EXPLORING THE UNDERSTANDING AND USE OF 'CASE BUSTS' WITHIN TWO ASSERTIVE OUTREACH TEAMS

By

MAEVE ANN LYNCH

A thesis submitted to the University of Birmingham for the degree of MRES CLINICAL PSYCHOLOGY

Word count 14,997

School of psychology

University of Birmingham

June 2014

THESIS OVERVIEW

This dissertation is comprised of three parts: a consultation document outlining the design for a study investigating change in personality over the course of psychodynamic psychotherapy; a presentation with notes covering the content of a literature review that examines the concept of social cognition in relation to psychosis, and a report recommending measures of social cognition for use with a client group with psychosis; and a qualitative study of the understanding and use of case busts in two Assertive Outreach (AO) teams. The most obvious theme linking these three areas of research is that they are all in the area of adult mental health. The services that commissioned these pieces of research are all tertiary care mental health services with a rehabilitative focus that work with individuals with mental health difficulties of a severe and complex nature. In two of the services, the Non-acute Inpatient Service (NAIPS) that commissioned the second piece of research and the AO service, the psychologists work in multidisciplinary teams.

In my first and second placements I developed skill in conducting a replicable literature search, presenting the findings of a literature search using annotated bibliography and literature review formats, and research design. In both placements the area of interest was the structural or underlying factors of the mind and the ways in which psychological development can be blocked or delayed, albeit from two different perspectives. The themes 'measurement in psychology' and 'operationalisation of psychological constructs' link the first and second placement. Over the course of the first placement, with the support of my supervisor, I developed an understanding of the way that psychodynamic theory conceptualises key structures of personality and the way in which psychodynamic psychotherapy works to facilitate an individuals' growth and personality development, thus resolving psychological problems. My supervisors'

clear passion for psychodynamic theory inspired keen interest, and I hope to continue to develop my knowledge of psychodynamic theory in the future. In my second placement, the focus was also on understanding mental health difficulties, psychosis specifically, with a view to informing therapeutic work. Of late there has been a growing interest in the role of social cognition[1] in psychosis and the purpose of the research in my second placement was to review research in this area, and approaches to measurement of social cognitive ability, with a view to informing the development of a therapeutic group remediating aspects of social cognition for individuals with psychosis. Writing a literature review was a more complex proposition than I had initially imagined and my supervisor was invaluable in helping me to understand the different types of literature review and the appropriate way to approach the task. While there is some overlap between the concept 'social cognition' and the psychodynamic concept 'mentalisation'[2], and both have been implicated as key processes underlying social behaviour, the research reviewed in placement two is from a cognitive psychology as opposed to a psychodynamic perspective. The overlap in these concepts did however lead to some interesting theoretical discussions with my supervisor.

In both my first and second placements I received feedback from a wider group of clinicians on my research. In the first placement I had an opportunity to present the

[1] Social cognition is defined as: 'the ability to construct representations of the relation between oneself and others and to use those representations flexibly to guide social behavior' (Adophs, 2001 p.231).

[2] Mentalisation is defined as: 'a form of mostly preconscious imaginative mental activity, namely, perceiving and interpreting human behaviour in terms of intentional mental states (e.g. needs, desires, feelings, beliefs, goals, purposes and reasons)' (Allen & Fonagy, 2006)

research to the staff team in the psychodynamic service and in the second to attend and present at meetings of the working group of professionals developing the social cognitive therapeutic group. This gave me further insight into the practical considerations of conducting research and setting up a therapeutic group in tertiary care mental health services in the NHS. Towards the end of the second placement I had an opportunity to visit a NAIPS service and this gave an interesting insight into the role of clinical psychology work within a multi-disciplinary team in a residential treatment service.

My third placement gave me further opportunity to see the role of the clinical psychologist within the multidisciplinary team in action and also more opportunity for client contact. The knowledge of psychosis accrued from my second placement was invaluable in understanding the client group of the AO service. The key learning in the third placement was in regards to the process of qualitative research, from designing an interview schedule, conducting the research interviews, to analysing, interpreting and presenting the data. Feedback from both supervisors was essential in this process. Dr. Meaden, a supervisor and senior clinical psychologist within AO services, has worked within AO services since their inception. He shared his broad knowledge on AO and work with risk within a multidisciplinary context. My university supervisor, Dr. Michael Larkin, guided me through the process of undertaking qualitative research. The key learning in relation to conducting the interviews was the position of the researcher: an open-minded listening position that seeks to impose as little as possible on the process. This was a challenge for me as I have worked for several years as a psychotherapist and as such am used to a different role and foci in a 1:1 dynamic. The process of data analysis was a more lengthy and anxiety-provoking process than I had anticipated. Initial feedback from my supervisors indicated that I needed to be more

interpretative in my analysis and I was encouraged to see the process as an evolving process that entailed numerous re-appraisals of the data and constant re-evaluation and revision. I learned that there is no formula to credible, high quality qualitative analysis and the value of creativity, perseverance, and triangulation in the qualitative analytic process.

Overall I believe that I have increased my knowledge of mental health difficulties, psychosis in particular, and approaches to treating these difficulties. I have also developed skill in research methods and a clearer understanding of the role of the clinical psychologist in tertiary care mental health services.

ACKNOWLEDGEMENTS

I am indebted to the dedicated and inspirational supervisors I have had the good fortune to work with over the course of this piece of work. Dr Rachel Hirschfeld who was incredibly supportive and has inspired in me a fascination for psychodynamic theory. Dr Chris Jones who helped me to find structure. Dr Andrew Fox who helped me to understand the research process, to stay focused and to feel part of the wider project. Dr Michael Larkin who guided me through the exciting territory of qualitative research and helped to quell my anxiety. Dr Alan Meaden for his enthusiasm for the project and willingness to share his time and clinical insights. I would also like to thank the staff of the AO services for giving their time so generously and a valuable window into their experience. I am particularly grateful to Dr Lisa Bird for acting as my mentor and guide during my time with the AO services. Lastly I would like to remember Finn, a friend who gave me a stark reminder of the importance of work with risk with individuals with psychosis.

CONTENTS

List of tables

CHAPTER ONE: STUDYING CHANGE IN THE STRUCTURAL ASPECTS OF PERSONALITY OVER THE COURSE OF PSYCHODYNAMIC PSYCHOTHERAPY

Reflections on placement one

Aim: The Psychotherapy service at [redacted] intend to contribute to the evidence base for psychotherapy by carrying out an outcome study of psychodynamic psychotherapy that includes assessment of client internal (intrapsychic) change and of impact of psychotherapy on service utilisation rates. My aim is to assist in this research process by fulfilling the stated objectives.

Core Placement Objectives:

- To carry out a review of relevant literature
- To explore study design and methodology
- To review relevant measurement tools and investigate procedural and practical considerations for using these tools with a view to aiding in the assessment of feasibility/practicality for use by clinicians in the [redacted] Psychotherapy service as part of routine assessment.
- To write and submit an ethics proposal through IRAS

Secondary Objectives:

- To develop skill in literature searching, research design, and application for NHS ethics approval
- To develop understanding and knowledge of psychodynamic psychotherapy theory and practice

I consider the overarching aim 'to contribute to the design of a study of internal change over the course of psychodynamic psychotherapy treatment' to have been achieved. The original placement objectives reflect my optimism and enthusiasm for the project but also my lack of understanding of the work that each stage of the research process entails and the time required to design a viable study in a routine clinical setting. My

learning is reflected in the placement review form (appendix 1), in which the placement objectives are adapted and take on a more realistic achievable form.

My starting point was to review relevant literature. This was initially represented as a secondary objective but on reflection I recognised this as the foundation for the whole process. The proposed project seeks to explore concepts that are at the very heart of psychodynamic theory and practice. It was imperative to have a grasp on the psychodynamic conceptualisations of personality and personality change in order to begin to think about operationalising these concepts for an empirical study. In our initial meeting Dr Hirschfeld introduced me to some of the key concepts in psychodynamic theory, to the way in which this theoretical orientation thinks about the human psyche and human behaviour. The seed papers were given to me by Dr Hirschfeld and along with any documents produced by the service that pertained to the project.

Dr Hirschfeld and I decided that conceptualisation of personality and options for operationalising personality structure would be explored by reviewing existing empirical research. A key design issue was the selection of appropriate psychodynamically oriented instruments to measure change in the structure of personality. It was agreed that the study should make use of existing validated measures where possible as the development of measure would be time-consuming and use of existing measures allows comparisons to be made with prior research. This stage of the process proved more complex than initially envisioned as there was a large variety of diverse measures being used. Initially my methods of searching and reviewing the literature were broad and unfocused. A lecture on literature searching

midway through the placement provided guidance. I found that defining and re-defining the search terms was key to conducting a replicable search. However, I think that the broad sweep of the literature initially was useful in this regard as it enabled me to evaluate the quality of my initial searches on the basis of the papers that were found and omitted. Results of the search were presented in the format of an evaluative annotated bibliography (appendix 2).

In conjunction with searching, reviewing and evaluating studies that included measurement of personality change as an outcome of psychodynamic psychotherapy I sourced copies of these measures where possible. Two meetings took place between Dr Hirschfeld, Dr Blurton (Psychodynamic Psychotherapist) and I. We discussed measurement of inner change and the criteria that would be used to judge the suitability of the various measures for use in the [redacted] service. We reviewed a number of measures using these criteria.

The final objective involved study design and ethical considerations. It was decided that the project was at too early a stage to consider an ethics application and to instead produce a consultation document as a basis for discussion with potential stakeholders. The purpose of these consultations is to find a workable way to take the project forward. The document takes its format from the core items of a University ethics application form (items A6 – A10) a format suggested by supervisor Dr Chris Jones.

Overall the knowledge and skills gained as a result of this placement have exceeded my expectations in every way. It has been an uphill climb through exciting terrain and

ultimately I feel that I have not only acquired research skill and an understanding of the process of research but also knowledge of psychodynamic theory and practice.

Consultation Document (Ethics form A6-1 – A10-1)

A6-1. Summary of main issues – summary of the research

This study is a quasi-experimental study in a routine clinical setting that explores the development of personality structure over time in individuals with complex and chronic mental health difficulties and the impact of psychodynamic psychotherapy treatment on this developmental change in the structural aspects of personality. The study will investigate differences in personality development in a total of 40 individuals, a group of 20 individuals who receive two years of psychodynamic psychotherapy treatment (PPT) and a cohort of 20 individuals who are accessing general psychiatric treatment as usual (TAU) for 2 years. Participants will engage in a research interview at assessment, at one year, at the end of two years of treatment and at a follow-up point of one year after the end of the 2 year study treatment period. In this interview data will be gathered to allow the assessment of internalized object relations, a key aspect of personality structure according to psychodynamic theory (Klein, 1933, 1935; Kernberg, 1976, 1983). Data on wellbeing, symptoms, risk to self and others, and general functioning will be collected using the measure Clinical Outcomes in Routine Evaluations (CORE; Evans et al., 2000). Health service utilization will also be assessed pre and post treatment. In addition to investigating changes in the structure of personality over time, the relationship between measures of symptoms and functioning and changes in personality will be analysed at these different time-

points. Rates of service utilization pre and post the treatment period will be also be calculated.

A6-2. Summary of main issues – ethical and design issues

Key design issues in a study of long-term psychotherapy in a tertiary care NHS service are the sourcing of a comparison group and random allocation to treatment conditions. For ethical reasons it is not considered feasible to include a no treatment control condition or to consider random allocation to treatment conditions, as such a naturalistic approach is adopted.

Recruitment

Psychodynamic Psychotherapy treatment (PPT) condition: participants will be recruited from individuals referred to the [redacted] Psychotherapy service who proceed, by agreement between client and clinician, to psychodynamic psychotherapy treatment after completing the assessment process.

General Psychiatric services TAU group: This group will be recruited with support from our partners in the CMHT, Psychiatrists and Community Psychiatric Nurses. Our partners will be asked to invite participation from clients on their caseload who meet our inclusion criteria (ages between 18 and 65, presence of an Axis II or treatment resistant/relapse prone Axis I) and not our exclusion criteria (presence of untreated psychotic illness, organic brain damage, current addiction).

As attrition rates may be high due to the nature of the client population the study will utilize a dynamic cohort design continuing to recruit until the target samples of 20 completers in each condition has been reached.

Researcher bias

To reduce potential researcher bias no therapist will be involved in the scoring of data collected from their own clients.

