each of the judges who took part in this study had a particular experience of the field of severe, enduring and acute mental health and client process. This experience was either because they were a professional psychotherapist or psychologist, or because they had a history as a carer for a person with personal experience of mental health issues, or because they were an expert by experience. Judge profiles are provided below, with one judge who chose to remain anonymous.

The judges' profiles and including any expectations of outcome were as follows:

Judge A, "Dion van Werde: Belgian Psychologist/ PC Psychotherapist, supervisor of the Flemish PCT Association; member of the editorial board of the World PCT Journal; Coordinator and Certified Trainer of the Pre-Therapy International Network.

After having worked in Gent, Belgium, in residential psychiatric care for 32 years, serving people suffering psychosis, now working in Germany in a centre for helping people finding their way back to work after a period of mental distress (after psychiatric admissions, and/or psychotherapeutic/psychiatric care).

I had no specific expectations. I was open to what I would be confronted with".

Judge B, Anja Rutten: "I have 20 years of experience as a counsellor/therapist specialising in clients with autism spectrum disorder (or autistic process). My academic training is psychology/health psychology and I trained as a PC-counsellor. I have additional training in EFT (Level 1–3), a two-day pre-therapy training and extensive autism training (with intervention/assessment training). Theoretical orientation: broadly: humanistic-experiential; specifically: emotion-focused and I have developed EFT for clients with autism spectrum, which is a group therapy method. I have 10 years of experience as a psychotherapy researcher with expertise in task analysis, grounded theory analysis and skills with HSCED method." In addition to my core therapy training, I have a BSc (Hons) in Psychology, and am in the final phase of a Practitioner Doctorate in Counselling Psychology. During this course I have trained also in CBT and relational psychodynamic therapy. My practice remains largely person-centred/experiential. My client experience covers a wide range of settings and client groups. I have some experience working with clients who are at times not in contact, and extensive experience working with autistic clients and their families.

I have been a judge for several HSCEDs and try to approach the judging with an open mind, rather than coming to the documentation with ideas about the outcome of the process. I try to do this by paying careful attention to the data, and the quality of arguments put forward by affirmative and sceptic teams".

Judge C: Neil Caton: "I have experienced psychosis and various therapies and mental health services. I did part of a social work MA and have also been influenced by ISPS UK who I am a trustee for and has exposed me to psycho -social perspectives to psychosis.

I expected that person centred therapy would have a positive impact on a service user that experienced psychosis. I was aware that Wendy had a good insight into psychotic processes and subscribe to the principles and theory behind the person- centred approach.

Judge D: Marion Worth, Mental Health Service User.

"I expect that any form of empathy and support for a person with mental health problems will be an act of caring and so help in that the person no longer feels alone in solving or processing life experiences.

If the therapy is good -with a good therapeutic relationship, sessions carried out over an appropriate length of time, good outcomes celebrated and reinforced, then I would reckon that to have been effective.

I have participated in a variety of different therapies over the last fifteen years to help with my mental health recovery journey".

Judge E :“Judith”: “I am an informal family carer, with 18 years’ experience of mental health services'. I have attended, participated in and contributed to many mental health courses and conferences in those years. Generally, the amount of education given to carers to enable them to be most effective both in looking after themselves and the person they love and care for is lamentably poor. Caring for someone who has become totally unpredictable is very difficult and with, but especially without any, training often traumatic, and many are on their own doing this as partnerships and families break under the continued stress.

Expectations before reading through the documents.

I had quite an open mind I think.

However, I had heard Gary Prouty speak at conferences and so was aware of his version of person- centred therapy, and also heard something about Carl Rogers' work ('Watching the Ox') but have had no personal / family experience of either. However, intellectually this little information had intrigued me and it made sense as both Prouty and Rogers seemed to value listening to /being with the person / patient, instead of just ticking symptom boxes and coming to a 'diagnosis' on the basis of a score (x out of y boxes ticked), and that 'diagnosis' leading straight to a pharmaceutical response, often given in perpetuity. So, I looked forward to reading something of these techniques in practice, albeit second hand, and to finding out whether the approach lived up to what I'd heard”.

Documents which argued the case for and against causal efficacy of the therapy were presented to the judges for their consideration.

The judges were coached through the process of the documents. One had familiarity with the HSCED process and others did not. I tried to remain as neutral as possible with all instructions.

Two of the judges found that the term “substantial change” was difficult to quantify in this context and asked for further guidance, which they were given. I encouraged them to think about 100% being the most change imaginable and 0% as no change, and to try to find a point between this, justifying it. After the process was complete, I received feedback stating that this part was difficult.

4.2.4 Measures

The HSCED data focusing on a single client emerged as a subset of a wider study design that had originally intended to use this battery of measures on a set of clients. However, after the first client, “Becky”, had commenced the trial the study was modified and ethically approved by both the University of Strathclyde and the NHS Research Ethics Committee. This meant that “Becky” was the only participating client, resulting in a single case of data from the original study. Measures used with this client (see Appendices B, Vol 2) were conducted in strict adherence to ethically approved protocols with only occasional omissions due to the client being particularly exhausted or vulnerable at times, making them ethically inappropriate. The client usually found the measures to be of value in terms of aiding reflection and informed the therapist that she was glad to contribute to developing understanding of therapeutic process. Measures were selected and embedded into the therapy itself and the evaluative process into the therapy relationship.

The original pre-amendment study flow chart of battery of measures is presented in appendix A3 with individual measures in appendices B1 to B7 excluding measures which were not used or removed from the final design after amendments which are detailed in the ethical correspondence included in part A of the appendices.

4.2.4.1 The positive and negative syndrome scale (PANSS)

The positive and negative syndrome scale (PANSS; Kay, Fiszbein & Ople, 1987) was used from therapy session 5 with a plan to repeat this at the post-therapy stage. The assessment chart for his is included as Appendix B7 with other lengthy documents not included as this measure was less featured in this case. This is a medical scale that was developed to measure the symptom severity of adults with a diagnosis of schizophrenia, and has been widely used in trials of therapy for psychosis. The scale measures both "positive symptoms" (e.g. hearing voices) and "negative symptoms" (e.g., low mood) and psychopathology. The researcher who was not the therapist administered the measure. They had received training from a researcher who had been formally trained in an EIP service to a recognised regional research project standard. The measure was chosen as it links to medical model symptoms but also uses non-medical descriptions and fits well within a PCE model where links to diagnostic frameworks may be useful for comparison with other studies but without imposing such language on the client. A disadvantage is that it takes about 50 minutes to complete and asks in-depth questions in a recorded interview.

4.2.4.2 CORE

The CORE Outcome Measure (Barkham et al., 2001) was used in this case study in both the full CORE-34 and shortened CORE-10 versions but since the CORE 34 was only fully analysed with regard to the overlapping items with the short CORE-10.These measures are affected by copyright but now freely available online (CORE systems Trust, n). During the course of Becky's therapy, the CORE-10 was applied every week from session 5, apart from every fifth week. Thereafter, the CORE-OM was given instead. The CORE measures were used for the client to rate a wide range of issues and "symptoms" and their frequency of occurrence over the previous week.

These are two forms of self-report measure with ratings for the degree of difficulty in a specific area over the previous week. They are used in the therapy session to support the client to record how they have felt over the previous week and in this study the measures were given to the client for completion at the start of each session and as a part of the in-session therapeutic dialogue between therapist and client. Giving the measures early in the session ensured that there was sufficient time to deal with any issues arising from the outcomes as well as any other dialogue in the session. The CORE measures rate of occurrence and severity of issues numerically and thus generates quantitative data. Outcomes for CORE-34 could only be correlated with those for CORE-10 by considering only the questions and responses occurring on both versions of the measure and the mean of just those specific question responses, rather than comparing the overall mean of each full measure. The CORE measures are validated. They gather 10 areas of data, as defined in the CORE manual (2007). These are described as subjective wellbeing, anxiety, depression, physical, trauma, general functioning, close relationships (functioning), social relationships (functioning), risk to self, and risk to other.

4.2.4.3 The therapeutic relationship scale (TRS)

The therapeutic relationship scale (TRS) (Sanders & Freire, 2007) measures the quality of the therapeutic relationship as perceived by the client and by the therapist (see Appendix B1 and B2). Freire & Grafanaki (2010) identified that the TRS could be a shorter (and more accessible) alternative to other longer measures within a PCT framework. A client version and a therapist version of the questionnaire are available, and these are used in parallel so that after each session the client and the therapist can complete the scale in private. The scale measures qualities in terms of Rogers' conditions for a therapeutic relationship such as empathy, congruence, unconditional positive regard, transparency and non-directivity (Carrick & Elliott, 2013) as well as additional aspects such as collaboration, power, safety, trust and level of directivity. The pilot version used in this study included 27 items including warmth, empathy, acceptance, feeling safe and genuineness (Table 6, Rich Case Record, Appendix D1). Item 25 was deleted from this early version as it proved problematic in testing stage. Both client and therapist rated the alliance as positive. The client rated all but one session with the maximum satisfaction score. The relationship was perceived as warm, genuine and close, to name just a few of the elements rated.

4.2.4.4 Qualitative assessment

Helpful Aspects of Therapy (HAT)

The Helpful Aspects of Therapy Form (Llewelyn, 1988) can help to identify therapy processes that are linked to changes in the client. The form, which takes 5–10 minutes to complete, is given to the client at the end of the therapy session and is included in

Appendix B3. It has open-ended questions to enable the client to write in their own words which aspects of the session were helpful or unhelpful (hindering) and to rate the degree of helpfulness. The measure is non-intrusive and can help to identify change process in the therapy. The client's own accounts may be cross-referenced to other records or measures taken at that time to unfold a wider picture. Elliott (2012) explains that despite its advantages, one possible disadvantage is that thin data may be generated consisting of vague or global reports. There may also be inconsistencies and differences in reporting between different perspectives from client, researcher and therapist, which can cause complexities in analysis. Nonetheless, this measure seemed a useful addition to the battery to seek client report data.

Therapist process notes. These were brief notes made by the therapist shortly after each session (on the same day), recording a summary of the session and any significant factors.

4.2.4.6 The Change Interview.

The Change Interview (Elliott et al., 2006) is a semi-structured post-therapy measure that takes the form of an audio recorded interview with a researcher who is not the therapist (see Appendix B.5). In this case, the researcher received training in relation to conducting the interview. The resulting qualitative data consists of the client's accounts of change and change process as well as the client's rating of the degree of, importance of and expectation of change. The measure also asks about attributes and barriers, as well as contributing negative or positive contextual factors. This measure was used post-therapy.

4.3 Results

4.3.1 Summary of the referral process and service context

The service where Becky was offered PCE therapy was flexible and accessible and followed a pluralistic model. The alliance, the real relationship and the foundation of a person-centred ethos were seen as central to the therapy with goals or an agenda raised by the client. The therapist had more than 20 years of post-qualifying experience of working with clients with complex and psychotic processes. The person-centred experiential therapy supported Becky to work at her own pace and to work creatively if she wished.

Becky presented in a state of distress reporting trauma, guilt, loss and longstanding family difficulties including the recent suicide of her sibling. She was experiencing anxiety, psychotic process and was in a state of emotional torture. She found it difficult to be with others or to function in relation to daily tasks.

Becky was committed to the therapy and explored painful issues, including their impact and her coping. In the post therapy Change Interview, Becky said that her quality of not taking things too seriously had helped the process.

4.3.2 Rich case record and therapy overview

The following incorporates a summary of Becky's Rich Case Record, which is located in full in Appendix D1.

4.3.2.1 Context

Becky was referred by her family to the service where she received counselling. She was in crisis with an escalating psychotic process. She was offered PCEP within the context of the National Institute for Health and Care Excellence (NICE, 2009) guidance that was in place at this time. On commencement of the PCT therapy, the therapist entered into dialogue with Becky regarding her overall treatment. In line with NICE guidelines, which recommended CBT for all adults with psychosis, the therapist referred Becky to the EIP team, who offered such approaches, and communicated with her GP. The referral was formally acknowledged at week 10 of the PCT. The therapist supported Becky to make use of the PCE therapy and to consider accessing other services, making choices regarding treatment. Becky did not engage in this treatment until the end of the PCEP therapy when she was more emotionally stable.

4.3.2.2 Background and course of treatment

Becky presented to the PCEP therapist over the first sessions with experiences of hearing voices, noises and unusual perceptions of reality. Becky reported a long history of family and relationship issues. She had experienced two recent family deaths, one being the loss of a sibling through suicide, and a third traumatic loss. After her sibling's suicide, Becky had begun to feel outside of herself; she was not feeling connected to reality and felt that her voice was not hers and that she was not real. She reported experiencing panic attacks, anxiety and sleep difficulties. She also experienced unwanted thoughts and was scared of acting on these. These thoughts involved her sometimes considering taking her own life and she also revealed that she felt scared that she might hurt others.

The therapist-researcher-author was an experienced qualified PCE therapist with additional mental health training and extensive experience of psychotic process as described in the Rich Case Record (Appendix D.1)

The battery of measures produced a set of rich data incorporating quantitative outcome data and qualitative outcome data.

A PANSS assessment was conducted by a researcher therapist who was not the PCE therapist who was offering the therapy. The EIP team reported that that the PANSS assessment verified that Becky was experiencing an episode of psychosis. A post-treatment PANSS had been planned but was not conducted for ethical reasons as Becky felt that it was a potentially stressful lengthy measure.

4.3.2.3 Quantitative outcome data

Although no Time 2 PANSS data could be collected, the initial PANSS demonstrated that Becky was experiencing psychotic process.

The CORE 10 was collected weekly from session 5 forward, and the CORE-OM instead of the CORE-10 every fifth week. Data could be combined where questions were identical. This resulted in a decrease from 2.33 in the moderate range of severity to 1.24 in the mild range of severity. This degree of change is considered as statistically reliable change, suggesting that the change was likely to be related to the therapy (Connell & Barkham, 2007; Barkham et al, 2013). There were fluctuations in overall mean distress shown in Figure 1 (Rich Case Record, p. 4) appendix D.1 but this gradually reduced over the therapy by a substantial amount in connection with Becky's increase in functioning and reduction in distress. She remained in a clinical range (more distress than the average baseline) but much improved.

4.3.2.4 Qualitative outcome data

The Change Interview was conducted by a researcher who was not the therapist. Table 2, p 5 in Appendix D1. illustrates how four specific changes were rated by Becky as being very unlikely without the therapy.

Becky felt that her feelings were more real and indicated that she was very much surprised by this change, that it was very unlikely without the therapy and very important. She commented, "And before I didn't feel that stuff was real, and I do feel like stuff is a bit more real now" and "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, Rich Case Record, p. 5).

Becky stated that a further specific change consisted of her getting out more (locally) and that she was very much surprised by this change, that the change was very unlikely without the therapy and extremely important for her.

She stated that another change involved her getting out of the city she lived in. She was very surprised by this change, felt that it was very unlikely without the therapy and extremely important. She commented, "Getting out of the [named] city – like, I never used to be able to go out – I went to the caravan the other weekend" (1.1/56, Rich Case Record, p. 5).

Becky also noted that she was more able to meet people and that this change was somewhat expected, neither more nor less likely without the therapy and was very important. During her Change Interview, Becky also described further changes that were not rated, such as being more in control, coping better in general, coping better with anxiety, getting on with stuff more, less dwelling on the bad stuff, coping better with being around people and coping better with talking to people.