Informed consent

Study information sheets will be included in pre-assessment information packs for [redacted] clients and given to individuals meeting the study inclusion criteria by our partners in the CMHT. Individuals who are interested in participating will be offered the opportunity to discuss the study in more detail with the researchers and then asked to sign a consent form if they wish to participate. The consent form includes a section requesting consent to access health service utilization information from the computerized system 'Rio' for the purpose of the study.

Individuals will be asked to take at least 48 hours to consider whether they wish to participate prior to signing the consent form. Participants will be free to withdraw their consent at any time up to the point of data analysis.

Risk

We do not anticipate that any participants will be harmed or disadvantaged in any way through participation or non-participation in the study. No potential client will be

denied treatment because they have declined to participate in the study or have elected to with draw their consent.

In the event that participants find the research interviews distressing they will be offered support. [redacted] clients will be offered support by their therapist and an agreement will be in place with the CMHT that support will be offered by the treating psychiatrist/community mental health nurse if required.

Participants in the control group will not be refused entry into the psychodynamic psychotherapy service if referred through the usual channels and considered suitable after assessment. In the event of this occurring the individual will cease to be a study participant.

Clinician time in assessment and scoring procedures

A key concern in a study of this nature is impact of the study on service provision. With this concern in mind the additional assessment and scoring procedures to be added were chosen carefully. The means to measure personality change selected is one which does not require clinicans to attend training courses but relies instead on in-house training which can be scheduled for minimal interference with service provision. The measures selected are intended to be quick to score by trained raters. It is envisioned that the minimal additional time taken in training, assessment and scoring will be off-set by the long-term benefits to the service-users of the inclusion of a measure of psychic change. If this measure and scoring system proves its sensitivity to change within this service it can be incorporated into routine assessment protocol by the service. The addition of a measure of psychic structure to assessment has the capacity

to inform the understanding of the patient's problems and as such to guide idiosyncratic treatment planning. The assessment of psychic structure is recognised to be a key component in the formulation of the patients' problems and to have a decisive influence on the planning of psychotherapy (Magnavita, 2004).

Confidentiality/data protection

Taping of research interviews will be done using an dictaphone, the session will be transcribed and anonymized and the original recording stored electronically on a password protected BSMHFT computer. All data collected will be anonymized using a unique patient identity number generated for this study. The BSMHFT data protection guidelines will be followed for all study data as for data routinely collected by the service.

A7. What is the principal research question/objective?

Does the [redacted] individual psychodynamic psychotherapy service demonstrate a capacity to change aspects of unconscious life (i.e. the structural aspects of personality)?

A8. What are the secondary research questions/objectives?

- Does Psychodynamic Psychotherapy treatment at [redacted] demonstrate a differential capacity to change aspects of unconscious life compared to general psychiatric treatment as usual?
- Do changes in aspects of unconscious life correlate with changes in symptoms, general functioning and deliberate self-harm behaviours?

- ❖ Does health service utilization of participants differ pre and post psychodynamic psychotherapy treatment and pre and post the same time period of general psychiatric TAU?

A9. What is the scientific justification for the research?

Long-term psychotherapy services at a tertiary care level have been regarded by some as a costly luxury (Marks, 1994) however evidence is beginning to emerge that these tertiary care services actually reduce as opposed to increase the financial burden on the health care system in the long-term by reducing health service utilization (Menzies et al., 1993). Evidence suggests that individuals with complex and chronic difficulties such as personality disorder are heavy users of healthcare services (Perry et al., 1999). If it can be demonstrated that treatment with Psychodynamic Psychotherapy in tertiary care services can reduce health service utilization this treatment could be seen as a cost saving service for individuals with complex and chronic mental health difficulties. With this in mind the impact of treatment on service utilisation will be assessed in this study with a view to understanding the impact on resources of the long-term psychotherapy treatment provided by [redacted] Psychotherapy service.

The capacity of psychodynamic psychotherapy to reduce health service utilization in the longer term is hypothesized to be due to the different action of psychodynamic psychotherapy. Psychodynamic psychotherapy aspires to more than symptom relief. Symptom reduction is seen as only one of the goals of psychotherapy (Schulte, 1997). This form of psychotherapy aims to effect changes in the internal world of the patient, changes at the level of personality structure, which are seen as the basis for more lasting improvements (Blatt & Auerbach, 2003) and as such may play an important role

in continued psychic development over the lifespan and in relapse prevention. Research investigating long-term psychodynamic psychotherapy is relatively scarce (Crits-Christoph & Barber, 2000). Studies investigating the key and unique treatment target of Psychodynamic Psychotherapy, a sustained and significant change in personality, are even more rare. A comprehensive meta-analysis of 25 studies of psychotherapy effectiveness with patients with a diagnosis of personality disorder (Leichsenring & Leibing, 2003) revealed that most studies had used symptomatic outcome measures without including measures designed to assess changes in the structure of personality. Without an evidence-base for this central claim made by long-term psychodynamic psychotherapy it is impossible to accurately evaluate its effectiveness and in today's world of evidence-based health care it is essential to have a solid basis for judging the effectiveness of psychological interventions and understanding their method of action.

One of the difficulties in assessing change at the level of personality structure is defining and operationalising the concepts – what do we mean by 'personality structure' and what is expected to change at the level of personality over the course of treatment? Whereas there is divergence on the nature of psychic structure and structural change in psychodynamic literature there is an emerging pattern in the empirical studies to date in terms of what researchers are choosing to operationalise when investigating psychic structure. One of the most frequently referenced constructs is a construct central to many Psychodynamic theories of personality - object relations. Object relations theories (e.g Klein, 1933; Fairburn, 1952; Jacobson, 1964; Winnicott, 1965) differ to some extent in style and terminology but all place the relationship with early caregivers at the centre of human psychological development. These theories

state that early interactions with significant others are internalised as cognitive-affective structures within the human psyche. These enduring representations of self and others form the basis for self-definition or identity and guide interpretations, emotions and behaviour in subsequent interpersonal experiences (Blatt, 1974; Kernberg, 1975; Kohut; 1971; Stern, 2000). In the normal course of events these mental representations mature and develop over time accommodating and changing with life experience and becoming increasingly complex leading to the development of a differentiated and integrated self-definition and identity and to the capacity for mature reciprocal relationships. However, when early experience overwhelms the child's' capacity to cope, normal development of these cognitive-affective schemas can be impeded (Blatt, 1991, 1995). Many of the studies that have looked at change in psychic structure have conceptualised object relations or internal representation of self and others as central to psychic structure and have operationalised this concept.

This study will contribute to the evidence-base for long term psychodynamic psychotherapy at the tertiary care level by investigating the effectiveness of this intervention in effecting durable change in a core aspect of personality structure, object relations, and reducing strain on mental health care resources through reduction in health care utilization.

A10-1. Give a full summary of your design and methodology.

Design

This is a mixed methods design. Quantitative methodology will be employed to test the hypotheses as stated above. Qualitative methodology will be used to allow a more open exploration of change over the treatment period. In each group the three respondents

who have improved the most and the three who have improved least (the outliers) will be selected for qualitative analysis. We hope that information gathered through qualitative methods will allow the deepening of our understanding of differential responses to treatment.

The effectiveness of the interview method designed in generating useful data and of the methods for scoring the data generated including the inter-rater reliability of these methods will be investigated in a pilot study prior to the commencement of the study proper.

Participants

Power analysis (appendix 3) indicates that a sample size of 20 per group is sufficient for planned quantitative analysis. A sample size of 20 is in line with prior research in the area. As attrition rates in similar studies range from 24% (Lindgren et al., 2010) to 37.2% (Vermote et al., 2011) it will be necessary to recruit 28 participants per treatment condition to allow for non-completion.

Socio-demographic details, history of psychological treatment and clinical factors will be collected at intake to check the comparability of the samples in the treatment conditions and these will be reported to allow the reader to judge the representativeness of the samples.

Completer analysis and intention to treat analysis will be performed on data collected.

Treatment

Psychodynamic Psychotherapy Treatment

[redacted] is a Psychodynamically oriented psychotherapy service at the Tertiary level of service provision providing treatment of up to two years duration. Clinicians at [redacted] define themselves as Psychodynamic Psychotherapists, have a core mental health profession (i.e Clinical Psychologist, Psychiatrist, Nurse), and have completed formal psychodynamic psychotherapy training or are currently in training. The Psychodynamic Psychotherapy provided is not a specific branded therapy but most closely resembles Transference-Focused Therapy (TFP; Clarkin et al., 2001). Treatment will not be manualised, which increases the external validity of the study. However, efforts will be made to standardize the treatment by agreeing foci of treatment across clinicians at [redacted] and guidelines for the number and regularity of psychotherapy sessions. Regular supervision will monitor adherence to these agreements. It is anticipated that treatment will be once per week with an average of 45 treatment sessions per year and no longer than a three week break between sessions planned at any point during treatment. Number of sessions attended and frequency of sessions will be monitored.

General Psychiatry Treatment as Usual

A treatment as usual (TAU) comparison group will be sourced from the patients attending Psychiatric services in the Birmingham and Solihull Community Mental Health teams general psychiatric services. These services provide general psychiatric care and management including psychotropic medication, supportive outpatient contact, hospital admission when required, and clinical review. Agreement will be made with our partners in the psychiatric services to offer a standardized amount of

regular clinical review meetings to participants in the TAU group. Attendance for these appointments and engagement in other forms of psychological treatment will also be monitored.

Measures

Measures – Symptoms, self- harm and general functioning

- Clinical Outcomes in Routine Evaluations (CORE, Evans et al., 2000)

Measures - Health service utilization

- *Self-report questionnaire asking about service utilization in the past year.*
- *Information from RIO*

Self-report of health service utilization will be checked against RIO and where there is a difference in reports the higher figure will be used in analysis.

Measures – Personality

- *Object Relations Inventory (Blatt & Auerbach, 2003)*

The Object Relations Inventory is a set of procedures for assessing Object relations by evaluating the descriptions of significant others in terms of differentiation-relatedness, developmental level of cognitive organisation, and qualitative or thematic dimensions (table 1). Transcripts of research interviews will be scored using the Object Relations Inventory by three experienced clinicians and a blind independent rater (a PhD student) who have all acquired the required level of competance in using the system.

Inter-rater reliability estimates for these raters will be estimated and a mean of their scores will be used in data analysis.

Scale name	Scale description	Psychometric properties
The Differentiation-Relatedness Scale (DRS; Diamond, Blatt, Stayner & Kaslow, 1991)	A 10 point scale based on the theory that during the course of normal psychic development mental representations of self and others become progressively more differentiated, integrated, complex and empathically attuned.	➢ Sensitive to change over the course of psychotherapy treatment (Blatt, 1996; Harpaz-Rotem & Blatt, 2005; Vermote et al., 2012; Lindgren et al., 2010) ➢ Excellent inter-rater reliability and substantial test re-test reliability (Harpez-Rotem & Blatt; Blatt et al., 1996) ➢ Construct validity is supported by positive correlations found between the DRS measures assessing similar constructs (Blatt et al., 1996; Levy, 1998).
Conceptual Level Scale *(Blatt, 1974, Blatt et al., 1979, 1988)*	A nine point ordinal scale on which participants can be rated on a continuum that includes sensorimotor, concrete-perceptual, iconic, external iconic, internal iconic and conceptual.	➢ Acceptable levels of validity and reliability using this scoring procedure (Blatt et al., 1979, 1988; Bornstein & O'Neill, 1992)
Qualitative-Thematic Scales *(Blatt, Stayner, Auerbach & Behrends, 1996)*	Descriptions of significant others are rated on a series of 7 scales designed to assess each of 12 qualities that could be ascribed to the person being described.	➢ Acceptable levels of inter-rater reliability (Blatt et al., 1979, 1988; Bornstein & O'Neill, 1992).

Table 1: Procedures of the object relations inventory

Procedure

This study will employ "inherently mixed data analysis where both a single source gives rise to both qualitative and quantitative information" (Bazelay, 2009 p. 205). The source for both qualitative and quantitative data will be the research interview.

Interpersonal Research Interview

A semi-structured research interview will be used to collect data. Interviews will be carried out by two doctoral level students. This interview focuses on the collection of data on significant relationships past and present and is based on two existing interview methods: Blatt's significant other interview method (Blatt et al., 1996; Harpaz-Rotem & Blatt; 2005) and the Relationship Anecdotes Paradigm (RAP; Barber et al., 1995). In addition the interviewer will request that the interviewee describe an early memory and a recent dream. Research interviews will take place post assessment prior to the commencement of psychotherapy for the PPT group, at the midpoint of therapy (one year), at the end of therapy (2 years) and at the follow-up point (3 years). Interviews with the TAU cohort will be timed to take place at similar intervals.

Data Analysis

Quantitative

All quantitative analyses will be performed using the Statistical Package for the Social Sciences (SPSS). Bootstrapping methods will be used in analysis to increase the accuracy of sampling estimates. Mixed design ANOVA will be used to investigate differences in personality structural factors as measured by the scales of the Object Relations Inventory (ORI) within participants at different time points and between treatment conditions. A mixed design ANOVA will also be used to investigate the

differences in symptomatology and functioning as measured by CORE at different time points (within participants IV) for participants in different treatment conditions (between participants IV). A regression analysis will be used to investigate whether there is a linear relationship between changes in the ORI scales and CORE.

A mixed design ANOVA will be used to investigate differences between in the two treatment condition groups on health service utilisation pre and post the treatment period (with treatment group as the between participants factor and time point as the within participants factor).

Qualitative

Qualitative analysis will be carried out on a purposive sample of 6 participants from each treatment group. Data from each research interview with each of these participants will be analysed using Thematic Analysis (TA; Braun & Clarke, 2006) This analysis will be completed by an independent investigator, a doctoral level student, with triangulation from an experienced psychodynamic psychotherapist and an external supervisor.

Descriptive statistics will be used to summarise participant demographics.

CHAPTER TWO: SOCIAL COGNITION AND PSYCHOSIS

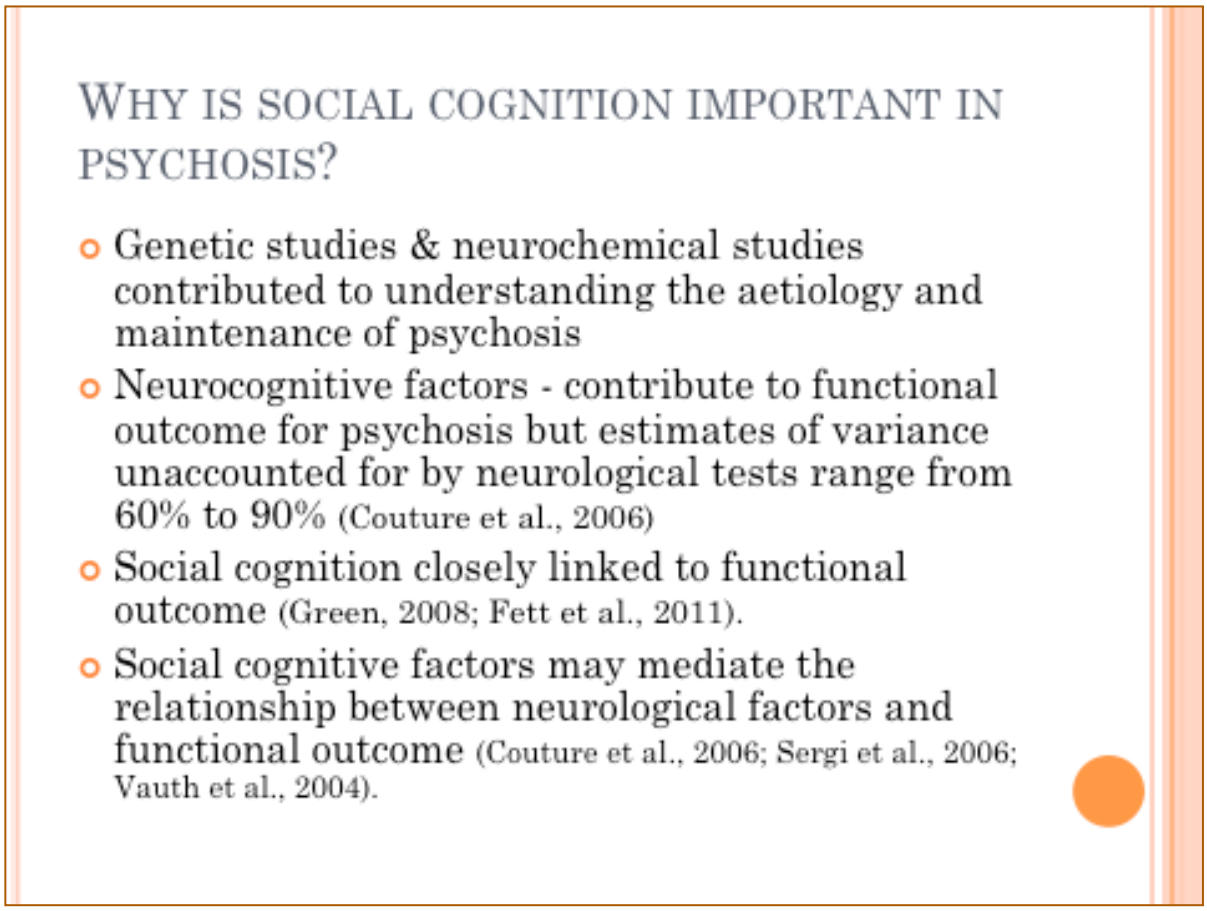

Social Cognition and Psychosis
A symptom-based approach

OVERARCHING AIM AND PURPOSE OF THIS REVIEW

- To inform the development of a treatment group for individuals with psychosis attending NAIPS services in Birmingham with particular reference to:
  - Session content/focus
  - Participant recruitment – profile of the client who would benefit from the group
  - Selection of measurement instruments to assess outcome

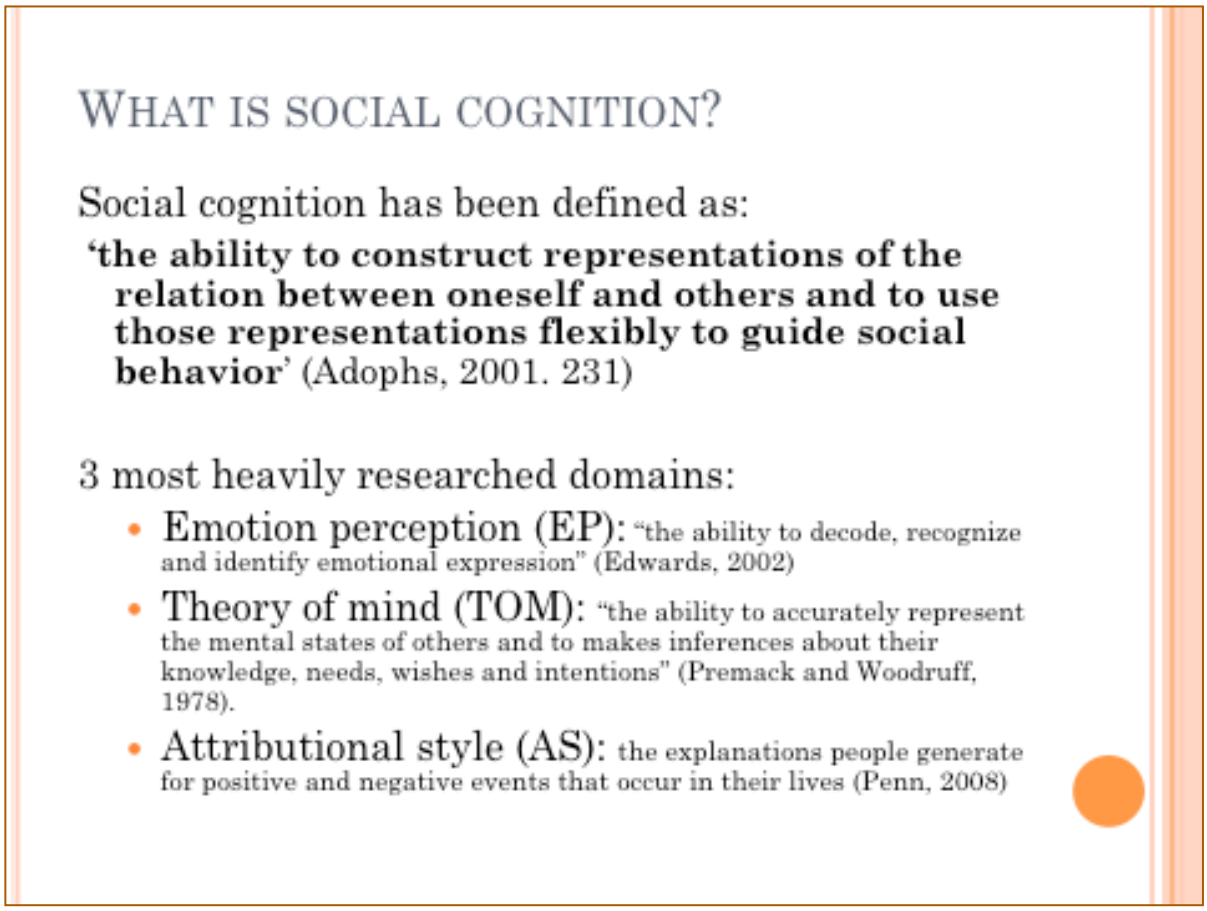
PLACEMENT OBJECTIVES

- Core objectives:
  - To carry out a replicable literature search
  - To write a review of the literature that includes a summary of social cognition measures
  - To present findings to supervisors and colleagues
- Secondary objectives:
  - Effective time management and use of supervision
  - To develop my understanding and knowledge of social cognition particularly where the concept applies to psychosis.
  - To increase my knowledge of approaches to working therapeutically with individuals with psychosis.

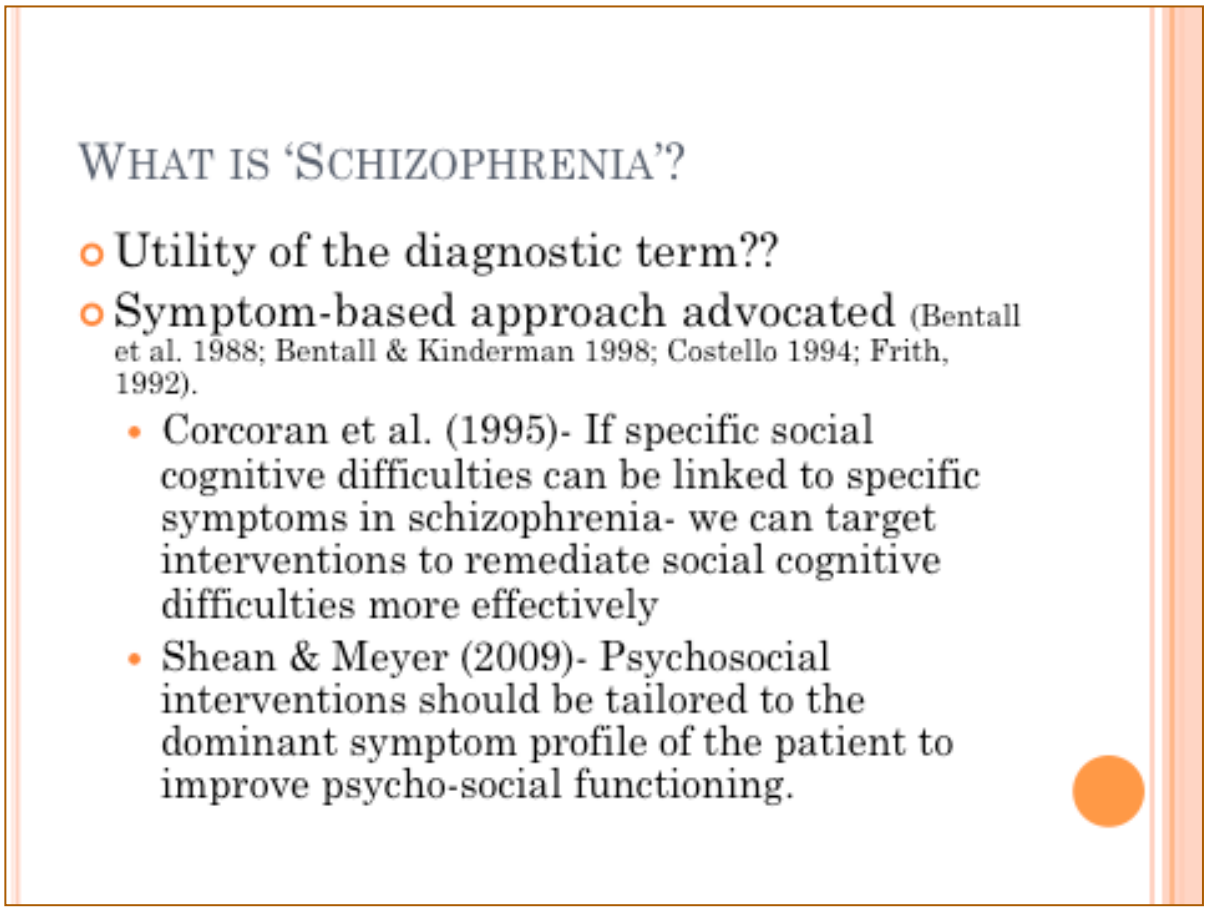


Despite years of research the aetiology, onset, and maintenance of psychosis is not fully understood. There is robust evidence from twin, family and adoption studies that genetic factors may play some etiologic role in schizophrenia (Kendler et al., 2000) and research on the dopaminergic system has also shed some light on aetiology and maintenance of some aspects of the broad range of difficulties that come under the heading psychosis (see Kapur, 2003). However, evidence indicates that the clinical benefit of anti-psychotic medications targeting the dopaminergic system does not directly translate into substantial gains in functional recovery (Bellack et al., 2004; Robinson et al., 2004). This is particularly pertinent as deficits in a wide range of functional areas are common in psychosis (Couture, Penn & Roberts, 2006) and deficits in social functioning are considered to be a defining feature of psychosis (Penn et al., 1997). There is evidence that social functioning impacts