4.3.2.5 Change Interview data

Two kinds of change process data were collected in this study. They consisted of Change Interview data distinctly relating to process, and the Helpful Aspects of Therapy (HAT) form.

Change Interview data is shown in Table 3 of the Rich Case Record, p. 6 (Appendix D.1) and is additional to quantitative data from the Change Interview Table 3 shows Becky's descriptions of helpful aspects of her therapy. She described immediate therapy effects such as feeling understood ("The therapist [named] just *gets* me") and relieving stress ("venting" it and leaving it in the therapy room). Becky described the relational atmosphere as supporting her in being able to discuss "stuff that I wouldn't be able to talk about with family and friends". She said, "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 that at all, but T really gets it" (1.1/31b, Table 3, Rich Case Record, p. 6). Becky discussed de-stressing and relieving stress occurring in the therapy, and discussed the relational atmosphere providing the opportunity to talk about issues or vent. She also described therapist actions and stated that she found multidisciplinary referral helpful. Becky also described personal and situational resources that helped her to make use of the therapy. This included being laid back, not being obsessed, and leaving her job, which she found stressful. In terms of beneficial processes Becky found it was helpful to talk about painful experiences and discuss issues that she had previously not discussed with others. Becky also discussed helpful aspects of participating in the research. She reported that questions in the research helped her to remember to say things she may otherwise have forgotten.

Table 4 in the Rich Case Study describes unhelpful factors regarding the attributes, unhelpful others and contextual factors outside of the therapy. Becky described her unhelpful attributes as “being a worrier”. In terms of unhelpful others, she named issues with unhelpful family, including feeling ignored and not being taken seriously by friends or pressures to conform to unhealthy behaviours. Becky found that medication made her feel worse and suicidal, and also experienced “really bad withdrawal symptoms”. She was disappointed that she did not become totally well or improve at a faster rate.

4.3.2.6 Becky’s data from the Helpful Aspects of Therapy (HAT)

The Helpful Aspects of Therapy (version 3.2, 2006, Llewellyn, 1998) was used. Becky’s experiences of what events were helpful or unhelpful in each therapy session are shown in Table 5 of the Rich Case Study (p. 9). In one therapy session Becky described how talking about her brother relieved some sadness and she felt a bit relieved (towards the end of the session). She described this as moderately to greatly helpful. Becky also described helpful events in later sessions, including crying making her feel more real, talking about loss, talking about things that scared her, getting stress out and letting everything out. She commented that expressing how she felt in session 16 was helpful as it was the “only time I can” and talked about the themes of feeling understood and working creatively. All of these experiences were rated as slightly, moderately, greatly or extremely helpful.

4.3.2.7 Summary of Therapy Process

The summary of the therapy process (Appendix D1, Rich Case Record p. 13) provides a description, compiled by the therapist, of Becky’s therapy process from screening to her final session. Within this summary of therapy processes, the HAT data is mapped onto the session notes to show how Becky’s accounts of significant positive events connect with therapist summaries of session content and process. Three weeks after referral by her family Becky received an initial assessment with her consent. She presented as distressed, describing multiple losses. Two of these losses were traumatic and one was her sibling’s suicide. Significant difficult issues with others, including relationships with others including family, had been present for several years. She was becoming more socially withdrawn. She discussed what could be psychotic process and depersonalisation. Issues of grief, guilt, self-identity and worth were explored, and coping strategies were developed.

Becky explored issues in depth in the therapy, as well as how to manage and enhance coping. In an early session she discussed suicidal ideas and fears that she might hurt someone but had no immediate plan to act on these ideas. By session 3, further exploration relating to feeling unreal and other difficulties occurred and a referral to EIP services was discussed. Becky consistently expressed feelings of emotional torment, unfinished business and regrets, guilt, grief and anxiety. She began to develop a stronger connection to her feelings and self-identity.

In session 5 the therapist recorded an exploration of Becky debating a possible visit to her sibling’s grave (in relation to exploration of grief). Becky rated talking about releasing sadness as moderately helpful and talking about her brother as greatly helpful, showing a connection between therapist and perceived outcome. As sessions progressed Becky explored these themes and there was some normalising of her experiences, exploring issues and building on coping. She reduced and withdrew from medication that she felt was making her feel worse and increasing her suicidal ideas. By session 8 she had started a new job. Fears of dying and being mad were managed and normalised.

By session 10 there was deeper exploration of Becky’s sibling’s death. The therapist held this and was also visibly moved to tears. This suggests that relational depth may have been present. This session’s HAT feedback was rated by Becky as greatly helpful. Further sessions explored work and issues with coping and others. In session 13 Becky described possibly hearing voices and the anniversary of a significant loss and managing this. She reported relief in her HAT data at “generally letting everything out” and said that this event had been “greatly helpful”. In session 14, Becky’s improvements were noted on the CORE. Becky was also scheduled to be assessed by the EIP team and discuss medication, which she wanted to stop completely. She explored her fear of madness and issues regarding control. In further sessions Becky discussed new friendships and in session 16 she felt that she was building strength. Describing the session in her HAT data, she reflected that “expressing how I felt” was “greatly helpful”. By session 18 Becky had not yet engaged with the EIP team but was engaging in PCE therapy well and exploring feeling trapped through creative media. Her HAT data recorded this as “extremely helpful”. By session 20 the EIP team confirmed that their PANSS assessment showed that Becky was experiencing “a psychotic episode”. In the last few sessions she continued to explore family issues, was mixing more with others and looking at travel in the future, was in a new intimate relationship and was now scheduled for active treatment with the EIP team. Three months after the final scheduled session Becky contacted the therapist requested a final formal ending, which she attended briefly, saying “goodbye” and hugging the therapist.

4.3.3 Affirmative Brief

The Affirmative Brief (Appendix D2) is summarised here. The Affirmative Brief document draws together evidence that demonstrates how Becky changed during therapy and that the therapy was the main agent of change. It includes a summary of pertinent evidence including Becky’s own feedback.

4.3.3.1 Client pre–post change did occur

Table R-1 and Figure R-1 in the Rich Case Record (duplicated here in text) show that Becky’s mean scores on the validated CORE measures show a reduction in distress from 2.33 (moderate/severe range) to 1.24 (mild). There was some indication of risk reduction.

Quantitative Outcome Data

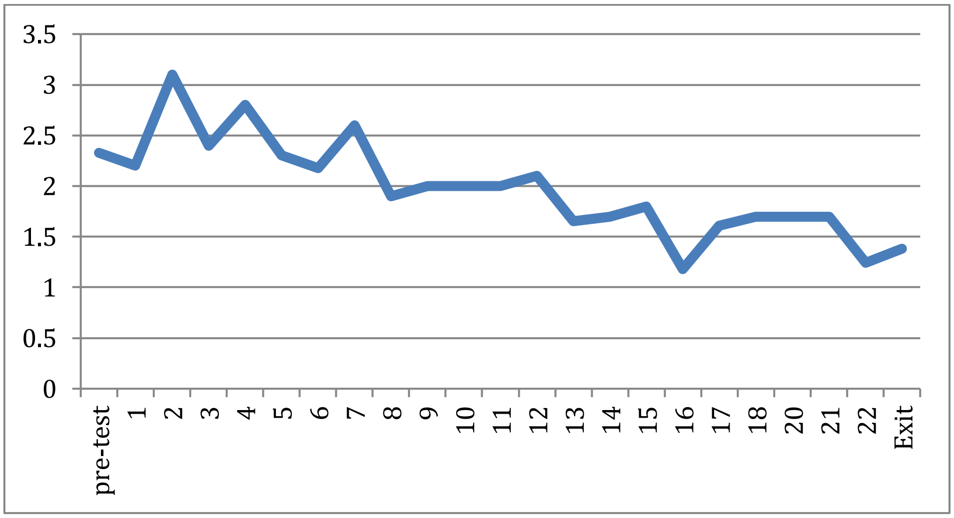
Table R- 1: Client Outcome Measures: CORE-34/Core-10

	Cut-off	**RCI Minimum**	**Screening**	**Session 7**	**Session 12**	**Session 22**
CORE-34/ CORE-10	<1.00	.5 (↓)	**2.33 (moderate)**	**2.6 (severe)**	**2.1 (moderate)**	**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. The graph shown below demonstrates reliable reduction in distress indicated from CORE_10 scores and the ten duplicated questions on the CORE-34.

Figure R-1



4.3.3.2 Specific pre–post qualitative positive changes

Table A-1

Change	Evidence of Change occurring
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*

Becky showed improvements in functioning. Table A-1 shows excerpts from Becky's post-therapy Change Interview where she described six changes, and some direct quotes are included in the table. The first change, "Feelings are more real" was rated by Becky as very important and very unlikely without the therapy. The second change, "Getting out more (locally)" was rated by Becky as extremely important and very unlikely without the therapy. The third rated change, "getting out of the city I live in" was rated as extremely important and very unlikely without the therapy. The remaining three named changes were not rated. Becky first described "coping better with meeting, being around people"; second "coping better, getting on with stuff more and less dwelling on 'bad' stuff" (depersonalisation, psychotic material, concerns); and third, "coping better with anxiety/stress".

4.3.3.3 Therapy interrupted a rapidly deteriorating condition

Becky presented with complex issues and was on a path of rapid deterioration, which was interrupted by the therapy process. The psychotic process may have both been influenced by and resulted in trauma, as it was a terrifying experience for Becky. Research supports early intervention for psychotic process to give the best outcomes and minimise the risk of a long-term condition (see Affirmative Brief, Appendix D.2 p3). Early counselling in the context of a strong therapeutic alliance reduced the severity of Becky's distress and issues, reduced risk and prevented further deterioration in her mental health. The counselling helped Becky to reduce distress and symptoms and to stabilise enough for her to be able to access other services, such as the EIP team, which were of further potential benefit to her.

The therapeutic relationship scale showed a strong alliance perceived by both the client and the therapist.

4.3.3.4 The client attributed her pre–post improvements to therapy (retrospective attribution)

The client herself attributed most of her changes to the therapy. Table R-2 (Rich Case Record) lists the changes rated by Becky in her post-therapy Change Interview. Becky rated three of the four rated changes as very unlikely without the therapy. This therefore shows retrospective attribution of change according to the client herself. Further examination of the Change Interview data provides further evidence. For example: "I do think it's improving me" (1.1a.); "I think it helps" (1.1b).

Becky described the ability to discuss issues that could not be discussed elsewhere and also discussed feeling understood by her therapist.

Table A-2 in the Affirmative Brief (p. 4) summarises helpful factors identified by the client after the therapy. The table demonstrates an immediate effect of the therapy such as the client feeling very understood even when they were 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). The client also described getting rid of the stress and, in terms of the relational atmosphere, Becky reported valuing the opportunity to talk about issues and to vent as she felt it was no longer inside her. Becky also described how talking about painful experiences that had not been discussed with others, was "horrible" but helpful.

4.3.3.5 Post-therapy outcomes can be linked to specific in-session processes (outcome to process mapping)

Outcome process mapping involves linking specific within-therapy events to overall changes experienced by the client. The process helps to establish the degree to which events within the therapy influence therapy outcomes. Table A-3 in the Affirmative Brief (Appendix D2, p. 5) shows evidence of change described by the client in the first column with the second column indicating how each of the specific changes could be linked to in-session process and where evidence supports this.

In sessions 15, 16 and 20, there was a relationship between Becky's change involving feeling becoming more real and the therapist's process notes, which show exploration in the therapy sessions regarding sense of self, identity and coping with a fragmented sense of self. Other examples include Becky discussing getting out more, which was difficult at the start of the therapy and was regularly discussed in session 16, including Becky describing how she had been able to enjoy a social occasion with friends as well as trying to plan travel. This was a named change on Becky's Change Interview and featured in the therapist's process notes. Table A-3 also shows how Becky coped better with meeting and being around others, and the therapist process notes (TPN) for sessions 7, 14, 16 and 21 track this change, with session 21 showing Becky as more able to mix with others.

4.3.4 Sceptic Brief

The Sceptic Brief (Appendix D.3) was compiled by Anna Robinson, a therapist who was not the therapist working with Becky. It reviewed the evidence put forward that the person-centred experiential therapy offered to Becky was instrumental in the changes she experienced and the main causal change factor and put forward the case to dispute this claim and argue that alternative factors may have influenced change.

In general, the Sceptic Brief challenged the assertions of the affirmative case that PCEP caused changes in psychotic process. The sceptic researcher also pointed out that in terms of the quantitative change measures, there was sole reliance on CORE which does not specifically measure degree of psychotic process. The Sceptic Brief went on to address the following points:

4.3.4.1 No evidence for change in psychotic process

No reliable change in psychotic process was established:

- **General overall client pre–post change did occur but was not specific to psychotic process.** The Sceptic Brief challenged the use of CORE to measure psychosis and recommended more suitable measures. The CORE can only measure anxiety, depression, trauma, physical problems, functioning and risk, and so changes can only be evidenced in relation to these items.
- **Circumstantial evidence pointed to a lack of change in psychotic process**. The Rich Case Study did not present the pre or post treatment scores for the Positive and Negative Syndrome Scale (PANSS). When the EIP team conducted the PANSS between sessions 7 and 17 they concluded that Becky was experiencing a psychotic episode, suggesting that at this point the PCE therapy had not impacted Becky's psychotic process. Becky also commented in session 15 that the depersonalisation was "as strong as ever", suggesting no change in depersonalisation. Other factors

may have influenced change. For example, a reduction in medication and the development of a new friendship in session 15 were followed by the feeling that Becky was building strength in session 16.

- **Reported general change in general distress could be due to bias.** Since the CORE is a self-report measure, bias may have impacted scores; this methodological weakness was not acknowledged in the Affirmative Brief. Becky might have found it difficult to give accurate accounts regarding change in psychotic process. CORE and other measures are also vulnerable to response bias in clients. Becky giving reports such as “Just talking and letting things out” might support this claim.
- **Qualitative change data did not point to change in psychotic process**. The post-therapy changes reported by Becky in the Change Interview did not capture change in her psychotic processes, with only one of four changes referring to this area of change. The Sceptic Brief argued that this was thin data that was not substantial enough to support claims of change in psychotic process symptom severity. When Becky reported “Crying made me feel more real” in session 7, this might have signified change but was linked to an emerging sense of self that was not itself linked to client data.

In conclusion, the Sceptic Brief argued that the weak body of data did not form a comprehensive set of evidence to support the claims made. The session reporting and therapist process notes relied on recall and showed inconsistencies that weakened the case further.

4.3.4.2 Other explanations adequately account for apparent client change

In support of the argument that only minimal changes in psychotic process were experienced by Becky, the data were evaluated using Elliott's (2001) list of competing explanations for client change. The list examines possible explanations for change other than the therapy, claiming that some changes occurred due to non-therapy affects:

- **Negative or trivial change.** The evidence presented from the PANSS assessment did not show improvement but instead validated that the client was in psychotic process, which proved that the PCE therapy had no causal effect on symptom reduction.

- **Extra therapy events could have affected client change.** Extra therapy events that could have brought about change included: new employment opportunity (in sessions 8 and 9 it was reported that Becky began a new job, which was going well); the development of new friendships (it was reported in session 15 that Becky was engaged in a new positive friendship); and getting a dog (in session 10 Becky mentioned that getting a dog was a source of comfort). Research studies show that animal-assisted therapy can be effective for this client population in symptom reduction and social skills enhancement (e.g. Villalta- Gil et al, 2009). Although Becky did not actually receive animal-assisted therapy the dog may have had a positive impact on her outcomes.

- **Non-PCE therapy intervention activities by the therapist could have affected client change**. The therapist used non-PCE therapy interventions, supporting the client to access other services such as a GP and the EIP team. The therapist also wrote a letter to Becky's work regarding her issues.

- **Other agency intervention could have affected change.** The contact with the EIP team, including assessment, was easier for Becky and could be linked to positive change.

- **Self-correction: natural healing in the grief cycle.** Self-corrective processes may have impacted upon positive changes. The client may have engaged in self-corrective activities independent of the therapy process. For example, Becky's natural grief recovery process may have contributed to her positive change. Session 14 notes provide evidence of this process as they reported that Becky was coping with an anniversary of a death.

- **Medication uptake and withdrawal**. Becky's uptake, management and withdrawal from medication may have contributed to change.

- **Reactive effects of research.** The research process influenced Becky's reports of change. The late introduction of the Helpful Aspects of Therapy measure may have resulted in Becky feeling the need to please the therapist. Researcher bias may further have impacted on outcome, as the researcher may have wanted to prove the efficacy of PCE therapy.

4.3.4.3 Affirmative Rebuttal

The Affirmative rebuttal (appendix D4) identified evidence and systematically challenged the sceptic position arguments, particularly the Sceptic Brief claim that

Becky's positive changes in psychotic process were not significant and that changes in these and other areas were not due to the therapy. The rebuttal claimed that although other factors may have influenced Becky's outcomes, there was no evidence to support this in both outcome measures and the client's own accounts. The evidence did suggest that the therapy was a causal agent of positive changes. Becky's positive changes included symptom reduction, decrease in distress and increase in self-regard, wellbeing, coping and functioning.

Becky showed some small but important change in psychotic processes that impacted on her ability to function and cope. Evidence suggested that these changes were to some degree attributed to the therapy. There was a reduction in her associated self-stigma, terror, guilt and distress. The therapy halted the progression of an escalating and terrifying psychotic process. Psychosis itself can be terrifying and may cause post-traumatic stress symptoms in around half of those who experience psychosis (Bendall, McGarry & Krstev, 2009). The PCE therapy was based on a person-centred model and focused on normalising distress and supporting client-led process and goals in contrast to a medical diagnostic approach.

The current National Institute for Health and Care Excellence (NICE, 2014) provides treatment recommendations for the treatment and management of psychosis. The guideline in place at the time of Becky's therapy (NICE, 2009) recommended CBT and the option of psychotropic medication. However, Becky was unable to access other services for some time and the PCE therapy was flexible and accommodated her chaotic process of engagement. Becky stabilised in the PCEP therapy, enabling her to take up the EIP service by session 20 of the counselling.

4.3.4.3 Affirmative Rebuttal /Summary: Changes and factors affecting the therapeutic process

(1) Strong therapeutic alliance. The Therapeutic Relationship Scale data (see Table 6, Rich Case Record), the HAT data (Table 5, Rich Case Record) and the Change Interview data (Table 3, Rich Case Record) showed evidence of a strong therapeutic relationship. Becky felt close to her therapist and felt that she was accepted, no matter what she said.

(2) Reduction in risk. Becky reported in her post-session 5 PANSS that if she did not get better her life was “in danger”. She had thoughts of ending her life, and said, “Sometimes, I wish that I wasn’t there”. At the end of therapy Becky’s clinical notes and CORE showed less fear of death or fear of hurting herself or others.

(3) Reduction in psychotic process. Becky’s post-session 5 PANSS scores were initially in the clinical range for psychosis. She said that she had experienced visual snow for a year, twitches, olfactory hallucinations, and visual and auditory hallucinations. She described how she heard voices and noises that reminded her of significant others. By the end of the therapy Becky reported that the voices had ceased and that she was coping better with existing “symptoms” (see Table A1, points 1 and 5, Affirmative Brief). This was reflected in the therapist’s clinical case notes.

(4) Improved social functioning. At the start of therapy Becky was finding it hard to mix with people (Rich Case Record, session 3) or go out; she found it overwhelming to do so and said it made her feel “freaked out” (Rich Case Record, session 7). In her post-session 5 Change Interview she reported feeling sad and tormented, and lacking trust.

Becky initiated discussions regarding coping strategies and worked on her self-identity, self-caring and self-soothing. Over time she progressed to a point where social situations were more possible, distress lessened, and she developed greater coping. By session 15 Becky discussed new friendships

(5) Reduction in distress and other positive changes. In her assessment Becky reported distress, issues of guilt and self-blame. In therapy she explored loss and trauma, sadness and guilt and reframing of emotions. Becky's post-therapy Change Interview illustrates how she found this exploration of loss difficult but helpful (Table A2, point 3.1). As the therapy progressed Becky reported changes and appeared less distressed, and her appearance changed. She embraced positive self-identity and sense of self. She connected to her own creativity more and made connections to others.

(6) There is no evidence that reactive effects of research impacted on Becky's reporting. Other factors and natural processes may have impacted changes and there may have been researcher bias but there is no specific evidence supporting this. Becky showed the ability to be assertive, make active decisions and discuss both positive feelings and any reservations regarding the therapy in the data, and so the potential impact of wanting to please the therapist and researcher seem minimal.

(7) Impact of medication and other interventions or other factors that may have affected change. There is no evidence that other interventions were beneficial during the therapy. In her initial PANSS assessment Becky commented, “I didn't want antidepressants prescribed as I am not depressed”. Becky attributed suicidal feelings to the effect of medications as the feelings had increased since she had commenced the medication.

When Becky reduced her (antidepressant) medication the suicidal feelings diminished. Becky did not describe early contact with other services as helpful to her but later, by session 20 of the PCEP therapy, she had begun to access the EIP service. At this point she had already experienced some positive changes and was more emotionally stable and more able to go out and be with other people, as well as access other services. Becky did use self-soothing and obtained a pet, but this was not on her agenda at session 1, where the future was difficult and coping strategies were supported and enhanced within the therapy.

(8) Changes and factors affecting the therapeutic process: Conclusion

The Affirmative evidence in the form of qualitative and quantities data supports the case that therapy significantly impacted upon Becky's positive changes. Some psychotic process symptom reduction helped Becky to improve other aspects of her functioning. The therapy had a significant impact in halting Becky's rapid deterioration in a first episode psychotic process. She was becoming less distressed and more able to be with others, work, go out and engage in other services. Although biases and other factors may have operated to some degree in addition to the therapy, it is clear from data including Becky's self-reporting that her PCE therapy significantly contributed to her positive changes.

4.3.5 Sceptic Rebuttal

The Sceptic Rebuttal challenged the points made in the Affirmative Rebuttal and claimed that Becky's psychotic process did not show significant improvement and that therapy did not substantially impact on it. However, the Sceptic Rebuttal went further, by additionally claiming that the conclusions of the original analysis had been flawed. The sceptic researcher argued that the reliance on qualitative data rendered the data set weak and insufficient to allow data triangulation and to demonstrate change in psychotic process.

In addition, the Sceptic Rebuttal asserted that the Affirmative Rebuttal failed to acknowledge the reliance on patient self-report data. The sceptic researcher also stated that the Affirmative Rebuttal's explanations of the client being assertive and not coerced did not take account of possible data bias, which suggested the client's behaviour was potentially modified to please the therapist. The Sceptic Rebuttal cited Becky hugging the therapist in their last clinical session as an example of such behaviour.

The Sceptic Rebuttal also claims that the Affirmative Rebuttal failed to address points made in the Sceptic Brief that suggested that extra therapy events, such as contact with an animal, could have reduced the severity of psychotic process and that models of therapy and related evidence support this possibility.

The Sceptic Rebuttal stated in conclusion that the Affirmative Rebuttal had not demonstrated evidence that supported the claim that PCE therapy caused the reduction in Becky's psychotic process.

4.3.6 Sceptic/Affirmative Summary

This analysis; analogous to the closing arguments in a legal trial. The affirmative/rebuttal summary in table AS1 shows a section completed by the affirmative researcher and the sceptic researcher.

Table AS1

Becky: Affirmative and Sceptic Summary Narrative (see also appendix D6)

	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	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, and other interventions and events
Client relevant background (moderators)	Becky's psychotic 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 longstanding 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 for her 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 measurable 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 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.

4.3.7 Adjudication

Specific Process followed in this case study with reference to proforma table and report summary appendices (explained here)

Each judge was provided with the relevant documents by email. They were also offered access to resources for alternative formats if required. The documents sent to each judge consisted of the judge's form for completion, the Rich Case Record, the Affirmative Brief, the Sceptic Brief, the Affirmative and Sceptic Rebuttals, the Affirmative/Sceptic case Summary and an anonymised transcript of the Change Interview. They were also provided with instructions as well as a published HSCED to demonstrate the context of the method and how it worked.

Two of the judges asked for a face-to-face meeting with me to learn about the process before committing to involvement. All were offered follow-up support to explain or clarify processes and this was utilised by the four judges who were unfamiliar with the HSCED process. The HSCED method was also new to me as the researcher and where appropriate I received guidance from my supervisor and consulted relevant literature, some of which was discussed earlier in this chapter.

The judges were instructed to familiarise themselves with the method and judge's form, to examine the evidence and provide their verdict. The role of the judges was to help to establish how helpful the therapy had been for the client and the impact. First, the form directed them to consider whether change had occurred and the degree of change. Secondly, they were required to establish whether the change had been due to the therapy or other factors and to what degree. For each section a table was provided in which the judges mapped how each document had influenced their decision and how greatly each document had impacted on their views (see Appendices D7 and D8). Third, the judges were asked to describe mediating factors in the therapy that may have been helpful, as well as moderating factors consisting of helpful client attributes or resources influencing change.

Judges worked independently but as noted could ask the chief investigator for clarification if needed.

4.3.7.1 Summary of judges' reports of their opinions regarding change over the course of therapy

The five judges' reports are combined and shown in Appendix D8.

I examined the mean, median and majority decisions of the judges in each area, as well as noting their specific qualifying comments and how their arguments were influenced (see Tables 1.a, 1b, 2a and 2b below, also in Appendix D8 in Volume 2). Four of the five judges were most influenced by the change interview and HAT data (See 2d in Appendix D8, Volume 2)

Table 1a Extent of Change over Course of Therapy

Judge	**Extent of change (%)**
A	40
B	80
C	80
D	30
E	30

Table 1b Likelihood of Substantial Change over Course of Therapy

Judge	Likelihood of change (%)
A	20
B	100
C	80
D	20
E	50

Table 2a and 2b

Judge	Extent change due to therapy (%)	Likelihood of change substantially due to therapy (%)
A	40	40
B	80	80
C	80	80
D	60	40
E	50	40

There was a very wide range of numerical values in the quantitative elements to both questions 1 and 2, which estimate the possible extent of client change and the degree to which this is attributed specifically to the therapy and if the impact of the therapy was substantial in relation to change outcomes (see Tables 1a, 1b, 1c and 1d) which relate to. This diversity of data existed within the group of experts as carers and by experience, as well as with the therapist judges, and this may have been somewhat affected by the difficulty in negotiating the method of quantifying processes with limited instructions. I certainly puzzled over this when trying to clarify it and sought advice from my supervisor. There was more consensus within the qualitative data.

For question 1a, which asked about the extent of change over the course of the therapy, the mean is 52% and the median is 40%. This means that the judges' consensus was that the client was considered to have changed between a moderate and considerable amount.

Question 1b (the likelihood that there had been substantial change of over the course of the therapy) has a mean value of 62% and a median value of 50% for the likelihood of the change being substantial. For this question, most judges (three of the five) thought that the client showed at least substantial change over the course of the therapy.

For question 2a (the extent of the client's changes that were due to the therapy) the mean value is 62% and the median is 60%. Most judges (three of the five) thought that the client's changes were attributable to the therapy by at least a considerable amount.

For question 2b (the likelihood that the client's changes were at least substantially due to therapy) the mean is 56% and the median is 40%. Most judges felt that there was at least 40% likelihood that the client's changes were substantially due to the therapy, with two judges saying they were 80% likely and three showing a wide range of opinion.

When we examine the qualitative data in more detail there is a higher consensus within the content.

4.3.7.2 Summary of opinions about change over the course of therapy

The judges' opinions in relation to key areas, justifying the percentages shown in the charts in Figures   are summarised here. Appendices D8 show the judges' full reports.

Judge A noted that Becky's CORE scores demonstrate statistically significant reduction in distress and that self-report measures indicate positive change in emotional experience and behaviour. Judge A also noted that Becky reports increased contact with reality, improvements in coping skills and social engagement, and more meaningful work, with an overall view that considerable change has occurred. Judge A added that that there was a lack of clarity regarding outcome evidence for change in psychotic process or what experiences might have been attributed to complex grief. Judge A also noted that the client did not improve to the point of crossing the clinical cut-off on the CORE, justifying their view that substantial change did not occur.

Judge B noted that the client's negative spiral of symptoms and reduction in wellbeing was halted. They noted that the client remained vulnerable with some symptoms still occurring but that positive changed had occurred.

Judge C noted that Becky's changes were related to the negative impact of psychosis and agreed with Judge B in stating that further deterioration was prevented during the process. Judge C noted that recovery narratives often deal with the more problematic impact of psychotic processes rather than symptoms themselves. Judge B noted that an independent researcher was involved in some measures with no evidence that Becky was giving positive feedback to please the therapist. Judge B also noted that the measures show that Becky was very surprised that the change occurred, "indicating that an out of the ordinary shift had taken place in her mental health".

Judge D noted, in agreement with judge A, that the CORE data showed a clear reduction in distress and difficult symptoms, which gradually reduced over 22 weeks. They also referred to the Rich Case Record and Change Interview showing four changes, three of which Becky said were very unlikely without the therapy. These changes were "feeling things are more real”, “getting out more”, “meeting people”, “getting out of the city I live in” and Becky stated that three of these would have been very unlikely without therapy. Judge D highlighted further changes described in the 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”. Judge D stated that “These are definite results which will improve Becky’s mental health. These are also life skills that can lead to further changes.” Judge D felt that there were both identified and immediate changes, as well as Becky being able to ask for help and gaining the ability to use therapy when facing difficulties. Judge D also noted that globally there was some change documented in the Change Interview, although less than the client had hoped for.

Judge E felt that considerable changes occurred in Becky’s socialising, functioning and quality of life. Judge E also considered that Becky demonstrated increased autonomy and creativity, the ability to trust her therapist and the ability to discuss issues that she could not take elsewhere, and that she had moved on with life. Judge E also noted that Becky stopped hearing voices, was no longer thinking of suicide and showed reduced self-stigma.

4.3.7.3 Summary of opinions regarding whether the change was due to the therapy

Judge A pointed to the difficulty in assessing evidence but did feel that Becky consistently rated the therapeutic relationship highly and felt that to some degree this suggested the effectiveness of the therapy. Judge A did not see any evidence that Becky’s responses were attempts to please the therapist or researcher. Judge A felt that the therapy had led to Becky's increasing stability, facilitating her regaining the ability to cope with life and engage in work and relationships with friends and others. Judge A also thought that the therapy might have released Becky's actualising tendency, which had been previously negatively impacted upon by family conditions of worth and her own guilt in relation to her brother's death, although they expressed their difficulty in connecting this to the specific evidence provided.