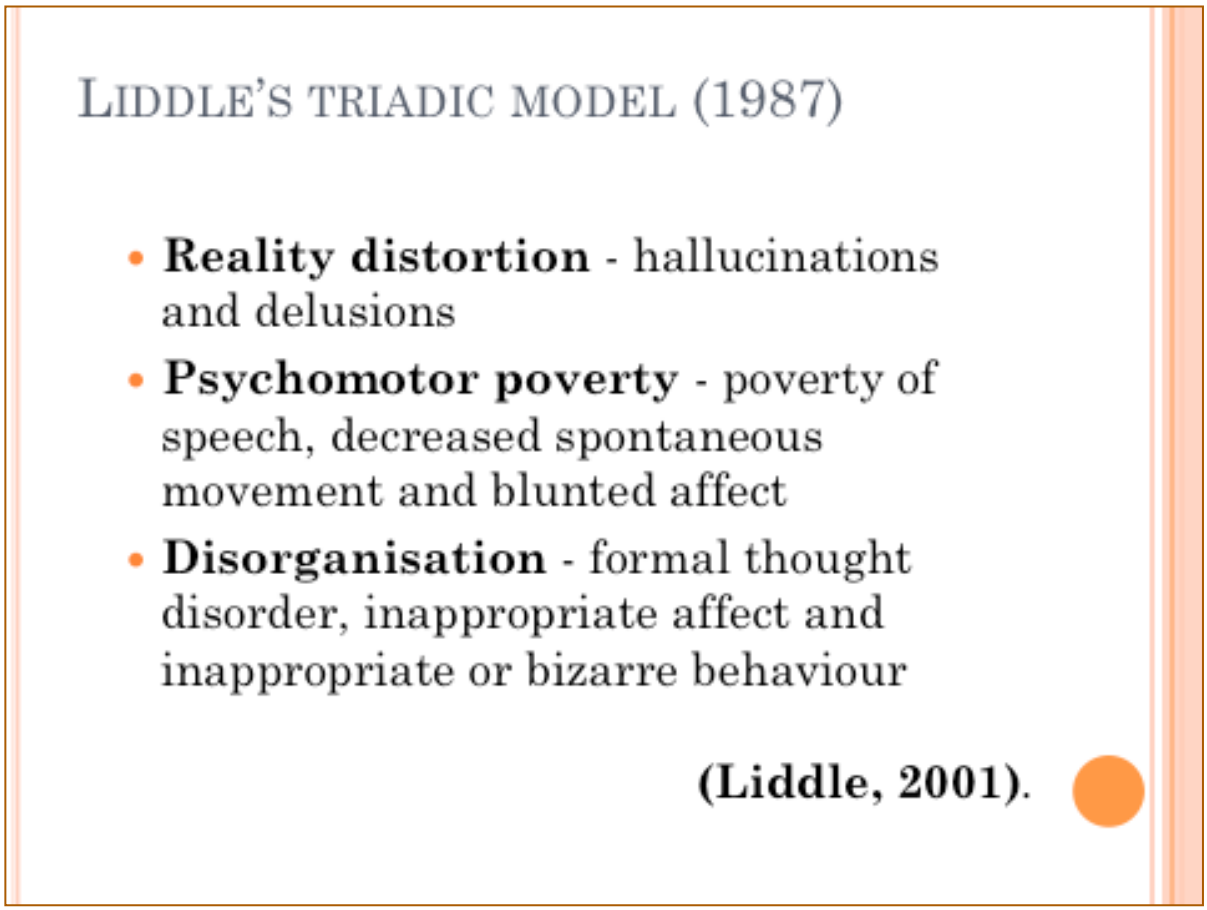
on quality of life (Penn et al., 1997) and predicts outcomes for individuals with psychosis (Perlick, 1992). In recent years research has attempted to identify factors that contribute to functional outcome. Social cognition, a related but independent construct to neurocognition (Mancuso et al., 2011; Sergi et al, 2007), is the most promising contributory factor identified to date with studies indicating a clear, consistent relationship between functional outcome and social cognition (Couture et al., 2006).



Research exploring social cognitive difficulties in psychosis as a unitary disorder has identified deficits in a range of domains including emotion perception, social perception (EP), theory of mind (TOM) and attributional style (AS) (Pinkham et al., 2003; Penn et al., 1997; Green et al., 2008).

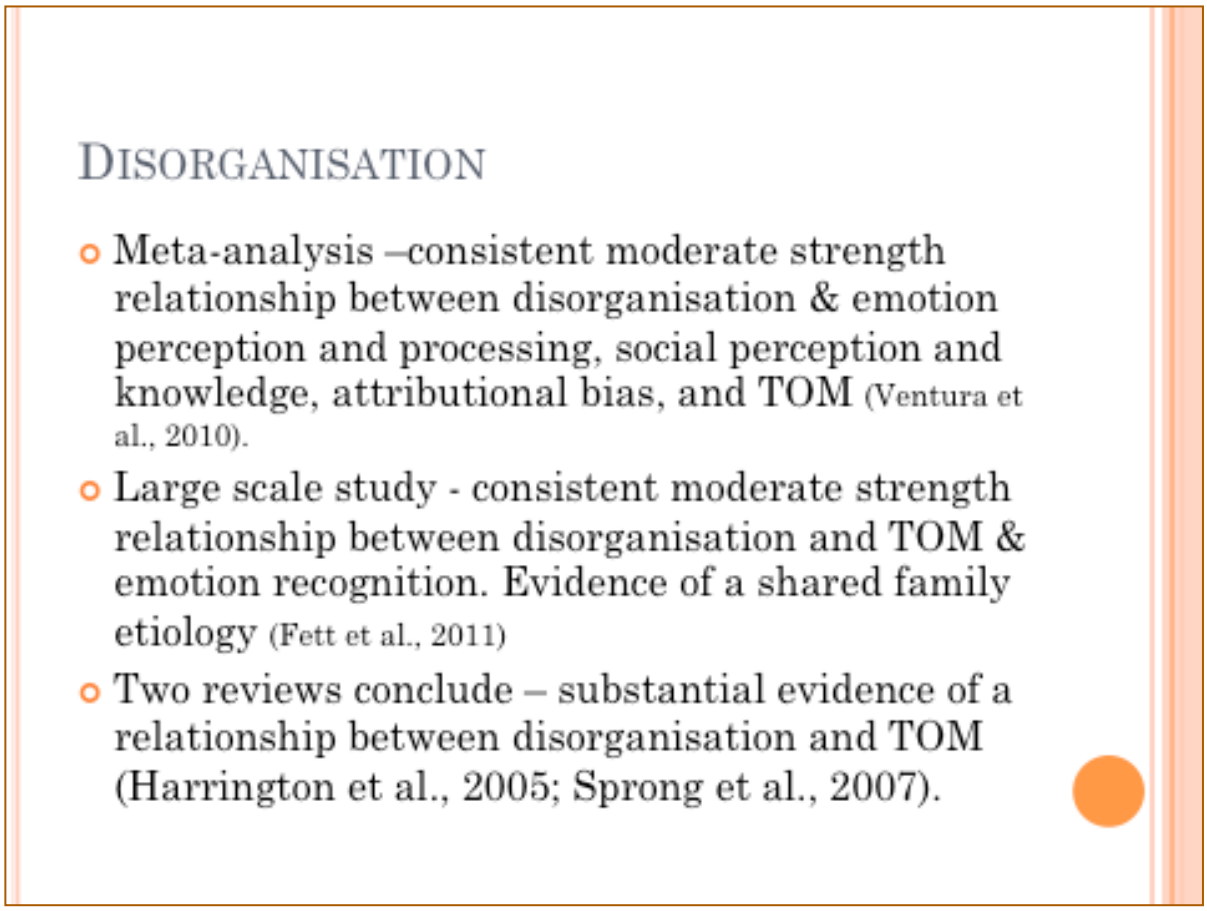


Psychosis is also referred to within the literature using the diagnostic label 'schizophrenia' but many theorists have questioned the utility and accuracy of the diagnosis of 'schizophrenia'. They point out that the utility of a diagnosis lies in its ability to give some indication as to the aetiology and the factors involved in the maintenance of the problem in order to guide treatment (Kendall & Jablensky, 2003), but that a diagnosis of 'schizophrenia' does no such thing (Bentall, 2004). An alternative perspective is offered by those who take a symptom-based approach in their attempt to understand the underlying difficulties experienced by individuals with psychosis and the interplay between these difficulties and the etiology and maintenance of the troubling symptoms (Bentall et al. 1988; Costello 1994; Frith, 1992).

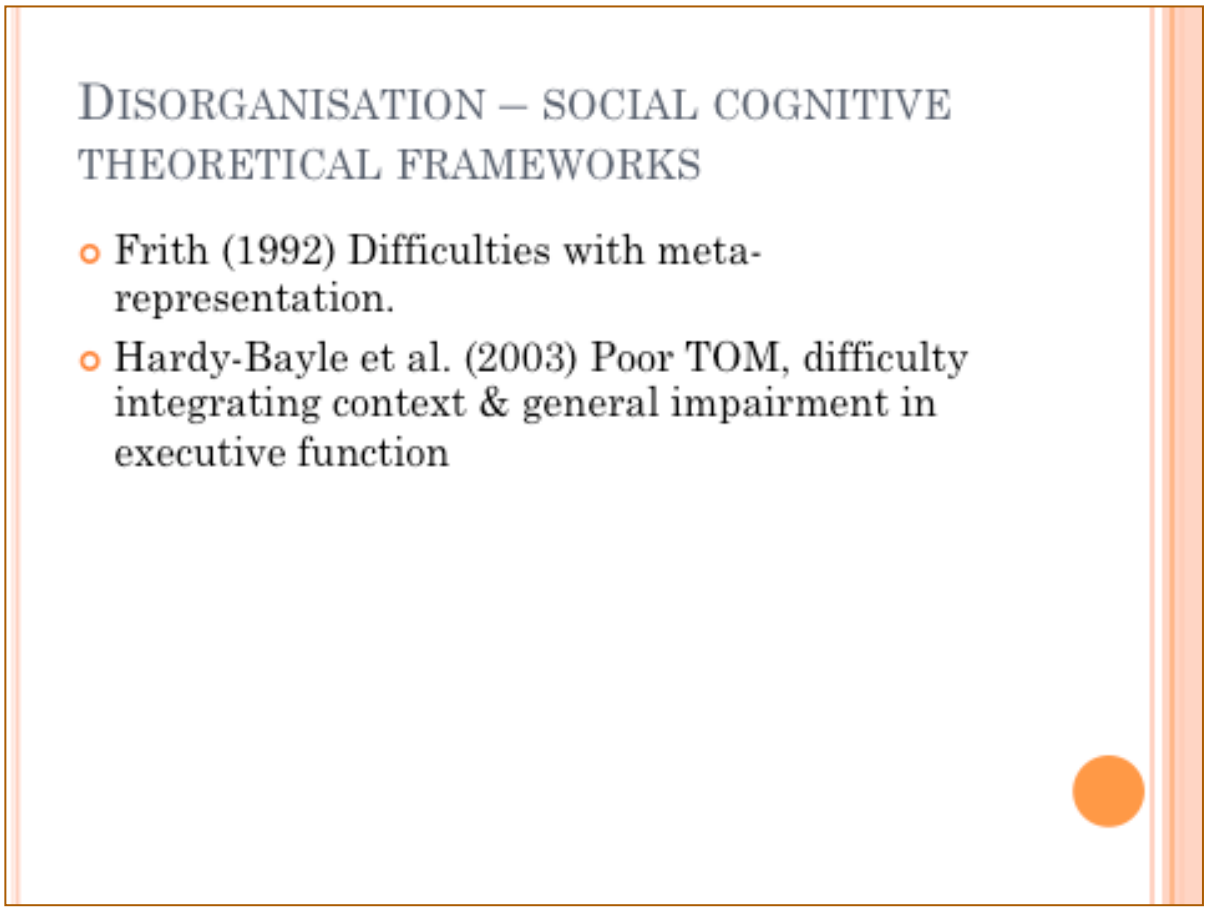


Research has found support for this 3 factor model (Malla et al., 1993; Andreasen et al., 1995; Cuesta & Peralta, 1995; Grube et al., 1998).