Judge B felt that the therapeutic conditions and the relationship offered met Rogers' (1957) necessary and sufficient conditions for constructive personality change and made substantial measurable and observable change possible for Becky. Judge B's theoretical position supports that of judge A in giving high importance to the effectiveness of the therapeutic encounter with different stances regarding degree of change.

Judge C also noted the strong therapeutic alliance, evidenced by evidence that Becky felt understood and was able to release emotion. Judge C viewed Becky as gaining more control of issues attributed to her psychotic process and considered these changes to be due to the therapy. Judge C felt that Becky's commitment to the therapy indicated that she was benefiting. He felt that getting a dog, a new relationship and changing employment may also have positively impacted on Becky, but that therapy existed in the context of Becky's life, which is to be expected.

Judge D decided that Becky's changes were considerably due to the therapy. Judge D also noted the strength of the therapy relationship and that the commitment to this relationship as a place to process. Judge D noted that the therapy relationship was good enough for Becky to feel understood and seek relief. She noted that the HAT data demonstrated that Becky valued being understood and expressing her feelings, rating this as greatly or extremely helpful. She also felt that Becky being able to trust and talk to the therapist about things that she could not take elsewhere, vent, find relief and feel understood was helpful, as evidenced on the client Change Interview. Judge D also felt that getting a pet dog, other support and employment, and Becky's own natural healing process probably also helped and that this was usual as therapy happens within the context of wider life.

Judge E felt that Becky was responsive to the therapy and valued and enjoyed it, attending regularly despite setbacks and feeling free to explore other ways of coping such as medication and early intervention, growing in confidence and control of her life on her individual recovery path.

In summary it seems that all five judges noted the strength and positive impact of the therapeutic alliance. Additionally, there was some consensus regarding Becky's reduction in distress and higher functioning on many levels and increased ability to cope and the noting of the specific changes highlighted from the Change Interview Protocol. At least two judges also specifically agreed that further deterioration had been prevented.

4.3.7.4 Mediating factors: Helpful therapy processes

Judges identified processes within therapy that they felt had brought about the changes. Judge A thought that Becky's consistently very high ratings of the therapeutic relationship and the fact that this served as a space in which she was able to talk and feel understood were important, with Becky rating several changes as unlikely without the therapy. Judge A felt that this was important and allowed Becky to access her own inner resources, build on coping strategies and make positive progress.

Judge B found it difficult to distinguish between grief process and psychotic process and whether these were separate or changed due to limited quantities of relevant quantitative data. Judge B felt that the changes of diminishing anxiety, fear and depression were in relation to Becky taking control of her life and that a trusting therapeutic relationship provided conditions for these changes to occur. Judge B pointed out that the therapist was not treating the psychotic symptoms with the goal of reducing them but was working with Becky to help her to self-empower as a result of the impact of the therapeutic relationship.

Judge C also noted that changes were due to the therapeutic alliance and Becky feeling understood, as well as the fact that the therapist was familiar with psychotic processes.

Judge D placed importance on particular positive processes influencing change, and implied that there were others. These named helpful processes were: the space and time to talk; the therapeutic relationship quality; being and feeling understood; the validation of Becky and her thoughts by an experienced therapist in a multi-sector context; and utilising creative resources (such as painting) at times. When considering possible unhelpful processes, Judge D wondered whether the measures could be slightly intrusive or affect the flow of ideas.

Judge E felt that a helpful process was the fact that Becky stayed with the therapy, building confidence and trust. Judge E noted that medication was not helpful and so Becky withdrew herself from it.

In summary it seems that three judges (A, C and D) specifically noted how Becky felt understood in the therapy and was validated.

4.3.7.5 Moderator factors: Helpful or unhelpful characteristics affecting change

The judges identified characteristics or personal resources that they felt helped Becky make use of her therapy to reach positive outcomes or else had adverse effects.

Judge A saw that Becky had difficulties with relationships with family and friends, which could have negatively impacted her progress. Becky’s increased social contact, change of employment, increased travel and getting a dog could have facilitated her change. Becky was also supported during referral to specialist support. The impact of medication uptake and withdrawal was difficult to assess.

Judge B saw that Becky was able to engage in the helpful therapy relationship, leading to her increase in personal strength, and enabling her to take risks in being assertive, connecting with others and trying out new experiences.

Judge C noted that Becky showed the ability to release emotions in the therapy sessions and a willingness to learn new coping strategies.

Judge D thought that the process was likely to have varied, but that Becky persevered and engaged fully in the process. She was motivated to attend therapy regularly and showed tenacity, using the help offered to facilitate change in herself.

Judge E felt that Becky demonstrated optimism, tenacity and assertiveness. She was able to leave a job, plan a holiday and develop new social relationships without the family difficulties holding her back from changing.

Summary of themes raised by judges

In summary the judges noted a wide range of change factors pointed to Becky's determination in engaging with the therapy to release and manage emotions as well as developing coping mechanisms and building on increasing resources and new relationships.

4.3.7.6 Moderator factors: Contextual factors affecting change

Each judge independently identified aspects of Becky's life situation or contextual issues outside of the therapy that impacted positively or negatively on change.

Judge A felt that Becky's emotional difficulties appeared to have been significantly affected by difficult family relationships with a lack of other support. Judge A also viewed stabilising relationships positively impacting on Beck's functioning.

Judge B felt that Becky made successful steps in engaging with the world, which "created an upward spiral of trust, resulting in positive change".

Judge C felt that getting a dog, changing her medication, developing a new relationship and her introduction to the EIP team affected positive changes.

Judge D noted that Becky experienced grief from the loss of her sibling, experienced difficult family relationships and was isolated, without emotional support, and that this would impact negatively. Leaving her stressful job, gaining new employment, becoming more engaged socially and the health impact of getting a dog were positively impacting events. Judge D found it difficult to know the extent that different events impacted on Becky but felt that Becky was able to bring her life events to therapy. Judge D added that by the end of the therapy it seemed that Becky had increased self-awareness and had future hope, evidenced by a new relationship and exploring the possibility of a flat-share with a friend.

Judge E felt that Becky socialising and getting a dog had a positive impact.

In summary it seems that judges noted a wide range of factors aside from the therapy were likely to have positively impacted on Becky's wellbeing including new and stabilised relationships and getting a dog.

4.3.7.7 Adjudication Review

The data from the case documents, along with the judges' outcomes, present a range of reflections with some common areas. The data and judges' opinions suggest that the client change was at least considerable, with most judges stating that the client's change was at least substantial and a majority also concluding that the changes were attributed to the therapy by a considerable amount.

If we break down the data and consider the wide range of views that emerged, it raises interesting questions regarding the case and around how we can evaluate the level of change and contributing factors. However, there were definite areas of consensus and all judges noted the positive impact of the positive therapeutic alliance.

The client was found to have changed over 22 sessions of PCT and the PCT therapy was found to have contributed to this change.

The integration of the judges' reports leads to the following consensus:

Hallucinations can be a part of grief and both sudden loss (as in the suicide of Becky's sibling) and complex grief and psychotic process can cause trauma; thus, Becky's issues were a complex integration of these processes. Therefore, whilst carefully considering factors relating to various presenting issues or aspects of these, it is also important to consider the complex presentation as a whole, as well as the person-centred-experiential therapy offered, which inevitably hoped to reduce distress but was focused around presenting issues session by session and offering Rogers' therapeutic conditions within the context of a PCE therapy relationship.

4.4 Interim Discussion

4.4.1 Discussion regarding findings

This case study raises consideration of whether person-centred experiential psychotherapy may be helpful for adult clients who experience psychotic process. The evidence and judges' verdicts suggest that considerable (but not substantial) change occurred in Becky's case, which was likely to be attributable to the therapy. Some changes may have been due to natural or other factors as well as the therapy itself. However, when Becky presented to therapy, she was contemplating taking her own life and was disengaged, escalating downwards, terrified of psychotic process and scared of harming others. At the end of the therapy she was feeling more herself, working, going out, planning a holiday and had friends, a new relationship and a new job, with some symptom reduction and stress reduction.

One of the most prominent features of the data in this study was the strength of the therapeutic alliance and the value attributed to this by Becky herself as evidenced in the change interview, and the TRS. This compliments literature discussed in Chapter 1 such as the fact that Becky had both long- standing problems and showed marked improvement soon after the therapy began which suggests a change in stable process and also explicitly attributed change to the therapy (Elliott,2001,2002) Becky was determined to attend and actively engage in the therapy. Over the duration of the therapy she made some progress and then was able to push herself to re-engage with others and the external world. She worked on releasing difficult emotions including those associated with complex grief was able to enhance her coping strategies as well as developing new ones. Getting a dog was seen by some of the judges and sceptic researcher to be significant but there was no actual evidence in the case documents to support this as a factor contributing towards change.

All judges noted some global changes and specific improvements and increase in Becky's quality of life. Just because Becky's change process was complex and involved both the therapy and other contributing factors. Becky's change was typical of a client in psychotic process and was non-linear and involved a package of support and personal and contextual factors that both created barriers and impacted on outcome .Overall, it was noted that Becky was tenacious and used the therapy well and was active in making changes with the therapy as part of the process where she "vented" and offloaded, evidently feeling understood.

Becky felt less mad as she discussed and embracing her unusual experiences and they reduced over time.

If one considers the spectrum of therapies and treatments for psychosis, person-centred-experiential therapy is a non-intrusive, client-led treatment that can exist well in the context of a multidisciplinary package of care and may be helpful to some clients. Whilst the model can incorporate elements of gentle technique – such as pre-therapy – the client's agenda and presentation were placed in the centre of the therapy. The model worked with the real relationship. Accepting that many clients who experience distressing processes may wish for symptom reduction, this might not be realistic for any modality of treatment or treatment combination with some clients. The support team sought to support the client to progress as much as could be realistically achieved with an optimistic attitude but accepting that some people will continue to experience distress or difficult "symptoms" and will need to manage these. Each person is an individual and, while the efficacy and cost-effectiveness of care is important, no treatment can predict substantial outcomes or be sure of symptom reduction. However, minor but significant changes can improve a person's quality of life enough for them to be happier and more self-accepting and engaged in society and employment.

If we looked at a medical condition or newly acquired physical disability paralleling this case and managing it was the best realistic outcome, we would be unlikely to deem this as a failed treatment. A balance is needed in which we aim to help individuals to reduce distress as much as possible but also need to consider the wider perspective of what good outcomes look like in complex process and take careful consideration of how individuals with unique needs can move further towards leading what are, in their own terms, full and rich lives, wherever realistic, and always prioritising supporting the client's own agendas and choices.

Practitioners may need to take care to be open to being hopeful and optimistic but also cautious, acknowledging the complexity and severe trauma of some individuals. Without such sensitivity and awareness of non-linear change process we could be in danger of setting up both clients and therapists or practitioners to fail or of applying unfair pressure regarding prescriptive outcome expectations to complex processes which match society's medicalisation of distress and negative notions of disorder, which leads it to focus on "what is wrong" rather than helping progress which is mapped and rooted from a more open and less restricted value base. Thus, taking the judges' overall verdict into consideration, it seems that Becky's case shows that change can and has occurred. However, in the framework of the medical model, a complete alleviation of symptoms has not happened and neither has any change occurred that literature would suggest is realistic with any therapeutic modality. It is also important to be clear in concluding that Becky's own part in the therapeutic collaborative partnership and her own actions and helpful context factors are integrated into the change process and may be related to therapist contributions than being located as alternative change agents. The therapist does not necessarily perform an "intervention" on the client which has a possible impact. This simplistic notion of linear causality does not apply here. Instead the collaborative relationship, sharing of power and following the lead of the client with both parties being active impacts on change outcomes in complex ways.

Therapy can play an important but not an exclusive role in affecting the client's process of continuous change. The HSCED method is an example of a route which attempts to identify elements of nonlinear interactive processes, particularly in complex case studies. (Elliott et al, 2009)

This study compliments findings in studies 1 and 2. All studies' outcomes and implications will be discussed together in the final discussion and conclusion in Chapter 5 and questions raised for potential future research**.** It will be interesting to return to this issue in the final discussion and compare the HSCED outcomes to results in study 2 where clients show their own evaluations regarding change.

4.4.2 Strengths and limits of this study and the HSCED

This is a single case method, so generalisability is limited. However, the specific HSCED method is more conducive to comparisons than less rigorously or systematically conducted case studies. Despite this obvious limitation the study does provide rich data which would possibly not be picked up so readily in a larger scale study which raises interesting questions regarding the recovery and change process with both Becky and this client group and the factors.

Judges' process feedback

Feedback from judges indicated that further clarity of process and a reduction in clinical terminology could increase the ability of a broad range of judges to participate, and more explicit guidance regarding how to define substantial change in the context of this specific research method would have been welcomed and would have reduced variation in interpretation between judges and any similar future cases to enable valid comparison.

A wide range of judges provided a diverse range of expertise and counter-balanced different biases; I had tried to obtain the support of additional therapist judges from other models such as CBT or psychiatry to act as judges but was not successful. This could be considered in future HSCEDs. Some judges found some aspects complicated but their general overall reported experiences were positive and in one example a developmental journey catalysed by the judge role was acknowledged. One issue I faced when liaising with the judges was also raised by Stephen, Elliott and Mcleod (2011) who, in their HSCED of a client who experienced social anxiety with a complex data set, raised the question of whether the judges' interpretations of substantial change were different. In the case of Becky two of the judges themselves raised this issue; I sought consultation but still struggled to give explicit definitions and guidance.

Stephen et al. (2011) also found evidence suggesting that that perhaps the judges' understanding of scale anchors varied. The question was raised by Stephen et al regarding whether the scale should be developed, and the study of Becky reinforces this vulnerability in the process. If the scale were modified or clarified further this could ensure that all parties had similar interpretations of the scale and increase the consistency and reliability of data, both within a single HSCED and when comparing HSCEDs.

I wondered if s my HSCED title was itself misleading in labelling the client as in psychotic process when the there was no stated goal on the part of the therapist or client to reduce symptoms but work with all presenting issues and parts of the client whilst acknowledging that one of Becky's issues was distress.

Although the delay between therapy and analysis meant there was more distance and less bias, it also meant that minor data inconsistencies were harder to manage. Despite this, some meaningful questions and points for further study have been raised. Elliott and Widdowson (2017) explained that one difficulty presented by the HSCED method is the need for strong adherence to data collection batteries, and missing data can be problematic as well as the inability to know detail regarding the therapy process.

Elliott and Widdowson (2017) also point out that the stages of the process and write-up are time-consuming for all parties and the judges are required to inspect a large amount of information. They also state that HSCED and other case study methods can be difficult to generalise beyond the specific case. Benelli et al.'s (2015) systematic review of published HSCEDs finds that the patient difficulty or diagnosis may be unclear, and the treatment may also not be manualised. I am aware that in this case the therapy is a person-centred approach and does not lend itself well to diagnosis due to a clash in ethos with the medical model, but this can make comparison more difficult. This influenced measure selection (e.g. the positive and negative syndrome scale for psychosis, which I will describe later) to somewhat compensate for this difficulty without betraying the core approach.