As psychomotor poverty and negative symptoms are terms used interchangeably to some degree within the literature utilizing a three symptom cluster model, (i.e. Shean & Meyer, 2009), research referring to both psychomotor poverty and negative symptoms is included in this review.



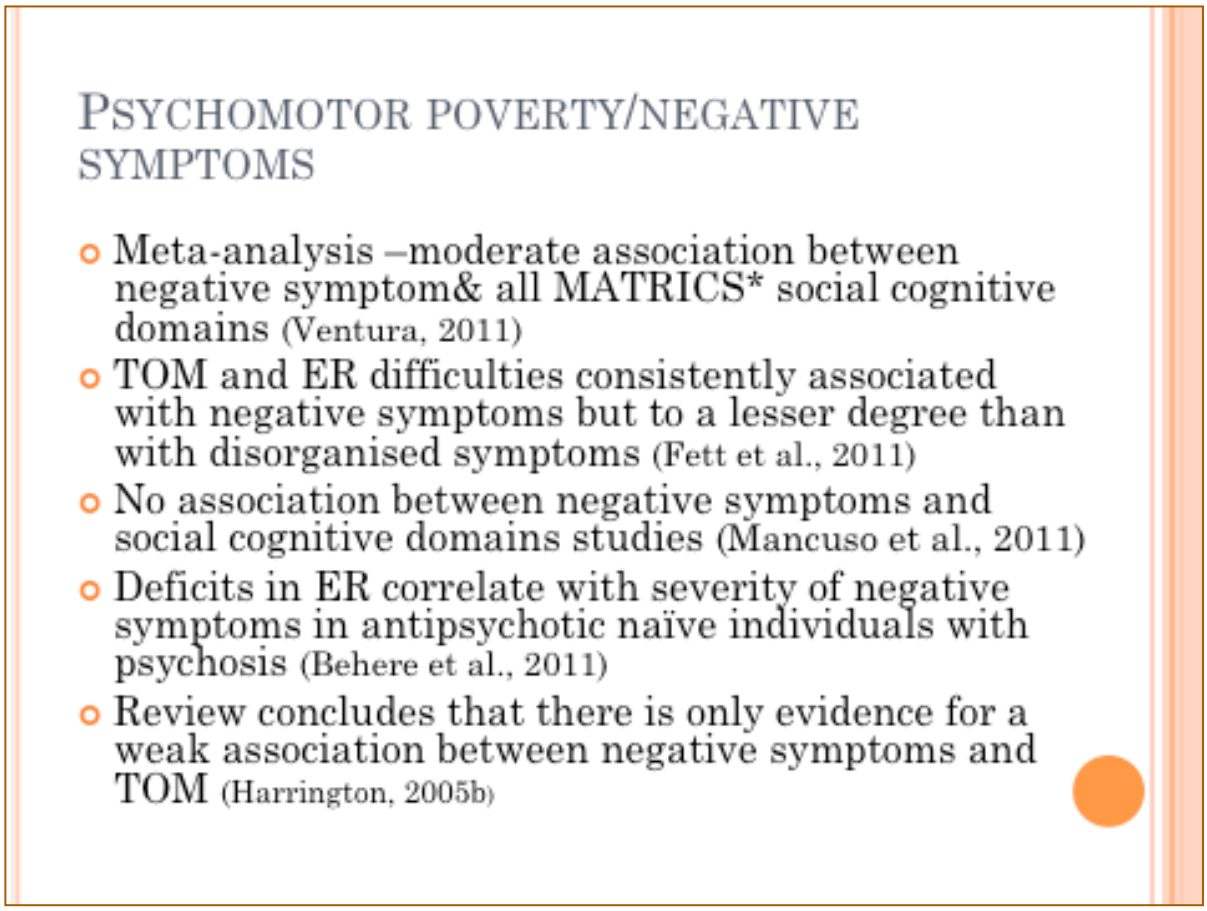
Evidence overall supports an association between disorganized symptoms and social cognitive difficulties, theory of mind and emotion perception in particular (Ventura et al., 2010; Fett et al., 2011). A recent review of the evidence base for theory of mind deficits in psychosis (Harrington et al., 2005) and a recent meta-analysis (Sprong et al., 2007) both concluded that the evidence of an association between symptom subtypes and TOM deficits is strongest for conceptual disorganization.



The two dominant social cognitive theoretical frameworks that have been proposed to explain disorganization symptoms in psychosis emphasize impaired TOM (Frith 1992; Hardy-Bayle et al., 2003). A number of studies have found support for the Hardy-Bayle model (Sarfati et al. 1997a, 1997b, 1999; Sarfati & Hardy-Bayle´ 1999; Grieg et al., 2004; Abdel-Hamid et al., 2009; Abu-Akel, 1999). Schenkel et al. (2005) also found support for the role of context-processing impairment in poorer TOM and greater disorganized symptoms in psychosis and proposed that poor TOM is related to poor social functioning in childhood and subsequently a presentation of psychosis with more disorganized symptoms. There is evidence supporting a relationship between disorganized symptoms in psychosis and poor premorbid adjustment and social functioning (Galderisi et al., 2002; Salokangas et al., 2002).

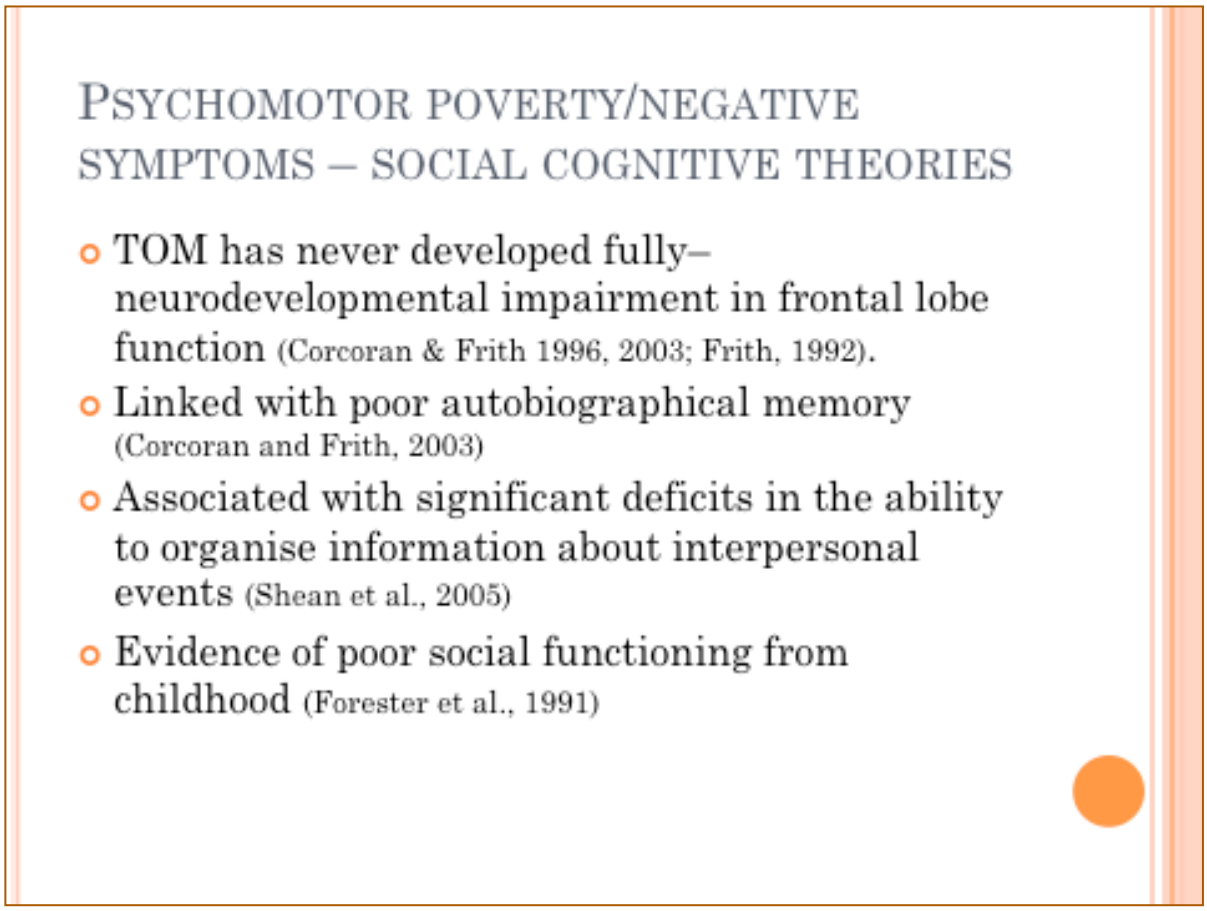
DISORGANISATION -WHAT CAN WE CONCLUDE?

- Individuals with disorganized symptoms require special attention in social cognitive skills training (Brune and Schaub, 2012)
- Individuals with symptoms from the disorganized cluster would benefit from work on all social cognitive domains but TOM development should be prioritized with this group.



Psychomotor poverty or negative symptoms have received much attention within the literature as there is robust evidence linking the existence of negative symptoms to poorer functional outcomes (Mueser et al., 1990; Pogue-Geile, 1989; Pogue-Geile & Zubin, 1987). The relationship between psychomotor poverty/negative symptoms and social cognitive factors may be less straightforward than for the disorganised symptom cluster. There is evidence indicating a consistent moderate strength association between the psychomotor poverty cluster and social cognitive factors, emotion perception and TOM in particular but the association was not found to be as strong as for the disorganisation cluster (Ventura et al., 2011; Fett et al., 2011). In a recent study Mancuso et al. (2011) found no association between negative symptoms and social cognitive difficulties however it should be noted that his sample only included

individuals with a low to moderate level of symptoms. Negative symptoms have been inked to a difficulty recognising fear (van Wout et al., 2007; Schneider et al., 1995) and associated with anger misperceptions (Cohen et al., 2008) and a recent study added to the weight of evidence supporting a link between emotion recognition difficulties and negative symptoms by finding that deficits in ER correlate with negative symptoms in anti-psychotic naive individuals with psychosis (Behere et al., 2011). As regards TOM, in a review of the literature Harrington et al. (2005b) concluded that there was only evidence for a weak association between TOM deficits and negative symptoms.