Elliott and Widdowson (2017) discussed the strength and limitations of the HSCED. They explained that the HSCED method is a fully documented structured approach and therefore has the advantage of being accessible and suited to both new and experienced researchers and can be a stimulating and powerful learning experience. Benelli et al. (2015) emphasised that the HSCED analysis must be conducted with academic rigor and must focus on clinical evidence. My personal experience is that the legalistic way in which the process unwinds, with intense study of data and consideration of it with opposing arguments, not only provokes deep consideration of therapy process and outcome elements but also creates a vehicle for explanation that is somehow more "alive" than other methods I have considered. Information may be pinpointed and almost dramatized in its delivery (while still sticking strictly to facts) in order to see them more clearly. Elliott and Widdowson (2017) also considered that the use of expert opinion limits researcher bias and provides another source of strength for this method, and they feel that the HSCED method includes transparency of data and therefore allows the reader to scrutinise it more readily themselves.

This study could have used more rigorous outcome measurement process provide a more comprehensive data set. A simpler measure to pick up on the change in psychotic process as well as other factors but less lengthy than the PANSS may have helped to satisfy sceptic researcher scrutiny of the case but also would have been in danger of colluding with a medical model framework which is not part of the person -centred position and would have posed yet another issue of differing belief systems regarding distress (see Sanders, 2006b) although another learning was the importance not to focus just on medical model defined symptom reduction as a measure of success or failure of treatment as complex factors are involved in recovery and progress can be made in symptom management as well as reduction.

The inclusion of a wide range of judges as the first HSCED to involve service users and carers as judges proved a worthwhile process bringing interesting dimensions to the results. This could have been further improved by the inclusion of therapist of other modalities than PCT.

Chapter 5

Discussion and implications for practice

5.1 Introduction

This chapter begins with an overview of the results of each of the three studies which were conducted as part of this PhD. Following this is a discussion relating to the results of all three studies, emerging themes and their contribution to the literature. The next section focuses on evaluating the success and challenges of the research methods used. Consideration is given to what methodologically worked well in the studies as well as what aspects of the methods could have been improved, with possible implications for future research. The validity and credibility of the data is then evaluated. A discussion then follows regarding implications for practice and the impact of the studies on my own practice. Finally, concluding reflections relating to the entire research project, draw this chapter and the overall dissertation to an end.

5.2 Key Findings

5.2.1 Study 1: Key Findings

Study 1 consisted of twenty interviews with PCT practitioners working with psychotic processes in clients. Results were organised into three broad domains: Domain 1, which related to helpful factors in practice, Domain 2, which consisted of perceived changes in clients by practitioners and Domain 3 which described contraindications and referral issues.

Data in Domain 1 showed that most participant practitioners completed professional training, typically a Diploma in PCT, later gaining experience with clients in psychotic process and seeking further training in this area. Most of the therapists incorporated elements of pre-therapy (e.g. Prouty, 1990) into their current practice, sometimes reporting remarkable and surprising outcomes in establishing psychological contact with clients who were out of contact. Several practitioners were influenced by Margaret Warner's work. (e.g. Warner, 2001).

Practitioners worked with sensitivity, sometimes with co-therapists or in multi-sector care contexts, sharing management of care and risk and explicitly contracting with clients. Results suggested that assessing risk and supporting vulnerable clients in psychotic process to cope in between sessions or feel safe to leave the session had involved greater directivity than some PCT therapists found familiar or, at first, comfortable. Data highlighted the need to consider tempering the intensity of the therapeutic relationship, managing the physical space to avoid overwhelming clients.

Practitioners found it important to work within the limits of their competency, gradually increasing their confidence and skills. They were optimally supported by clinical supervisors with relevant training and experience. Some practitioners were initially unsettled or distracted by client disclosures with dramatic and unusual content. However, familiarity with such material led to an increase in the practitioner's ability to stay grounded and remain more accepting and present.

An important theme arose for practitioners of meeting the client as an individual in a real relationship rather than focused on techniques, medical diagnosis or symptoms, supporting clients to embrace and normalise unusual experiences.

Practitioners frequently discussed building a person-centred relationship with clients, with frequent references to offering the core conditions. Positive Regard (UPR) was viewed by practitioners as the most important therapeutic condition for clients with psychotic processes, who are often stigmatised and excluded. Careful consideration of the use of congruence and the importance of empathy also arose. Minimising the power differential was another central theme.

Data in Domain 2, described perceived client changes. The largest change category of “improved connection” included many examples of more connection to reality, increased social adjustment and improved social skills. Other themes included lessened risk of harm to self or others, improvement in self-awareness and resilience. Reductions in problematic experiences were often noted, with improvements in mood and emotional state such as lessened anxiety. Less occurrence of and less trouble with unusual experiences such as voices or hallucinations was also often reported, as well as embracing and managing such experiences more effectively.

Improvements in sense of self was also a significant category, including reduced self-judgement, increase in self -acceptance and empowerment as well as increased self-integration incorporating more stabilised identity and increased insight. Improved quality of life was observed in 15 clients including general improvements, and increased resilience and coping.

Data in Domain 3 suggested that some clients may be more suited to other therapeutic approaches and some therapists had learnt to take care to moderate the emotional intensity of interactions in certain instances where this could be overwhelming for some specific clients who may need emotional distance at times.

5.2.2 Study 2: Key Findings

Study 2 involved structured change interviews with 20 clients who had unusual experiences, heard voices or psychotic process and received PCT. This study contained three domains of data: Domain 1 involved client post-therapy changes; Domain 2 addressed helpful aspects of therapy and other helpful factors; Domain 3 showed unhelpful aspects of therapy and other unhelpful factors.

Domain 1 contained data which showed positive global change in most clients. Three quarters of clients reported a reduction in problematic or unusual experiences, echoing Study 1 outcomes. Three quarters of clients in Study 2 reported reduction in problematic experiences which was also a theme noted by practitioners' observations of clients in Study 1. Mood states (such as depression or anxiety) also improved in most clients, with better coping with anger specifically reported by a quarter of all clients. Most clients experienced improvements in sense of self. This included more positive self -evaluation in half of the client participants as well as increased self-awareness in half of the clients. Three quarters of clients reported increased external connection, which included improved lifestyle, improved coping, increased engagement in the world and increased ability to be with others. These finding echoed Study 1 results. Study 2 also showed evidence of improvements in self-expression, assertiveness and interpersonal connection and ability to trust. Over a third of the participants saw reduction in risk-related behaviours including areas such as reduced suicidal ideation and reduction in risky lifestyle.

Data in Domain 2 of Study 2 covered helpful aspects of the therapy. Most clients brought helpful contributions to therapy such as helpful attitudes, qualities or beliefs and readiness for change including determination or perseverance, which featured in over a quarter of client interviews. Three quarters of clients reported helpful in-session or therapy processes such as therapist warmth, non-judgemental attitude or authenticity. In this category a third of clients experienced immediate effects such as feeling understood or relief of anxiety. Most clients experienced helpful therapist contributions with openness and cultural similarity featuring in this category and over a third of clients found that boundaries, use of space and other contextual parameters were helpful and important; these were also a strong feature of Study 1 data. Some clients also found other treatments helpful such as CBT, groupwork and dreamwork. Half of all clients acknowledged painful but helpful experiences.

Domain 3 explored unhelpful experiences including over a third of clients who described their own negative client contributions to the therapy process such as guilt or worry. A quarter of all participants, despite any positive experiences or aspects of therapy, also felt deterioration or expressed negative evaluation or missing aspects of the therapy. This was usually attributed to unwanted therapist behaviours and characteristics which were at variance to person-centred practice. For example, unwelcome directivity, the therapist adopting an expert stance, not being “real”, not being active or introducing unwanted structure, were reported as unhelpful therapist behaviours. Unhelpful therapist qualities were also reported such as a critical attitude. A quarter of clients reported missing aspects such as wanting signposting or the opportunity to work to their own goals.

Over a third of clients had experienced other treatments as unhelpful such as medication, CBT or psychodynamic therapy. Some clients noted as unhelpful the uptake of medication, leading to increased suicidal ideation.

Study 2 **rated** changes are incorporated qualitatively into the main study 2 data, but if examined separately, they showed a similar spread of changes with changes in self, ability to engage in life and improvements in mood, coping, normalising and reduction in unusual experiences.

5.2.3 Study 3: Key Findings

The HSCED study of “Becky” examined the person-centred therapeutic journey of one client with psychotic process. Evidence was gathered from the therapy, including reports and outcome measures; then, legalistic procedures were used to ascertain whether Becky experienced changes, the degree of change, and whether changes were due to the therapy or other factors.

Becky presented in a state of distress, finding it hard to go out or be with others, with feelings of not being real, hearing voices and unusual experiences as well as thoughts of suicide and fears of harming others. By completion of therapy she felt more real, was able to go out, travel, sustain better relationships, cope, work and consider independent living as well as self-advocate and engage with other services.

The affirmative case argued that Becky had long standing issues, was in a critical phase of early psychotic process and that the therapy caused significant positive changes in overall wellbeing and prevented further deterioration in mental health, with reduction in risk.

The affirmative brief noted that the PANSS assessment confirmed psychotic process and that the mid- therapy CORE data showed positive change from the severe to moderate range of distress. The Client Change Interview showed further evidence of client-rated changes with three changes viewed as extremely unlikely or very unlikely without therapy and very or extremely important. These changes were in feeling more real, getting out more locally and increased ability to leave the city.

The sceptic case accepted that some changes had occurred but suggested that these were influenced by factors such as bias, the natural course of events, other interventions employment, friendships and getting a dog, rather than the therapy. The lack of consistent, robust data such as a post-therapy PANSS and the lack of evidence for the reduction in psychotic symptoms were criticised.

The affirmative rebuttal to the sceptic brief accepted that some non- therapy factors may have impacted but confirmed that there was no evidence supporting this. The rebuttal stated that the sceptic researcher's focus on medical model- based changes detracted from the substantial recovery process undergone by Becky. The rebuttal asserted that Becky experienced a reduction in psychotic process, captured in client statements, and distress reduction as evidenced in the CORE measures.

The sceptic rebuttal followed this, stating that evidence only pointed to the occurrence of minimal client change and that even the qualitative evidence was weak, with positive data influenced by the client's need to please researchers.

The affirmative rebuttal of the sceptic case then disagreed with the sceptic rebuttal and stated that qualitative and quantitative data showed that the therapy substantially impacted upon Becky's changes. The sceptic rebuttal then claimed that the affirmative rebuttal did not demonstrate a convincing case for more than minimal client change and that any general change or reduction in psychotic process was not a direct result of the therapy. The affirmative and sceptic researchers then briefly summarised their positions before the judgement stage.

In the final HSCED judgement stage most judges, having reviewed all documents, concluded that the client's change was at least substantial and that the changes were attributed to the therapy by a considerable amount. Both the data and judges' opinions therefore led to the final conclusion that Becky's change was at least considerable.

Most judges particularly recognised the strong therapeutic alliance, how Becky felt that she was understood and noted the reduction in both her level of distress and unusual experiences. Also particularly noted, was the client's determination, tenacity and coping mechanisms; which echoed data in studies 1 and 2. Some judges noted the role of extra-therapy factors affecting Becky's change, which included her getting a dog. Judges also noted specific changes and deduced that Becky was now more able to engage with the world and access resources.

5.3 Overall Themes Across Studies and Knowledge contribution to existing literature

5.3.1 Contemporary Practice

If one considers the results of all three studies some common themes emerge as well as specific outcomes linked to each study. The results of Study 1 give an indication of the shape of typical recent UK person-centred practice with clients with psychotic process from a practitioner perspective, which has not been previously captured.

Most practitioners working with these types of client processes used pre-therapy or contact reflections, showing integration of pre-therapy as common practice in the UK in private practice settings, statutory services including acute psychiatric services and the third sector. Some practitioners alternatively or additionally implemented suggestions from texts by Warner (e.g. 2002) and others and their practice improved through learning by experience.

If we surmise that the sample of 20 practitioners in Study 1, recruited from across the UK, working in all sectors, is typical, this study demonstrates the contemporary nature of UK practice and integration of newer person-centred theories and styles of working. The additional training and developed practice offered increased opportunity to successfully engage with vulnerable client populations with many examples of positive outcomes.

Issues regarding nuances of practice and suitable contexts and parameters were also apparent, as previously described. These therapists were better equipped than some of the practitioners in earlier studies (e.g. Wisconsin; Rogers et al., 1967). An overall theme of practice seemed to suggest that highly committed practitioners would invest strongly in helping to establish a safe and often long- term supportive relationship, working *with* a client in difficult and sometimes psychotic process. Practitioners, often experiencing a degree of mutuality, coped with the challenges that this brought for the practitioner and often, with sustained effort by both parties, saw positive outcomes beyond their expectations. This finding is echoed by Warner's (2008) statement which captures the critical nature of this type of work for the person-centred practitioner.

"Deep changes in "difficult process" require relatively long, empathically sensitive therapeutic relationships. Yet, in considering the extent of this investment, it is important to remember just how personally debilitating difficult process is in the lives of clients. Clients in the midst of difficult process have high risks of suicide, extremely high levels of personal distress, loss of ability to work and loss of ability to maintain personal relationships. Taken together, the effects of difficult process can be as debilitating and as life-threatening as having a heart-attack or cancer. The therapeutic work can be life-saving, and seems well worth the cost" p22

5.3.2 Relationship and alliance themes

The therapeutic alliance was described as important in all three studies, therefore including the views of therapists, clients and judges, both generally and in terms of specific qualities attributed to positive therapeutic relationship. Furthermore, many narratives in these studies described clients who were vulnerable, found trust and engagement difficult, but often gradually built a solid therapeutic alliance. This alliance then appeared to act as a foundation for developing stability and growth and even a safe platform for challenge. This finding relating to clients in psychotic process supports research which suggests that the therapy alliance seems to be one of the most important factors affecting change in clients, regardless of client issue or modality, as discussed in Chapter 1. Data suggests that PCT therapeutic conditions as perceived by therapists and clients appeared to be important factors in building a strong connection, affirming themes discussed in chapter 1 when reviewing literature and specifically discussed in 5.3.3 here.

Llewelyn and Hardy (2001) and Farber and Lane (2002) tracked the history of process-outcome research identifying the alliance as causal regarding outcome in psychotherapy of all modalities. Chapter 1 has already discussed literature specific to psychosis, suggesting that positive alliance in this population can predict better overall outcomes. The value of an ongoing therapeutic relationship which may be long term is also listed within the International Society for the Psychological and social approaches to Psychosis charter with good practice recommendations (n.d.).This position is also supported by the outcomes of Frank and Gunderson’s (1990) study of psychodynamic therapy for clients diagnosed with chronic schizophrenia which found that patients were slow to engage in an adequate therapeutic alliance but that alliance quality in the first six months was a predictor of long term positive outcome at two year follow up.

These studies, particularly study 1, may support the position that the addition of pre-therapy to the repertoire of the PCT therapist seemed to enhance the building of contact and alliance and increase the likelihood of positive outcome with clients who experience psychotic processes. Focused research in this area could be warranted.

5.3.3 Therapeutic Conditions

The importance of a person-centred ethos incorporating Rogers' six conditions and particularly the core conditions of therapeutic change seemed to feature strongly in the results. Study 1 practitioner data and study 2 client data raised the importance of genuineness, empathy and an accepting, non-judgemental attitude, supporting core person-centred theoretical literature (Rogers,1957,1959). It seems that despite some of the early concerns regarding the potential to make psychological contact with clients in psychotic processes and regarding whether the conditions can be sufficiently received this research support, these studies support later literature that the conditions and contact can indeed be met within PCT and provide a basis for growth. The integration of pre-therapy and other contemporary developments within PCT may enhance this possibility.

The core condition that featured most was UPR, which was also the most named condition by therapists in study 1 and discussed by a third of participants in study 2, with its role implied in Study 3. This supports literature discussed in Chapter 1 including Roger's (1967) conclusions regarding the Wisconsin study. Data in these three studies, further suggested the possibility that unconditional positive regard may be particularly important to clients with psychotic process who may have been firstly subject to judgement and stigma and consequentially internalised negative judgements or feelings of being mad. This was reflected in many examples in the data, where UPR seemed to in some way help to remedy this by supporting normalisation of unusual experiences and influencing increased self-acceptance.

Rogers developed the concept of UPR with reference to the self-concept in 1946 (Rogers, 1946), later proposing it as one of six necessary conditions for constructive personality change in his 1957 paper (Rogers, 1957). In 1957 he described UPR as "warm acceptance of each aspect of the client's experience" (1959).

Many clients in Study 2 spoke of both the therapist's warmth and acceptance and the contrasting judgement of others. (also noted in Bjornestad et al, 2018) study of clients with psychosis experiencing psychotherapy). They also spoke about the negative impact of stigma and some treatments and diagnoses. Many clients in the study had struggled with self-judgement. Rogers discusses UPR in the context of dysfunctionality and how clients internalise norms that may be contrary to their desires or experiences, causing alienation from the deeper core self, so the UPR of the therapist may have been particularly important in this context.

Lietaer (1984) theorised that UPR creates conditions of sufficient safety and holding for unblocking painful feelings, and highlights and facilitates self-acceptance, leading to change. Barrett-Lennard (1998) expresses the view that UPR functions as a medium for interpersonal corrective experiences, fostering self-acceptance, self-love and self-empathy. He explained the facilitative nature of UPR. Barrett-Lennard asserted firstly that the high degree of safety and holding created by UPR promotes the therapeutic climate that enables the client to "unfreeze blocked areas of experience and allow painful emotions". Secondly, he stated that UPR serves as "a medium for interpersonal corrective experiences through which self-acceptance, self-empathy and self-love are fostered". Finally, he explained that UPR helps the client to become more "inner-directed" and self-trusting and true to their organismic experience, "as a compass for living" and enable the client to be their own self-therapist. (Barrett-Lennard, 1998)

Therapists in study 1 often discussed the importance of UPR in relation to different positions on congruence. Data seems to affirm Cochran & Cochran (2006) who discussed the action- based nature of UPR and how limit setting if challenged by the client's presentation or behaviour and working on offering the conditions was an important consideration. The implication of this in terms of therapist self- care may be important as this was a frequently discussed theme in study 1.

Data suggests careful judgements were required regarding the use of congruence, which may be discussed in clinical supervision as it could be either critical to offer to some clients or too much for other certain clients to manage in a particular time-frame.

Literature explored in Chapter 1 raised the issue of whether there are barriers to empathy being fully received by this client group. The findings here suggest that, despite hurdles, clients were often able to connect and experience the therapist's empathy. One could speculate that this psychological contact and alliance where clients were more able to receive the core conditions may have been easier to accomplish in contemporary person-centred practice incorporating pre-therapy and practice instigated by Prouty (1990) and Warner (2002) than in earlier studies by Rogers and his team. Rogers, Gendlin, Kiesler, & Truax (1967) were less familiar with this client group and identified this challenge. It is also important to note that contemporary psychiatric treatments and medications are different to when the Wisconsin study was conducted. Although many contemporary psychotropic drugs can cause sedation and other side effects there is greater variety of treatment and newer second- generation antipsychotic drugs(see Mind, 2016 for an overview) .In these three studies treatments experienced by clients varied with some clients taking medication and others who were not taking any medication during the time of the therapy.

Wood and Irons' (2017) study of 52 service users investigated how experienced stigma affected psychosis. The findings imply that those who experience psychosis as well as additional stigma and discrimination benefit from empathy, normalising support to mitigate against additional distress caused by shame and low social rank. This seems to align well to a person-centred ethos and the role of the core conditions, accepting all parts of the client and normalising unusual experiences (without minimising any distress). Therefore, the research findings and literature discussed in this PCT seem to complement Wood's findings.

5.3.4 Reframing and coping with voices and unusual experiences

Results in these three studies demonstrated a further theme of how clients receiving PCT often reframed unusual experiences into meaningful personal messages or dialogues and became more able to accept such experiences as part of themselves. Normalising unusual experiences such as hearing voices has been noted in a large -scale study by Romme and Escher (1993) as helpful and conducive to taking responsibility for self and thinking positively regarding self. McGowan, Lavender and Garety (2005) also concluded that clients being more open to new explanations in relation to their "psychotic experiences" in CBTp was a consistent positive therapy outcome.

5.3.5 Clients as active agents

Results also highlighted the importance of mutuality, building on earlier theories posed by Rogers (1959) and more recently developed by Murphy, Cramer & Joseph, (2012).

Teamwork typically took place in the PCT relationship with emphasis on both the therapist and client's own contribution as central to engagement and change process. Studies 2 and 3 showed clients attributing importance to the therapists' qualities, actions and relationship, as well as being self-reflective regarding their own barriers and attributes, recognising resilience and recognising themselves as self-motivated active agents in their own change.

Most clients in Study 2, even when vulnerable, were initiating their own self-help strategies and were resourceful. Many of them demonstrated that they were motivated, active agents in their own change process, self-initiating coping strategies, even when experiencing psychotic process and in high levels of distress. This finding builds on Roger's (1969) earlier assertion when referring to notes that he made relating to the application of the person-centred approach in education in 1952.His thoughts regarded growth as being centred around supported experiential learning, stating "I have come to feel that the only learning which significantly influences behavior is self-discovered, self-appropriated learning." The implication of this idea may be that in a therapeutic context the supported individual is learning to cope and self- initiating multiple individually tailored ways of managing which meet their specific needs. Bergin and Garfield (1994) supported this idea, stating "it is the client more than the therapist who implements the change process" (p.825).

Phillips, France, Edwards, & McMurray N (2009) conducted a meta-analysis of how individuals with psychosis used coping strategies in life stress and illness and found that clients typically adopted multiple strategies needed to cope with the wide range of issues and that this approach led to better outcomes.

Bjornestad et al (2017) interviewed 20 clients who had experienced first episode psychosis and experienced clinical recovery. Most participants reported the view that increased personal agency allowed their increased focus and constructive response to their own vulnerability, thus facilitating change and recovery after the acute phase and throughout their recovery journeys. This process involving self-agency seemed integrated with hope and sense of power which led to action. This compliments the data outcomes in this dissertation.

The data in these studies certainly do not perpetuate the myth of the psychiatric patients as vulnerable, passive recipients of care but, rather, show them to be potentially determined, creative and able to utilise the therapeutic space to take control of their own recovery process. This position is supported by Mancini (2007) who showed patient recovery discourse to transition from hopeless victim of disease and powerless to empowered and positive, with a sense of control. Bohart and Tallman (1996, 1999) challenged the commonly held, simplistic myth of therapist as the main active healer or expert, directing processes and facilitating change, and suggest that clients are more powerful, utilising the opportunities, ideas and experiences of the therapist in a resourceful way.

They describe how, within a supportive relational climate, in most cases clients have an intrinsic capacity to solve their own problems, suggesting that “clients can ultimately change themselves through experientially discovering meaning in what the therapist gives them” (Bohart & Tallman, 1999). They considered two alternative meta-models of change. One of these was based on Orlinsky (1989) and medicalised expert care, which is endorsed by care systems; Bohart and Tallman proposed a second more existential humanistic philosophical perspective that asserted that all therapy is based upon self-help with the client as the true therapist (1996). Others have supported the idea of the client as the initiator of change (Duncan & Moynihan, 1994; Gold, 1994; Orlinsky, Grawe & Parks, 1994; Miller, Hubble & Duncan, 1995; Orlinsky,; Levitt & Pommerville, 2016). Lambert and Barley (2002) estimated that therapist factors may be responsible for only 20% of client change and Norcross (2011) concluded that most outcome in therapy are related to client factors, with the relationship having more impact than interventions. Some evidence suggests that therapists can overrate their own performance and impact (e.g. Walfish, McAlister, O'Donnell, & Lambert, 2012; Hiatt & Hargrave, 1995)

Norcross (2011) and Rennie (2006) captured the complexity of the therapeutic encounter stating that "it may well be the case that much of what client's experience is due to unconscious influences. Nevertheless, clients are also self-aware and in control of a lot that goes on in the treatment"

This idea supports the theoretical concept of the actualising tendency (Rogers, 1957) and the potential for positive client growth, with clients finding their own way forward when provided with conditions enhancing this. The context of the therapeutic alliance may support this process.

The themes explored of both the possible relative importance of UPR for clients with psychotic processes and the client being in control of the process were together encapsulated by Rogers (1958) who stated "the more I can keep a relationship free of judgment and evaluation, the more this will permit the other person to reach the point where he recognizes that the locus of evaluation, the center of responsibility, lies within himself." p.123

5.3.6 Increase in self-connection

study 1 showed improvements in sense of self as a significant category. This included reduced self-judgement, increase in self -acceptance, empowerment and self-integration, more stabilised identity and increased self- insight.

In Study 2 the findings echoed this, in showing half of the client participants reporting increase in self- awareness or depth and almost half of the clients achieving greater self-connection, with a quarter experiencing less fragility or increased self-integration. Study 3 also supported this position, in showing Becky feeling more connected to self and less depersonalised experiences as therapy progressed.

Theories around psychotic process have considered a possible process of self-disintegration; positive change may involve reconnection or reintegration with self. Collapsing and rebuilding of self has also been historically discussed and the source of investigation. For example, the prominent philosopher Sartre took mescaline in 1935 to induce hallucinations, increasing his insight and understanding of such phenomena. He described hallucinations as occurring when the person crumbles and loss of self causes blurring between dreams and perceptions (Sartre, 1940,1956 1958). Laing's ideas support this in his exploration of fragmentation of self, masks of false self and recovery in patients with a psychosis, diagnosis of schizophrenia or other complex presentations (1960). This breaking up of self, development of sometimes rigid or unusual defence mechanisms and reintegration through recovery is supported within person-centred literature, as discussed in chapter 1(Rogers,1957,1959; Shlien , 2003, p. 48; Warner , 2017 p98, Rundle, 2017 p. 225).

This raises the question of whether the data from these three studies can be taken as supporting the idea of clients possibly rebuilding a fragmented sense of self through therapy and other helpful experiences with evidence of outcomes including both symptom reduction and increased self-connection and sense of self. The data certainly seems to affirm this possibility with the need for further research to explore this further.

Themes were uncovered by Lysaker, Buck, Hammoud, Taylor & Roe (2006) and Lysaker, Buck & Roe's (2007) in relation to patients with a diagnosis of schizophrenia using psychotherapy in which the patient's own agenda was central and forming personal self-narratives, increasing a sense of self and self-agency.

My own data appears to compliment some of the outcome themes in these two studies, where clients often reclaimed their own sense of self-value, self-coherence and identity as well as self-empowerment.; Chiu, , Davidson, , Lo,., Yiu,, & Ho (2013) empirical study of 204 people with a diagnosis of schizophrenia found that self -agency "loaded onto" recovery based models based on development of hope, empowerment, resilience, self-responsibility and self-mastery. The study also acknowledging the complexities of cross- cultural application of the concept of self-agency.

These three PhD studies found that clients did not always choose to disclose traumatic, problematic, friendly or benign unusual experiences such as hallucinations or necessarily see them as central to the issues which they brought to therapy, often preferring to focus on the source of emotional pain such as trauma. Some clients did not wish to change or eradicate their unusual experiences. Nonetheless, during PCT their unusual experiences often diminished even if not the client's plan. Narratives regarding this in the data could imply an association between diminished unusual experiences and increase in self-integration or self-congruence and increased engagement with the world.

5.3.7 Improved Social and interpersonal skills

One of the most dramatic and general findings in these studies was the role of PCT in enhancing client social and interpersonal skills. Increases in social functioning and improvements many areas of wellbeing stood out in all three studies. Roger's (1961b) own experiences as a therapist echo this finding as he described how even when working with those with the most disturbing troubles. He found that when focused on the act of sensitively understanding their expressed feelings and accepting them as individuals they tended to move towards self-actualization, maturity and socialisation. The relationship **is** the therapy and helps to create a positive in the moment experience which can be a model of or help to develop towards the ability to improve other interpersonal relationships

Given the degree of social isolation and interpersonal avoidance in this population, this kind of change is essential for helping clients to improve their quality of life (Davidson & Stayner, 1997/1999; Harding, 1987). This is consistent with the results of the Wisconsin project (Rogers, 1967) and the Essen study (Teusch, 1990).

Brohan, Elgie, Sartorius, & Thornicroft's (2010) European study of people with a diagnosis of schizophrenia or other psychotic diagnoses suggests that empowerment and an increase in social contacts enhanced reductions in self-stigma with clinical implications of developing interventions which reduce problematic elements of self-stigma. The implication of this finding could reinforce the importance of both individual support and social and public health work to tackle this issue on both an individual and preventative societal level. Davidson et al (2001) discuss inclusion itself as the basis of recovery.

Bjornestad et al’s (2018) 20 interviews with clients who had recovered from psychosis with focus on psychotherapy experiences found that therapies which supported specific functional challenges seemed crucial in promoting recovery and social integration with a warm, respectful therapeutic presence seen as crucial as often shameful and traumatic material was explored with sensitive pressure towards daily normative functioning being both challenging and helpful. Self -agency and increased sense of responsibility appeared to promot recovery and increased functioning whilst clients were held in a supportive space. Here they could examine perspectives and make meaning, establishing safety and hope. Social re-integration was directly helpfully addressed and processed in therapy and hurdles could be supported. This data integrates well with findings within this dissertation and show a path of warm, non-judgemental support and developing hope and personal power as a foundation to social integration and increased functioning as well as supporting Grafanaki, & McLeod’s (1999) research highlighting the importance of client’s opportunity for narrative flow which was also implied by data here. Bjornestad et al’s (2018) study goes further to indicate the usefulness of advice or education and gentle pressure as helpful to promote recovery in psychosis.

5.3.8 Accepting all parts/beyond diagnosis

Getting beyond labels and medical model definitions was considered an important feature of the work for both clients and therapists and occurred as a theme throughout all three studies. This theme seems to be closely connected to the core conditions mentioned in the previous section in this chapter. This notion of acceptance beyond diagnosis when applied to practice involved working flexibly with the client as a unique and complex individual with their own process rather than a focus on a prescriptive view of issue or progress. Therapists typically worked with the idiosyncratic process and recovery path of the client, fully embracing all parts of the client and only supporting a specific agenda if client-led.

Data demonstrated the importance of UPR and accepting all parts of the client as they presented rather than being problem-focused with both clients and therapists giving accounts of safe relationships where there was room for fragility as well as humour and celebrating growth. These finding supports Roger's (1961c) description of the person as "a continually changing constellation of potentialities, not a fixed quantity of traits." (p 122.) and the person-centred position that clients should be prized for all parts or configurations (Rogers,1961c; Mearns & Thorne, 2000b) Mindell's concept of democracy (Schuitevoerder & Zweig, 1996), discussed by Totton (2007) compliments this notion of embracing all parts of the self and wider external views.