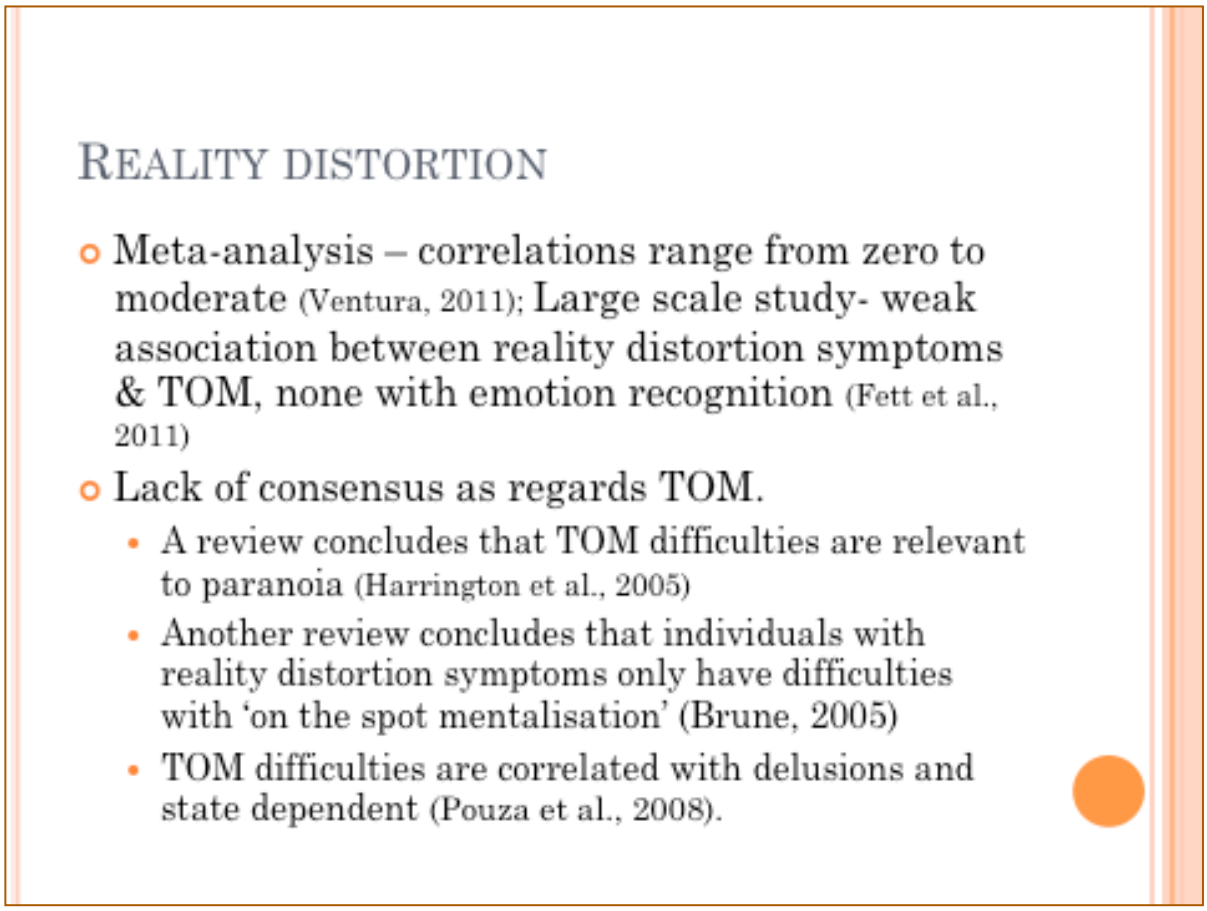


TOM difficulties have been implicated in social cognitive models developed to conceptualize negative symptoms in psychosis (Corcoran, 2000, Corcoran & Frith, 1996, Corcoran & Frith, 2003 and Frith, 1992). It has been suggested that TOM difficulties in individuals with negative features of schizophrenia may be due to TOM abilities never fully developing (Corcoran & Frith, 1996) and proposed that individuals with negative symptoms of psychosis have a limited store of social experiences to draw on and poor theory of mind because of a neurodevelopmental impairment in frontal lobe function (Corcoran et al., 1995). In line with this theory there is evidence that individuals with negative symptoms demonstrate some memory difficulties (Corcoran & Frith, 2003; Shean et al., 2005) and indicating that individuals with chronic negative symptoms show evidence of poor social functioning from childhood (Forester et al.,

1991). However as discussed evidence only supports a weak association between negative symptoms and TOM and it has been suggested by some researchers that illness chronicity and general cognitive impairment could account for this weak association (Pouza et al., 2008; Langdon et al., 2002). Lincoln et al. (2011) using a linear regression analysis, found that taken together the social cognitive variables they studied accounted for 39% of the variance in negative symptoms after controlling for neurocognitive variables and depression.

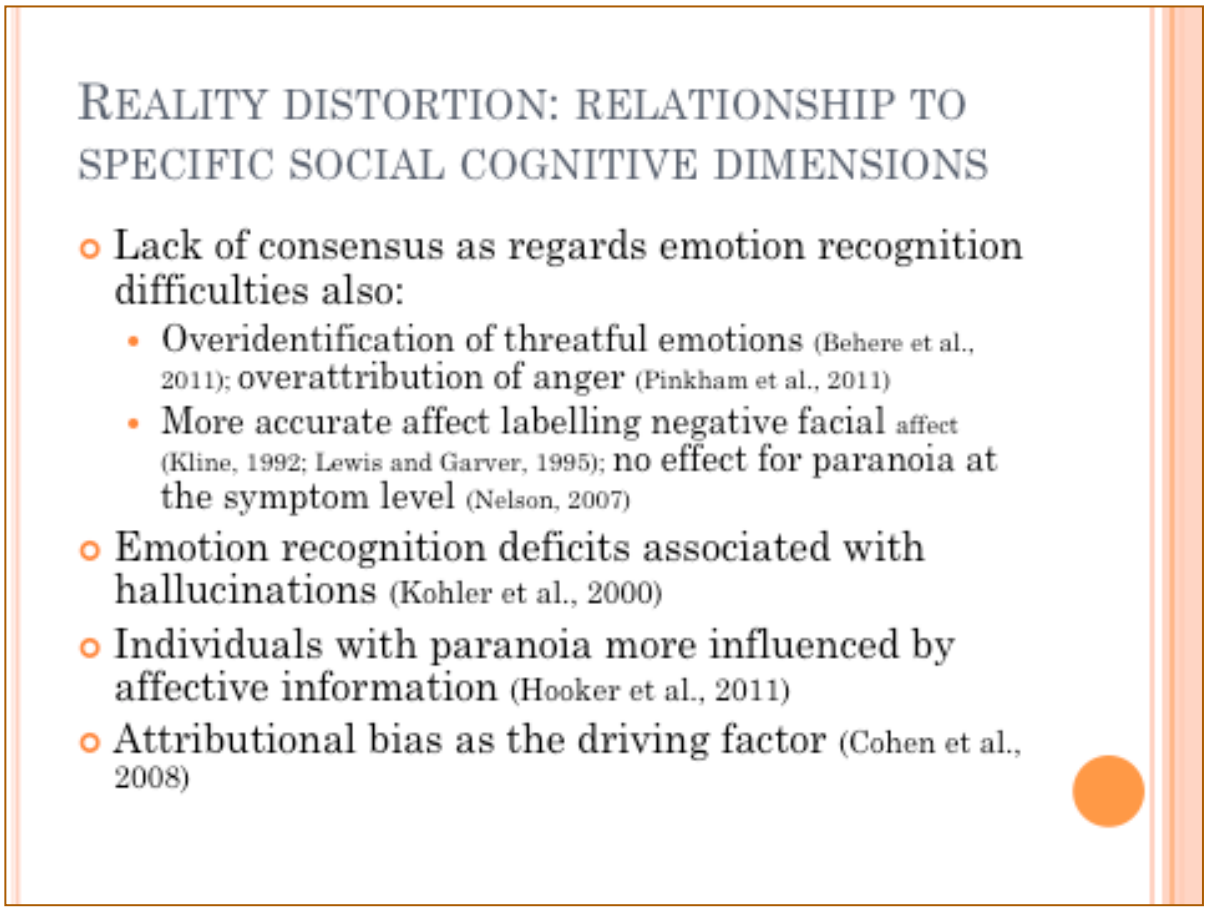
PSYCHOMOTOR POVERTY/NEGATIVE SYMPTOMS- WHAT CAN WE CONCLUDE?

- Social cognitive variables are a potential target for psychosocial interventions aimed at ameliorating negative symptoms (Lincoln et al., 2011).
- Individuals with symptoms from the negative symptom cluster would be likely to benefit from work on all social cognitive domains, the support is clearest for emotion recognition difficulties.



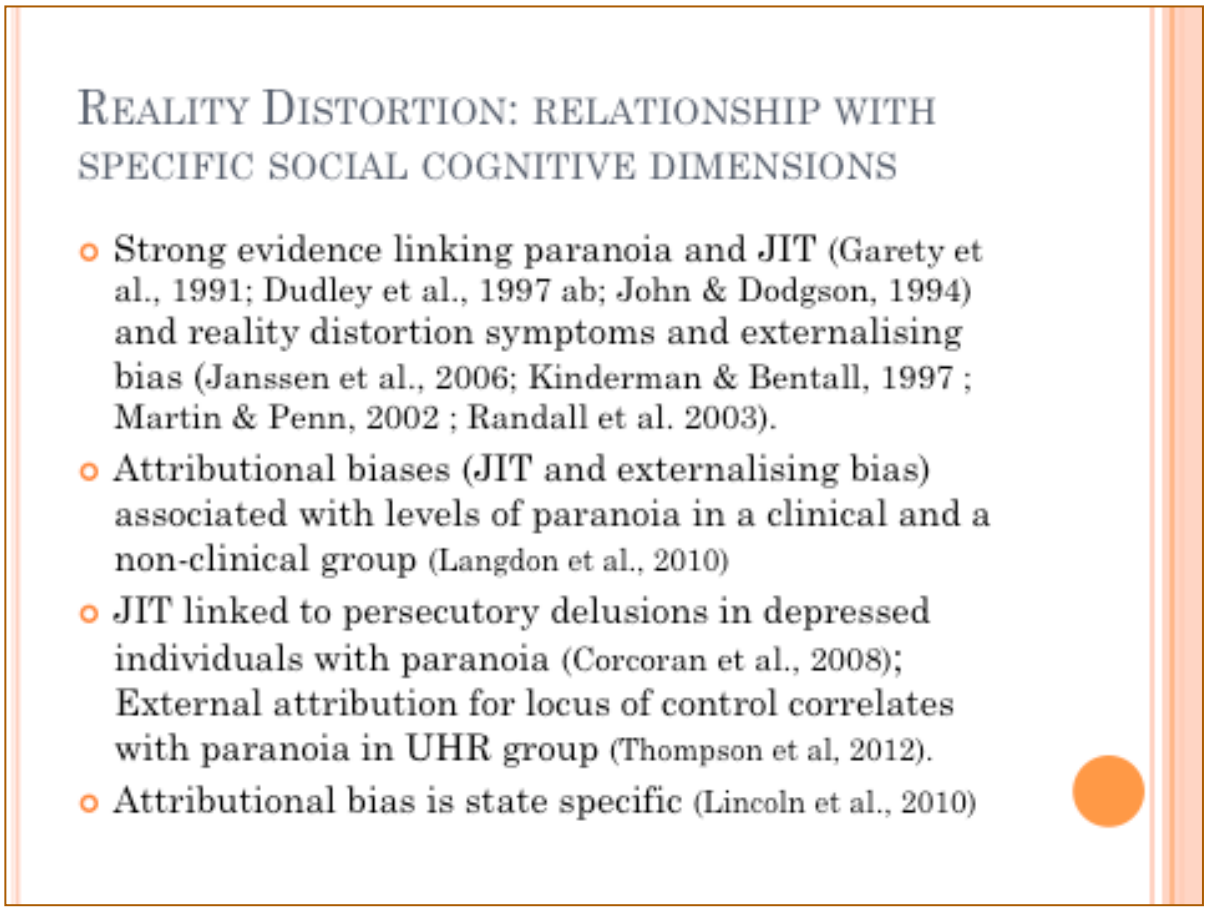
The evidence points to a strikingly different picture of social cognitive difficulties and reality distortion symptoms in comparison to the other two symptom clusters. Studies have found weaker associations between social cognitive domains and reality distortion symptoms than between these domains and the other symptom clusters (Ventura et al., 2011; Fett et al. (2011). There is in particular disagreement within the literature regarding TOM with some studies finding an association between delusions and TOM (Greig et al., 2004) but other studies not finding evidence of this association (Abdel-Hamid et al., 2009). There is evidence that patients who experience subjective symptoms of passivity such as thought insertion or delusions of alien control and patients in remission from reality distortion symptoms perform relatively normally on TOM tasks (Corcoran et al. 1995; Frith & Corcoran 1996). A review by Brune (2005)

concludes that individuals with paranoia are only particularly compromised when attempting to mentalise on the spot but may perform well when not under pressure, a theory which may account for the contradictory findings. This theory has received some support (Pouza et al., 2008).