The importance of UPR, is echoed in Perry's (2019) recent research from the perspective of pre-therapy practitioners who had worked with clients in psychotic processes. Her research reinforces findings here in also highlighting the cultural and societal context of psychosis and the move by practitioners to promote and provide acceptance.

5.3.9 Ethical issues and treatment context

Many positive experiences of therapy were shared. However, data also indicates that poor therapy experiences can occur, particularly if therapists intentionally or unintentionally misuse power, deviate from the theoretical model or are not attentive to clients' potential need for space and autonomy. Results support literature in implying that work should fall within the competency of the practitioner and be carefully supervised and often within multi sector treatment contexts to share areas of care such as risk with many positive case examples as well as some poor examples shared within the studies. Indeed Rogers (1942:108) discussed the value of therapist limits in enhancing effective practice by supporting the therapist to be free and natural.

These findings may affirm assertions by Mearns (2003) who highlighted the need to work within competency limits with high levels of supervision when counselling profoundly disturbed clients, urged practitioners to be extremely cautious of over-involvement or offering wider contracts, also retaining awareness and responsiveness to the treatment context and social system of the client. Mearns explained how person-centred therapists working with clients with psychotic processes should ensure that they work safely within a holding environment.

There is no doubt that this work can be demanding and unsettling for therapists, particularly when they are inexperienced. Whilst this type of work is not for everyone, the data show that experience and support can help therapists to stay grounded and in turn enable them to support clients, who often see positive outcomes which may be, in part, attributed to the therapy.

In these PhD studies most participating clients described effective, experienced, skilled and careful practice within a package of care which resulted in positive outcomes. However, some client's journeys, discussed in these three studies, were in their views, made worse by poor therapy practice and highlight the possible need for caution in undertaking this work. Lambers (2003) reinforced this position in stating that the optimistic person-centred philosophy can induce false confidence in the therapist or rescuer fantasies and lead to working out of the therapist's competency in an unsafe way. Her comment below encapsulates the sentiment of many of the practitioner participants in this study who expressed a strong sense of ethical awareness and caution regarding clinical work with this population. Lambers (2003) indeed stated that such work should not be undertaken if there is any doubt regarding the availability of wider support or the counsellor's ability to offer a safe relationship and explained;

"Working with deeply disturbed clients is demanding, challenging and requires a great deal of commitment and responsibility. It also requires skill, depth, a certain amount of knowledge and understanding, as well as acceptance of limitations." p116

Interviews demonstrated that clients with unusual experiences or psychotic processes needed time and support to navigate the sources of care available in order to find the best path for them and sometimes decide to have breaks from different treatments such as therapies or medication. Therefore, the data reinforces both Sommerbeck's (2003, 2017a, 2017b) and Freeth's (2007) notion, explored earlier in chapter 1, of the possibility of the therapist embracing how different treatments can and do work together, even if they differ in values; and that communication, or attending meetings where appropriate, can benefit the therapy and the client. Sommerbeck addresses the real-world reality of working with clients in complex process for their own or others’ safety or wellbeing.

Data in all three studies illustrated that in many cases clients were sometimes admitted to acute or longer stay wards or accessed medication or other treatments. This highlights the necessity of embracing a complex system of care in the UK and often in other countries. Person-centred practitioner’s shared narratives regarding embracing the political context of care. At times they sacrificed some of their idealism in terms of a perfect treatment model and applied the core conditions as well as some common sense, strategic thinking and advocacy skills to the medical model and other settings. They held onto the importance of offering clients the opportunity to receive a person-centred therapeutic or contact relationship when they were feeling extremely vulnerable, distressed or frightened, and most needed it.

Practitioner participants in study 1 reported utilising support as they sometimes place themselves in a service setting or situation where they themselves may be judged, misunderstood or stigmatised, therefore facing contextual challenge as well as the challenge of working with the clients. Practitioners who worked in private practice reported dilemmas regarding safeguarding and confidentiality; if they work on a ward there are often dilemmas regarding the clashes in ethos.

5.4 Implications for research: Evaluation of the research & Recommendations for Future Research

5.4.1 Strengths and innovations of the Research: What worked

Comparing firstly practitioners and then client experiences, plus an embedded case study as a final design worked well. Although the therapist and client studies used different structures, the focus was similar, enabling some comparison between the data sets to see the overlap in prominent issues and the differences in both perceptions of helpful and unhelpful practice and changes in clients. The HSCED enabled a more detailed analysis of one case and as well as the data regarding outcome adding an interesting dimension.

Although recruitment was a lengthy process, all research participants seemed very open and generous with their stories, seemingly censoring little and giving full accounts, including the less positive experiences of offering or receiving therapy, providing rich data.

It was methodologically innovative to involve clients and experts by experience to accompany therapists as independent judges in the HSCED. The client's voice and the carer's voice gave an important perspective to the evaluation process and as well as commonalities in evaluation with all judges being able to identify specific nuances in the data viewed through different lenses. I decided to invite a wide range of judges to contribute to the HSCED, with two professionals (one male, one female), a carer (female) and two individuals who had experienced mental health issues and accessed a range of services (one male, one female) of different ages. This was the first time that an HSCED involved experts by experience and carers.

In deciding this new path, I thought about the complex power issues in therapy where the therapist holds power in terms of role, societal and historical (see Proctor, 2017) and how this can be echoed in research; and yet much change in practice can come through listening to experts by experience. I was not sure how this would work as the materials were embedded with professional terminology, and the process did prove to be time-consuming. The time commitment required was high and I did not want to put anyone with vulnerable health under pressure, so these judges and I monitored the process together, and along the way I offered support to progress and encouragement to drop out if needed. I also spent time with two judges engaged in a training/explanation session about the role of judges before they agreed to embark on the task. The process worked well and some of the judges appeared to find the journey educational and empowering as well as raising important process issues relating to recovery criteria and process documents.

Enlisting the expertise of users by experience, carers and professionals/academics was methodologically innovative as a new style to the HSCED judgement process. This carer and expert by experience (i.e. service user) inclusion stayed truer to the person-centred approach with regard to the principal of minimising power differentials in what was nonetheless a complex process involving supporting all judges to navigate processes and terminology. Additional support was provided: preparing for this potential and proved productive. This method also brought interesting results with wide ranging yet overlapping judgements and no distinct differences due to the varying roles of the judges. For example, a fellow academic suggested that the experts by experience might give more favourable outcomes regarding efficacy and that I may have recruited them to "help my case" with a less than perfect data set; however, one of these judges had a research background (in a different field) and had had negative experiences of therapy, which resulted in their rigorously scrutinising the data. This specific process thus built a bridge between user-led methods and the HSCED and can be recommended for further HSCED studies.

All studies and particularly the HSCED also raised the important issue of what therapy process and outcomes expectations are realistic with this client group and would meet with person-centred values, as opposed to a more medical symptom reductionist approach.

5.4.2 Limitations of the Research: What did not work so well

It was initially difficult to plan a study that would be able to gather meaningful data from a vulnerable client population focusing on a treatment without proven efficacy while also for ethical reasons allowing clients to seek other recommended treatments. The redesign of the client study from an open clinical trial to a qualitative change interview study and HSCED in the context of changing clinical pathways needed much thought, but in the end did provide interesting outcomes and proved worthwhile.

The three studies and methods of data collection produced rich data but might have been more successful as a larger collaborative endeavour, as the analysis was lengthy with 40 transcripts and additional lengthy processes in the HSCED which were difficult to complete within planned time constraints.

The participant recruitment and data collection process were lengthy and complex in all three studies. In the practitioner study data was collected in the context of criticised and sometimes covert practice, studying a treatment which was not formally recommended. The client data was also difficult as it involved negotiating with both gatekeepers and clients to recruit and interview clients who were sometimes in chaotic process with fluctuating fragility and often issues relating to trust, having often been let down ad violated. Negotiations and contracting processes were sensitively conducted to ensure that the process was as safe as possible but that clients could opt out. However, no clients did withdraw and apart from some suggestions to improve the layout of some measures and improve processes, clients expressed feelings of valuing the opportunity to contribute to the research and process their experience. No clients asked for a de-brief or reported negative consequences. It seemed important for these often marginalised and under-valued clients to have a voice. The amount of data generated from 40 interviews for studies 1 and 2 was analysed using grounded theory. This was an enormous task in the time scale and on reflection I may have gained as much insight by gathering slightly less data. I imposed pressure on myself to gather a significant amount of data as the methods were less rigorous than those in the original design but could have limited this process to fewer interviews. Nonetheless, the findings with this amount of data offer more chance that data are typical as with this size of sample and themes seem to become repeated with about a quarter of the data with the most frequent findings, reinforcing the key messages in the results.

The HSCED proved time consuming in terms of resources and needed substantial involvement from others. However, the method provided an opportunity to rigorously investigate the kind of changes in a typical client process and to more deeply consider what was happening in their overall recovery process and specifically within the therapy.

5.4.5 Recommendations for further research

I considered the methods and possible changes to these which could have improved the studies and results. Firstly, I noted that the Client Change Interview Protocol extracted more relevant data in study 2 than the unstructured interviews for study 1, which brought rich but less focused results. The Change Interview Protocol is designed for change process research and was both focused and able to capture any outcomes as well as supporting a consistent process. This raises the question of whether study 1 could have produced a more comprehensive data set if more interview structure had been built, paralleling the same areas as the Change Interview but from a practitioner's perspective. However, this approach could have limited spontaneity of participants.

Interesting themes have emerged in this research are~~a~~ such as how clients with psychotic processes may optimise recovery within therapy in the context of multi-sector care with client agency and alliance as central features affecting long term outcome. These themes which may be interrelated could be explored further in targeted studies.

The relative importance of therapeutic conditions and parameters also leaves questions for further exploration. One person is already engaging in post graduate research, partly influenced by study 1 findings which suggested the particular significance of UPR for this client population.

The HSCED method enables replication, and future HSCEDs in this area could strive to gather more robust data to further investigate change process on a case study basis.

Future large-scale data sets from RCTs of contemporary PCT for psychotic process, meeting the criteria for Cochrane and NICE would contribute towards a formal evidence base of whether the treatment led to change with significant effect size, accepting the limits of this method. However, careful consideration may be needed when debating what constitutes recovery or change in terms of both addressing the need for comparison with other studies which focus on symptom reduction but also hold onto a wider notion of recovery and improvement in quality of life. Validated scales which address this issue and have been successfully used with this client group such as the Warwick and Edinburgh (Tennant, Hiller, Fishwick, Platt, Joseph, Weich, Parkinson et al, 2007) and other measures could be considered to map a comprehensive journey of possible recovery and change without over-burdening vulnerable clients.

Macpherson, Pesola, Leamy, Bird, Le Boutillier, Williams & Slade (2016) have explored other measures and the ways in which we may consolidate the differences in recovery and clinical symptom tracking and consider both client and clinician ratings

5.5 Practice Implications and contributions to practice

5.5.1 Practice implications/recommendations

It is important to consider the implications of these studies and supporting literature when embarking on clinical practice or planning resource provision. Results in these studies illustrate how this area of work can raise much challenge for the practitioner. Practitioners can carefully consider clients’ potential needs at assessment stage and if proceeding, stay within the limits of competency in relation to previous training and experience. They may need to seek substantial supervision and managerial support for practice; and take extra care of their wellbeing (BACP ethical framework for the counselling professions, 2018).

This type of work is not suited to all person-centred practitioners and, even experienced therapists in this area may need to think carefully about whether to refer specific clients with psychotic or other usual experiences to specialist services, depending on the specific situation and context and their emotional capacity at that time. Since this work could be demanding or unsettling, especially at first, practitioners needed to pay extra attention to self-care, supervision, breaks, management of caseload and sufficiency of context.

Data from these studies and the literature both suggest that practitioners may need to be careful not to deviate from the theory or approach that they have trained in and agreed to use with the client and, in particular, not to offer “false promises”. Practitioners may also need to be sensitive to and transparent in relation to the relevant NICE guidelines and recommended care pathways for psychosis and other presenting issues.

My results support client and practitioner preference for team work and transparency in a way that parallels Andrew Reeves position in working with risk of harm and suicide, exploring risk but not reverting to becoming “risk-driven” (Reeves, 2018). It may be important to name risk or unusual experiences when these appear to be in the therapy space, rather than “dancing” around them, therefore avoiding them from becoming “the elephant in the room”. However, it is also important not to push the client to this. If such unusual experiences or safeguarding issues are affecting a client, it may be appropriate for the therapist to make the client aware that the therapist accepts all of them and am open to discussing these experiences whilst respecting contractual boundaries and safeguarding protocols, being more explicit if risk is strongly implied.

The study shows how at best a person-centred relationship can offer mutuality, and a level of relational depth that a specific client can cope with at that time. Some clients appeared to be overwhelmed if the practitioner was not careful to tentatively check or be aware of the danger of violating the client's physical or emotional space, being intrusive, using unwanted touch, sitting too close, unwanted directivity and so on. This echoes findings from Barrowclough and Tarrier (1992) regarding the potential negative impact of high expressed emotion on patients diagnosed with schizophrenia and also ties in with Rogers' and Gendlin's notes regarding emotionally overwhelmed clients (Gendlin 1961, 1962, 1964, 1966; Rogers, 1976) which were discussed in Chapter 1.

Trainee practitioners may enthuse regarding the prospect of trying to offer relational depth to clients but where this could be misunderstood it or potentially detrimental it should be avoided. The closest some clients can be in any aspect of a relationship can be quite limited; it may take creativity and negotiation to work this out and so the strongest alliance is likely to occur when the therapist is respecting the limits of the client whilst being available. Some clients in these studies and my own practice experience could not cope with positive feedback or closeness or even being in a confined space with either a practitioner or others. Results suggest that therapists should take nothing for granted about boundaries when working with clients in psychotic process and should stay with the client's agenda as much as they can tell, staying alert and observing signs of possible difficulties.

The results in these studies illustrated how clients who have unusual experiences, hallucinations, paranoia or psychotic processes and sometimes histories of trauma or may feel diminished, vulnerable or may be directed by such experiences or dissociate or sometimes lose physical contact. This can leave them in a particularly vulnerable position in the presence of the therapist who holds power. Client-centred or person-centred practitioners could pride themselves on the relationship being negotiated teamwork, but these studies showed examples of the perceived status of the therapist which could be experienced as healing or abusive if the power was intentionally or unintentionally misused. Data highlights the importance of being particularly aware of the power of the therapist with clients who may feel fragile, dissociate or feel vulnerable and experience medication impacts, or have been abused, stigmatised, or are withdrawn. Under certain conditions (such as a client being admitted to psychiatric inpatient care), the therapist-client power differential may be magnified and extra care should be taken to mitigate against this powerful by being present and grounded in one’s own person and own sense of reality and the world.

This research therefore highlights the importance of being thorough in contracting, be aware of practitioner power and how experiences may be difficult to hold or misperceived or reframed so that the client may be more vulnerable to feelings of violation or experiencing misunderstandings. Physical contact or wider contracts, initiated by either client or therapist were seen as something to regard with caution as this could sometimes lead to unrealistic expectations or misunderstood or traumatising, because even if it was experienced okay at the time it was sometimes reframed later (see Mearns and Thorne, 2000) .The research outcomes have caused me to more consciously and conscientiously check out and consider such issues in supervision and with clients, taking even more care and not making any assumptions about what may or not feel to be okay or helpful for each individual.