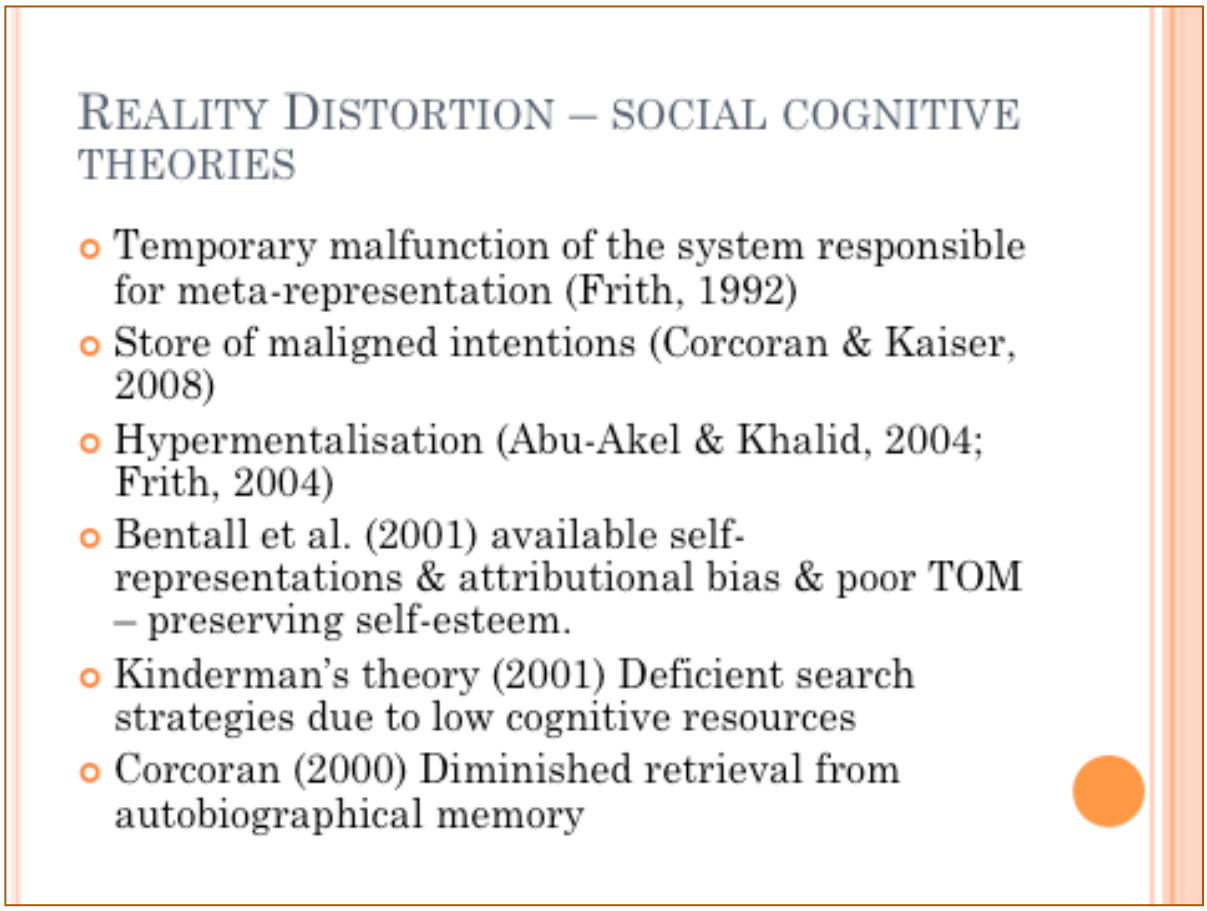
There is also a lack of consensus regarding difficulties in facial affect recognition and reality distortion symptoms. Some studies have found evidence that individuals with paranoia have difficulties with emotion recognition (Behere et al., 2011; Pinkham et al., 2011) while others have found evidence that individuals with paranoia are more accurate than individuals with schizophrenia without paranoid symptoms in labeling negative facial affect (Kline, 1992; Lewis & Garver, 1995). Hooker et al. (2011) suggest that individuals with paranoia may be more influenced by affective information in their emotion perception as they found that individuals with paranoia were particularly susceptible to negative affective priming relative to controls and tended to judge faces as more threatful following these negative affective primes than following neutral or

positive affective primes. Cohen et al. (2008) suggest that attributional bias may be the driving factor in difficulties with emotion perception.



Attributional bias has been the focus of a good deal of research investigating reality distortion symptoms and there is a body of evidence suggesting that attributional bias is associated with reality distortion symptom. The two types of bias with the strongest support are Jumping to Conclusions bias (JIT) and externalising bias. The evidence suggesting a role for attributional biases in reality distortion symptoms is bolstered by findings linking attributional bias with levels of the symptom of paranoia in depression (Corcoran et al., 2008) and a non-clinical control group (Langdon et al., 2010). Thompson et al (2012) found that in an 'ultra high risk' for psychosis group the tendency to make for external attributions of the locus of control for events was positively correlated with both negative symptoms and paranoia but not with overall psychopathology. Attributional bias has been found to be state specific as these biases

are only found in patients in an acute phase (Lincoln et al., 2010) and studies have failed to find a relationship between sub-clinical persecutory ideation and attributional bias (McKay et al., 2005).



An early social cognitive theory proposed that positive symptoms of psychosis were caused by a temporary malfunction of the system responsible for meta-representation or theory of mind (Frith, 1992). Later theories have all centered on the idea of disrupted processing, for example deficient search strategies (Kinderman, 2001) or diminished retrieval from autobiographical memory (Corcoran, 2000) as a result of a store of 'maligned intentions' i.e. memories of negative interpersonal experiences (Corcoran & Kaiser, 2008) or a combination of factors such as attributional bias, poor TOM and a need to preserve self-esteem (Bentall et al., 1994, 2001), Therefore social cognitive theories of reality distortion symptoms do not implicate skills or structural deficiency but processing difficulties.

Reality Distortion – social cognitive theories

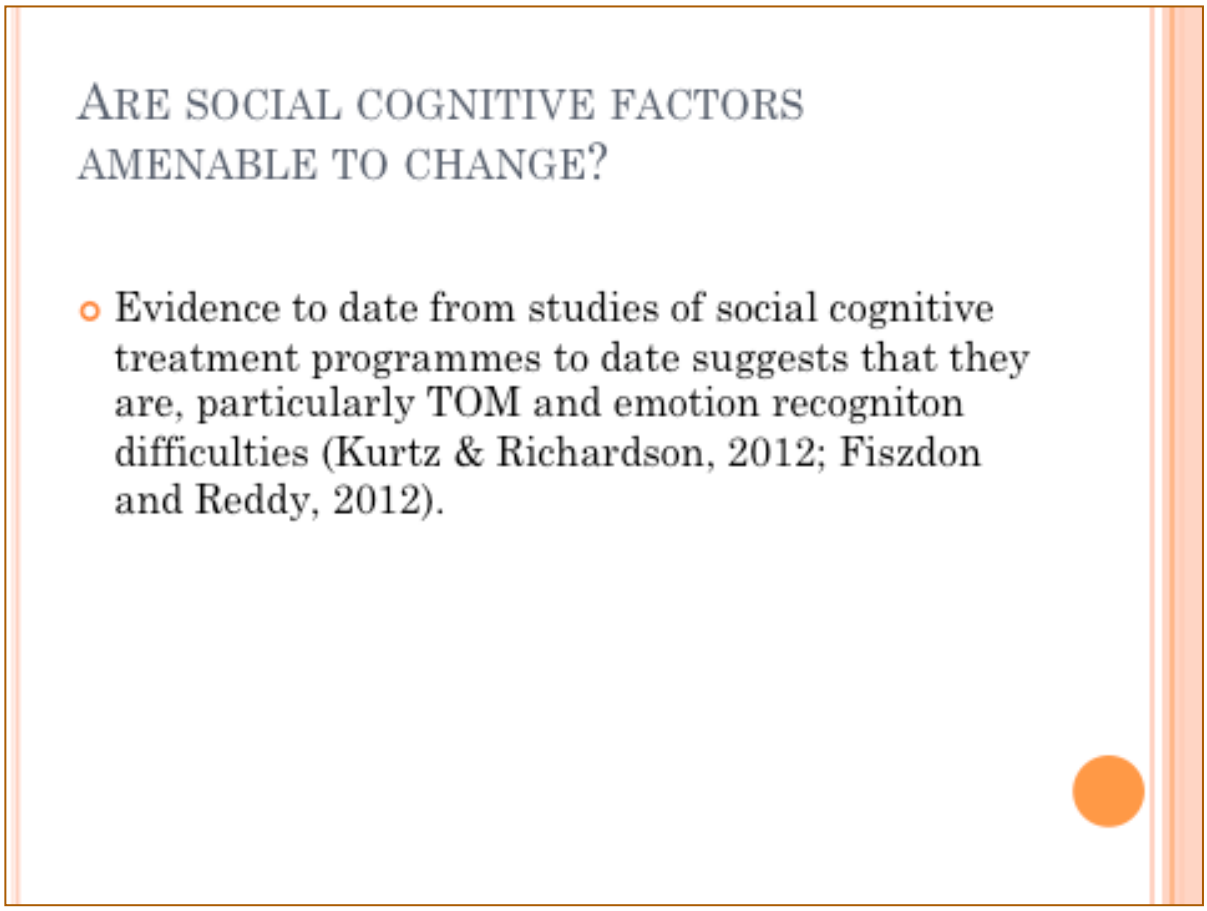
- Temporary malfunction of the system responsible for meta-representation (Frith, 1992)
- Store of maligned intentions (Corcoran & Kaiser, 2008)
- Hypermentalisation (Abu-Akel & Khalid, 2004; Frith, 2004)
- Bentall et al. (2001) available self-representations & attributional bias & poor TOM – preserving self-esteem.
- Kinderman's theory (2001) Deficient search strategies due to low cognitive resources
- Corcoran (2000) Diminished retrieval from autobiographical memory

Reality distortion- what can we conclude?

- The evidence is not as supportive of a link between social cognitive difficulties at a structural level and the symptoms in the reality distortion cluster. As such clients with predominantly reality distortion symptoms are less appropriate for the group.
- A module on attributional biases – JIT and externalising bias in particular could potentially be useful to clients with a tendency toward reality distortion symptoms.

Overall conclusions

- There are differing patterns of association between social cognitive dimensions and symptom clusters.
- Individuals with disorganized symptoms should be the primary target for the group.
- Also those with the core negative symptoms could benefit from the group
- There is less evidence that individuals with predominantly reality distortion symptoms are in need of a social cognitive remediation group.
- Emotion recognition and TOM are key dimensions to address in the group



A key consideration is how amenable these social cognitive factors are to change. The social cognitive dimensions addressed in treatment programmes are predominantly those that would be predicted from the literature reviewed and the weight of the evidence indicates that emotion recognition and TOM in particular can be improved through treatment designed to address social cognitive capacities (Kurtz & Richardson, 2012; Fiszdon & Reddy, 2012).

MEASURES -KEY CONSIDERATIONS:

- *Has the measure been used in empirical studies as an outcome measure?*
- *Has the measure demonstrated responsiveness to change in studies with individuals with psychosis?*
- *Ecological validity & cultural appropriateness*
- *Psychometric properties: reliability and validity*
- *Ease and speed of administration*
- *Accessibility and cost*

MEASURES REVIEWED AND CONSIDERED

Social Cognitive Domain tested	Psychometric Tests
Theory of Mind (TOM)	➢ **The hinting task** (Corcoran et al., 1995) ➢ **TOM stories** (Baron-Cohen et al., 1985) & (HappeÁ and Frith, 1994) ➢ **Second-order false-belief task** (Pickup and Frith, 2001) ➢ **TOM comic strips** (Sarfati and Hardy-Bayle, 1999) ➢ **Movie task of social situations** (Mehl et al., 2010)
Affect Recognition	➢ **Bell Lysaker Emotion Recognition Test (BLERT**; Bell et al., 1997) ➢ **Face Emotion Identification Task (FEIT**; Kerr &Neale, 1993) ➢ The CANTAB battery www.cambridgecognition.com
Social Perception	➢ **The Half-Profile of Nonverbal Sensitivity (PONS)** (Ambady et al., 1995; Rosenthal et al., 1979).
Emotional intelligence including emotional perception	➢ **Mayer--Salovey--Caruso Emotional Intelligence Test (MSCEIT;** [illegible] **Mayer 2003)**
Theory of mind and emotion recognition	➢ **The Awareness of Social Inference** Test (TASIT;McDonald S, Flanagan S, Rollins J.(2002)
Attributional bias	➢ **The Internal, Personal, and Situational Attributions Questionnaire** (IPSAQ; (Kinderman and Bentall, 1996) ➢ **Ambiguous Intentions Hostility Questionnaire** (AIHQ;Combs, Penn et al., 2007) ➢ **The beads task** (Phillips and Edwards, 1966)

MEASUREMENT- RECOMMENDED MEASURES:

The Awareness of Social Inference Test (TASIT; McDonald S, Flanagan S, Rollins J. (2002)

A newer measure that measures both emotion recognition and theory of mind. Developed specifically for use with adults unlike some of the other TOM tests. Part 1 is an emotion recognition test and parts 2 & 3 are similar to the hinting task assessing TOM by assessing the understanding of inferences made in everyday conversation.