Results illustrate how this client group may be particularly vulnerable due to stigma and marginalisation as well as unsettling experiences. Some clients who experience psychotic processes may hear voices, have hallucinations or other unusual experiences or dissociation in relation to trauma. Sometimes there can be uncertainty or the "blurring" of consensual reality or breaks in psychological contact. Both the data and my own practice experience suggests that if a person is experiencing breaks in psychological contact, paranoia or other experiences such as hallucinations this creates barriers to relating and—can affect trust or be distracting. The implication of this is that the practitioner may need to slow down or not assume what is said can be received or remembered and check this out from time to time with the client or communicate with significant others such as carers, partners or family if ethical and part of an agreed care plan to ensure that self-advocacy or advocacy are possible and that the client is as central as possible to all multi-sector treatments plans as well as within the therapy itself.

Therapist data and client data show similarities in practice and outcomes that were seen as important and those that were seen as helpful. Clients and therapists both placed great importance on the normalisation of experiences and getting beyond labels. This reflects the person-centred theoretical position regarding language, labels and diagnosis. The person-centred ethos stood out in terms of the qualities that were perceived by both groups as important for, and helpful to, therapy. Experiences identified that were not helpful – such as unwanted therapist directivity – were those that generally did not fit with a person-centred stance.

The majority of clients in both studies showed significant improvement in many areas including sense of self, identity, social functioning and distress caused by unusual experiences (including voice-hearing), including their frequency. In short, the most troubling symptoms of a medical model of diagnosis of “psychosis” were reported as improved. In addition, when working with person-centred therapists, clients were able to describe how stigmatisation and social pressure affected their comfort regarding disclosure of symptoms. Furthermore, some explained that they did not necessarily experience their symptoms as disturbing, and the non-judgemental attitude of the therapist allowed them to discuss this.

Both clients and therapists repeatedly gave examples of working with symbolic meaning, emotional content or underlying issues rather than symptoms or diagnosis unless the latter was led by the client.

Regarding further training and professional development, the most popular additional practice was pre-therapy. The introduction of pre-therapy or contact work to therapeutic practice, or within the context of a supportive relationship, was seen to increase the ability of therapists to make contact with clients and increase the likelihood of a positive therapeutic relationship. The work of Margaret Warner (2000, 2001, 2002, 2007) was also a strong influence for several therapists in PCT, allied with pre-therapy. Observations of contact and self-communication in the client and then increasing capacity of connection with others seems to support Rogers theories regarding how a person may move towards increased freedom in communication (1961a, p330).

“ the task of psychotherapy is to help the person achieve, through a special relationship with the therapist, good communication within themselves. Once this is achieved the client can communicate more freely and more effectively with others”

(Rogers, 1961a, p. 330).

Paralleling Warner (2001a) and Mearns (2003), the results suggest that responsible practice when working with psychotic processes may involve sensitive and appropriate adjustment of the therapeutic setting. Supervision and careful reflection were seen to be important to enable therapists to discern if and when boundaries should be extended or tightened. For example, some clients may feel safer or more comfortable working in larger spaces than a standard therapy room, while others might want to lie on the floor on cushions with the therapist sitting on a cushion at the same level.

In contrast, in some instances it may be important for the therapist to keep very clear and explicit time boundaries, have clear risk management contingencies and carefully observe the limits of their competence, for example considering referring if the client may need a higher level of care. This can help to reduce the risk of therapist burnout and supports client safety and continuity of care.

It is important for the practitioner not to have an agenda. We must be careful, in the current context of the need for proven efficacy and robust studies showing clinically and statistically proven effect sizes, that we do not lose something important with regard to the essence of the person-centred approach and person-centred research. In saying this I am reminded of Brodley's (2003) cautionary note, urging researchers to always prioritise maintaining the clinical practice and ethics.

Change or treatment may not look the same from different modalities and perspectives and we must take great care how we measure and define these, also accounting from wider cultural and other contexts. Is treatment success defined by marked progress and happiness, improved quality of life instead of just symptom reduction. Indeed, Law, Shryane, Bentall, & Morrison's (2016) longitudal study of people experiencing psychosis found that recovery was predicted in relation to negative emotion, hopelessness and psychosocial factors and a lesser degree in relation to symptoms and functioning. Bellack (2006) discusses the importance of recognising service user defined recovery in contrast to scientific definitions.

Recovery style was also investigated by Tait, Birchwood, & Trower (2003) who found that recognition of adjustment to psychosis as well as impact of symptoms was important to promote recovery. Law and Morrison's (2016) delphi study of 381 people who had experienced psychosis regarding their view of recovery, found extremely high consensus in areas such as quality of life, feeling better about oneself, increased sense of control, being happier about who you are, having a meaningful and contributing life, making sense of distressing experiences and accepting that symptoms are part of the person. They also identified many factors promoting and inhibiting recovery. Positive factors included good living conditions and feeling cared for and understood, being around people that believed in them and took into account their culture and beliefs and being able to be assertive and responsible. Inhibiting factors included not having control of services or being rigidly defined by professionals, isolation and factors linked to prejudice affecting job seeking. When asked to consider signs of recovery the study found that individual pathways to recovery and being able to find time to do the things that a person enjoyed, being able to ask for help, coping, facing fear, self-trust and active engagement, being in touch with emotions and connecting socially (making friends) as well as experiencing less problem in relation to psychotic experiences.

The data from this study is closely related to the key data from the three studies in this PhD which found that both practitioners and service users placed more focus on human qualities, engagement and self-worth and self- integration than symptoms. Caring, supportive, understanding and the provision of environments where people could understand and integrate difficult experiences and be more in control, utilising their own coping strategies were seen as important. It also seems unrealistic to define recovery path by symptom reduction alone, although this may be desired when many clients have encountered long and challenging paths before encountering psychotic process and the recovery which is realistic for the individual will map out its own path, with support, rather than being simplistically defined or easily predictable. This points to a picture of an optimal recovery journey placing the service-user in a supportive climate to reclaim their own power to actively cope and engage with the world and others and self-define and further refutes the rapidly deteriorating passive illness model. An important implication for practice may be to recognise the importance of both offering positive relational conditions which can promote growth and the need to engage in fully collaborative work with the service user regarding their unique style of recovery and progress. The practitioner may need to fully recognise factors within the therapy relationship and the wider context of support and care and be acutely aware of life factors and contextual barriers which can promote and inhibit recovery

Furthermore, that transparency and real encounter on the part of both parties involves risk. Many of the participant clients in the study had histories of broken trust so this possibility, from their descriptions, seemed both daunting and yet cathartic.

The following quote by Roger’s seems to support a key message from the practitioner and client data from all three studies. This relates to the importance of the real relationship between the therapist and client, meeting each other as unique human beings, enhancing an increase in connection to self and others. For clients who may be isolated and marginalised, this can be even more critical.

> “We are deeply helpful only when we relate as persons, when we risk ourselves as persons in the relationship, when we experience the other as a person in his own right. Only then is there a meeting at a depth that dissolves the pain of aloneness in both client and therapist."
>
> (1980, p.179)

Pearce and Sewell (2014) commented on the often tentative and tenuous contact that can occur within therapy with young people which involves very “in the moment” work and this links to practice within pre-therapy, discussed earlier.

5.5.2 Reflections on my own practice and Personal impact of the research

Research examples paralleled my own practitioner development with this client group as I began work with clients in psychotic process and through experience, training and research became more competent and aware of the need to work flexibly and creatively and to manage the demands with high levels of support.

In my own practice if I do embark on this journey with a client who may be experiencing complex processes such as psychotic processes, following assessment, I proceed tentatively. I try to work with myself and in the real relationship, demonstrating sensitivity and caution. I have learnt to monitor the progress or otherwise of the client by seeking feedback and by observation and close supervision, sharing decisions on how to proceed wherever possible whilst providing containment and safe but somewhat flexible boundaries and limits, following what most client valued in these studies.

In my work with both adult and child clients in psychotic processes I have often referred clients to community mental health teams and other specialist services as counselling alone has been clearly insufficient.

I have worked closely with doctors, psychiatrists, social workers, family members, friends, partners and others in mental health services to support particularly vulnerable clients and try to reach agreements and be consistent with care plans, communicating with other workers, wherever possible with the full consent and agreement with clients unless acute safeguarding issues overtake the situation. I have tried to be open and transparent with clients and others regarding the way that I was working with specific individuals and invite this in openness in others.

As a result of both clinical experience and this research process, I have become less defensive, when challenged by others. If I experience an emotional impact of the feedback, I am more able to put this aside to listen to what is being said to me, sometimes needing time to process this, initially before applying it to the therapeutic context or practice implication. I am more curious to unpick criticisms or suggestions and learn from them, listening instead of jumping to a position of defence or conflict and being open to try to understand. This has not always been easy and at times I have experienced negative judgements regarding the PCA approach, with suggestions that it could be detrimental but on containing frustration and enquiring further have often reached further understanding and no challenging professional has provided evidence of their concerns when I have asked them for more explanation or references. Instead a discussion has often resulted in discovery of commonalities in practices and reassurance that all are just supporting the client to lead and work as safely as possible.

One of my own early practice clients hardly spoke and often laid curled up on the floor, as if in a womb. I felt as if they were inside a house and I was sitting outside and could only see them through the window. I sometimes found this rejecting or frustrating and it tapped into my own self-doubt and insecurities but most of the time I accepted it. I voiced this feeling of the house metaphor to the client and acknowledged that it was hard for them to be close to me but that I would stay there outside the house, knowing that this was the closest contact that they could welcome, manage or feel safe with. At the time I was unsure if this was the "right way" to work but reflection in relation to both the literature discussed and the research outcomes has affirmed the need to check out tentatively where the client's boundaries are and to be aware of the need to be flexible – as the client's needs change - to offer predictability and safety.

I have always taken care as much as possible to work within the limits of my competency, supported to review this in clinical and managerial supervision and note that this is prominently mentioned in The Ethical Framework for the Counselling Professions (2018) which supports my practice. The research has reinforced this position as it has not only reinforced my enthusiasm but also highlighted the care, support and sensitively needed to conduct such work safely. I also place great attention on assessing if the context seems sufficient and if both the physical setting and supportive context for both myself and the client is sufficient, feeling more able to debate this openly with clients and referrers and monitor my own self-care.

My own experience and the research have also affirmed my confidence in the importance of transparent risk assessment, where appropriate and to be open to criticism by those who see this as a deviation from theory. To me, risk assessment, when warmly conducted within the relationship is part of transparency, care and congruent practice which has safe boundaries. I can interpret this as an act of humanity with my own unique sense of morality, frameworks and the client's view integrated into the outcome.

I am also careful not to assume that if a client has past or current unusual experiences that they will either perceive this as an issue or wish to discuss this and I consider the agenda of the client as well as my observations of their apparent focus or distress. My aim is to support the client to lead the session as much as possible but to help containment, facilitation and exploration within a PCEP relationship. As the research progressed, having originally trained in PCT and pre-therapy and creative PCT. I undertook training in emotion focused therapy (EFT). I continued to offer PCT and additionally also became open to more of the developing tribes of PCEP, wanting to offer more options to clients and increase skills whilst acknowledging that the PCT relationship is at the core of the therapy that I offer. I look forward to future work with this client population and assessing the impact of more recent training.

My own attitudes to be open to unusual processes, whether in the centre of the therapy or in the background, began with personal exposure to such issues from a young age within the community where I was raised. My research, reading and clinical experiences have all affirmed my values of openness and to work with the client as a team as much as possible and being open to explore their own issues at their pace and that if unusual experiences are raised that these can be held ,discussed, explored or dialogued with as the client feels is important to explore emotions or meaning, without an agenda.

Whilst I always hope that my clients will suffer less distress over time, I do not necessarily view this realistically as “symptom reduction”, but hold wider models of recovery, as raised earlier in this chapter. The research has reinforced my belief in clients’ own resilience and ability to actively make use of support. I now more fully appreciate how a wide range of formal and informal support options based on different ideologies (rather than just from a single modality) can maximise the chance of positive growth in clients and supports their autonomy.

In terms of power, I am more aware and careful with regard to my own power but also the research has increased my awareness of just how active and resilient clients can be to combine the therapy with their own resilience and coping strategies, as well as other support, in order to move forwards.

As a researcher academic I hope in the future to continue to unpick and disseminate these studies and be open to conduct further research in this area, perhaps collaboratively as well as also considering future case studies and small-scale projects to further build on this knowledge. My passion for PCEP has increased within this research as I see how the approach can offer such life changing outcomes for some clients who can be hard to reach and need open, flexible and creative approaches.

I conducted the research in what was sometimes a challenging and critical climate with PCT viewed negatively in many forums. However, as the data emerged I was excited by early findings and the learning for me within them as well as the urgency of participants to express their views, which energised me through to the end. As I reflect on the research process, I feel enormous relief that I managed to pursue this path, despite political, practical and personal hurdles and am myself more connected to both PCT and PCEP as they can positively impact on clients with psychotic processes.

5.6 Concluding reflections

This research is aimed at increasing awareness of helpful practice and change process and ultimately improving the practice and care and wellbeing of this underserved and often multiply disadvantaged and marginalised client group. The data in this study give an overview of UK practice if PCT therapy with clients with psychotic process, including some of the nuances involved that may optimise practice and benefit both clients and therapists.

The data presented here contradicts myths surrounding the PCT approach – which claim that it may not be suited to complex client issues and is conducted by naïve practitioners. Instead, practice examples in these studies demonstrated examples of the complexity and sophistication of forming real relationships with clients, offering conditions that may optimise positive actualisation and growth. Also, practise involving careful management and working with great responsibility, integrity, knowledge, skill, sensitivity and self-awareness (as opposed to over confidence).Furthermore, the themes of helpful factors to promote recovery and factors signifying stages in recovery which are apparent in the data in these studies compliment data from users by experience regarding their notions of helpful factors and signs of recovery. Data suggests that positive changes can be seen in many areas affecting functioning and quality of life with clients leading this process with the support of the therapist, sometimes seeing marked or surprising progress even when difficulties are severe.

It seems that PCEP has been frequently misunderstood, misrepresented and dismissed without sufficient robust data showing it to be either helpful or detrimental; at best it is seen as an option for clients, particularly if they find accessing mainstream services challenging. However, a consideration of both the literature reviewed here and the results of these three studies does suggest that PCT can be effective for clients who experience psychotic processes with examples of recovery journey’s where the PCT therapy was identified as an important influence or critical to this by clients themselves. Even allowing for bias and limitations the results do therefore suggest the potential of PCT to be potentially helpful. The results warrant further research, including larger scale studies.

The person-centred relationship at its best can provide a restorative space to help clients to make sense of or just cope with unusual experiences in a place where they have more control and are therapeutically held. Unusual experiences can be held, normalised and supported in process at the pace of the client, if relevant as a subject of focus or source of distress and can sometimes even reach clients with contact impairment or severe trauma. The PCT therapist can offer a real and yet safe and boundaried therapeutic space for clients who are often overwhelmed, traumatised, feeling fragmented, experiencing and internalising judgements or feeling disempowered. In this space they can be met with patience and sensitivity, respecting their need for a balance between closeness and distance. They can, potentially, make real connection, feel valued and place attention onto their own agenda of therapeutic focus, individual coping strategies and tasks, as part of what may be an uneven and challenging journey of recovery, self-affirmation and connection.

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