The beads task (Phillips and Edwards, 1966)

Has been widely used in research with individuals with psychosis. The beads test is an experimental task designed to examine individuals' reasoning style under conditions of uncertainty, assesses for a 'jumping to conclusions' reasoning style.

Reflections

- Overall aims achieved √
- Increased knowledge of different types of literature review and experience in the process of undertaking a conceptual literature review.
- Improved time management and use of supervision
- Increased understanding of social cognition and of psychosis and the relationship between these constructs
- Additional piece of work completed– Reviewed 'Goal Attainment Scaling' and recommended it as an additional client-centered outcome measure
- Gained an insight into the work of a clinical psychologist in the NHS and the processes involved in setting up a pilot psychotherapeutic group.

NOTES ON THE LITERATURE SEARCH

- **Psycinfo** using the following search terms: psychosis OR schizophrenia; social cognition OR social perception OR emotion recognition OR affect recognition OR theory of mind OR mentali?ation OR attributional bias OR attributional style.
- Limits: English language & peer reviewed
- Repeated on **Web of Science**
- Exclusion criteria: No differentiation into symptom clusters or symptom specific information, diagnostic label only.
- In addition -reference lists of studies were searched for additional relevant material and theories and concepts referenced in the studies were reviewed where relevant.

CHAPTER THREE: EXPLORING THE UNDERSTANDING AND USE OF 'CASE BUSTS' WITHIN TWO ASSERTIVE OUTREACH TEAMS

Abstract

Assertive Outreach (AO) services have been a key part of mental health services in the UK since 1999 with the primary aim of improving engagement with services and treatments and reducing the need for care. However an implicit key aim, that of risk management and reduction, has as yet received relatively little research attention. Case busts are one process introduced to AO teams in the West Midlands in response to concerns about risk. They are a multi-disciplinary team meeting that proposes to facilitate communication and to inform care. This study sets out to explore the experience and understanding of case busts for AO workers in two teams in the West Midlands from a range of professional perspectives. Data were analysed using template analysis. Four overarching themes emerged from the data: case busts: information sharing is a valuable function of the case bust; case busts are not a fully shared process; case busts are a process in need of structure and leadership; case busts only have a clear consistent impact on defensive risk management practice**.** It is recommended that formulation method in case busts is reviewed and that psychologists consider how to provide leadership in case busts within AO teams.

Introduction

Assertive Outreach (AO) was developed in the 1970's in Madison, USA (Marshall & Lockwood, 1998) in a response to the process of deinstitutionalisation to provide a service within the community for individuals with high levels of unmet need and frequent hospital usage. Also known as Assertive Community Treatment (ACT) the model demonstrated good outcomes in terms of reduced hospital usage, quality of life

and satisfaction with services in two Cochrane reviews (Marshall and Lockwood, 1998; Marshall and colleagues, 1998). These reviews had a significant impact on mental health policy in the UK in the wake of the Christopher Clunis enquiry (Richie, Dick, & Lingham, 1994) with dedicated Assertive Outreach Teams (AOT) forming part of mental health service provision in the UK since 1999 (Department of Health, 1999). The Richie report emphasised the importance of the assertive management of individuals presenting with high levels of risk. However despite the fact that debate has flourished regarding the way risk is conceptualised and managed in mental health services (Morgan, 2000a; McAdam & Wright, 2005) the understanding of risk has not received a strong focus in the deployment of AOTs. The report into the case of Earl Glaiser-Butler (Francis, 2009) has more recently reignited this debate.

Within this debate emphasis has been placed upon the need to promote positive risk taking if individuals are not to become stuck and non-progressive in their recovery (Ryan and Morgan, 2004). This endorses calculated risk taking involving making plans and taking actions 'that reflect the positive potentials and stated priorities of the service user' (Morgan, 2004 p.18). The Department of Health risk management framework counsels practitioners that 'over defensive practice is bad practice' (Department of Health, 2007 p.8), and recommends positive risk management and a strengths based approach in addition to collaborative working with the service user as core principles underpinning risk management in mental health (Department of Health, 2007). AO workers are in the position of having to find a balance between risk management and therapeutic risk taking (Meddings, Shaw and Diamond, 2010 p. 224), but finding this balance in work with complex cases may not be a straightforward proposition. Roberson and Collinson (2011) conducted a study on positive risk taking

in Assertive Outreach teams in the Midlands area of the UK and found that there were varying definitions of positive risk taking among AO workers. Without organisational coherence and support, some workers were likely to see positive risk taking as a gamble and to retreat into more conservative practices even though they were aware that such practices were potentially detrimental to therapeutic relationships and could lead to an increase in risk in the longer term.

Good quality risk assessment and management should be underpinned by a multi-disciplinary approach in which 'psychological and social factors, as well as psychosocial interventions, are at the forefront' (Ramon, 2005; p 197). Formulation is used in many forms of psychotherapy as a basis for intervention (Horrowitz et al. 1994; Luborsky, 1997; Persons, 1989; Caspar, 1995). Models for formulating and sharing risk with multidisciplinary teams have recently emerged emphasising different methods (Meaden & Hacker, 2011;Wholmsley, 2010). Whatever method is used a good risk assessment should 'lead to a sound shared risk formulation and promote therapeutic risk taking, enabling recovery as much as possible' (Meaden, 2010).
Case busts were introduced in Assertive Outreach teams operating in Birmingham in 2009 in response to the Glaister Earle Butler inquiry in order to facilitate communication and inform care; comprising part of the BSMHFT action plan (BSMHFT, 2009) which stated that 'a critical review must be put in place to ensure all patients (particularly those at low risk) should be subject to a full team discussion' case busts potentially provide a forum for a shared formulation approach. To date there has been no opportunity for staff to reflect upon their experience of this process within the changing nature of service delivery within the NHS. This study aims to provide such an opportunity. More specifically this study intends to and to explore the understanding

and experience of case busts within two AO teams in the West Midlands and their relationship to work with risk within these teams.

Method

Context

The research took place in two AO teams in the West Midlands. Both teams operate 24/7 9am to 9pm providing a service for working age adults with a severe and enduring mental illness (i.e. schizophrenia, major affective disorders), a history of in-patient or intensive home care treatment, and complex needs including a history of significant risk to self or others, co-morbid substance misuse, poor response to treatment and difficulties engaging with mental health services.

Researcher

The author is a postgraduate student at the university of Birmingham who also works as a Cognitive Behavioural Psychotherapist. She spent approximately a month on placement with each team prior to conducting the research, accompanying the AOT staff on visits to service users. Michael Larkin, a supervisor, is a psychologist and senior lecturer at the University of Birmingham with a particular interest in qualitative methods. Alan Meaden, also a supervisor, is a consultant Clinical Psychologist and lead for AOT services in Birmingham.

Procedure

Ethical approval was sought and granted from the University of Birmingham ethics board (appendix 3). The trust Research and Development department confirmed that University ethics approval was sufficient. Participants were recruited through the

provision of information sheets (appendix 4) at multi-disciplinary team meetings. Key criteria for inclusion in the study were employment in AOT as a member of the multi-disciplinary team and experience of the 'case bust' process. After a consideration period of at least one week staff who volunteered to participate were asked to sign a consent form (appendix 5).

Sample

Sixteen staff members were recruited, eight from each team. The following professions were represented in the sample: psychiatry, clinical psychology, social work, occupational therapy, community psychiatric nursing and support-time recovery workers (see table 2)

Participant	Team	Job role	Core profession	Number of years with the team
Kate	X	Team manager & Care coordinator	Psychiatric nurse	10+ years
Katherine	X	Care coordinator	Psychiatric nurse	10+ years
Liam	X	Social worker & Care coordinator	Social work	1+ years
Pauline	X	Care coordinator	Psychiatric nurse	5+ years
Diane	X	OT & Care coordinator	Occupational therapy	<1 year, 5+ years with a previous AO team
Tom	X	Support worker	Support time recovery work	6+ years
Michael	X	Consultant psychiatrist	Psychiatry	1 yr with current team
Meghan	X	Clinical psychologist	Clinical Psychology	6mths, previously with Y team for 1 year
Clare	Y	Team manager & Care coordinator	Social work	10+ years
Sarah	Y	Clinical lead	Psychiatric nursing	1 year in current team, 4+ years in a previous AO team
Dan	Y	Care coordinator	Psychiatric nursing	7+ years
Harry	Y	Care coordinator	Psychiatric nursing	1+ years
Susan	Y	Occupational therapist & Care coordinator	Occupational therapy	5+ years
Laura	Y	Support worker	Support time recovery work	7+ years
John	Y	Consultant psychiatrist	Psychiatry	1 year, previously with X team. 10+ years working in AO services
Paula	Y	Clinical psychologist	Clinical psychology	6 mths

Table 2. Participant information

Data collection

Participants were interviewed by the researcher using semi-structured interviews. Interviews took place at the AOT base in each of the teams. An indicative topic guide (appendix 5) was developed by the researcher and A. Meaden as per the conventions of semi-structured interviewing (see Smith, 1995). Interviews lasted between 40 to 58 minutes. The interviews were tape recorded and transcribed verbatim by the researcher with minor corrections made to grammar. Participants were given a copy of their transcript and requested to notify the researcher within two weeks if they wanted information omitted or wished to withdraw from the study. No participants contacted the researcher.

Data analysis

A 'subtle realist' (Hammersley, 1992) position was adopted in the approach to data analysis in the assumption that the researcher's perspective is necessarily influenced by her social position and inability to truly stand outside the social world but maintains nonetheless that phenomena exist independent of the researcher and are knowable through the process of research. Template analysis (King, 2004, 2012) was selected as the method of data analysis. This method provides a systematic technique of thematically organising and analysing qualitative data. It was selected as it allows the research to focus on particular aspects of the phenomenon under investigation in order to incorporate the concerns and questions of those the research is designed to help. This is done through the selection of a-priori themes. A-priori themes were developed by the researcher and supervisors on the basis of prior clinical knowledge and a desire to focus on specific aspects of the phenomenon under investigation. The a-priori themes were considered to be tentative and in an attempt to remain open to the data

and avoid presuppositions the development of the initial template (appendix 7) was an evolving process that was not considered to be complete until a preliminary coding was carried out on all interviews. This template was subsequently applied to each interview in turn, a process which involved constant revision with new codes being added, codes being refined or discarded if they did not prove to be helpful in capturing key meanings in the data, more salient themes moved to higher level codes and less salient themes to lower level codes as the analysis progressed (see appendix 8). This process continued until no new codes emerged from the data (see appendix 10 for an example of the data making up one code). The frequency of occurrence of certain themes within each team was analyzed to aid exploration of differences between the teams (see appendix 9 for an example). However, in accordance with Braun and Clarke (2006) the emphasis of the analysis was on meaningful coding and making links between the interpretation of themes. A research journal, which incorporated an audit trail of the analytical process, was kept by the researcher. Supervisors provided triangulation through 1:1 and group meetings to discuss the analysis

Verbatim quotes from the data will be presented to illustrate the key themes. Pseudonyms are used throughout.

Results

Four overarching themes emerged from the analysis of the data on case busts as a process relating to risk: information sharing is a valuable function of the case bust; case busts are not a fully shared process; case busts are a process in need of structure and leadership; case busts only have a clear consistent impact on defensive risk management practice**.**

Information sharing is a valuable function of the case bust

The clearest agreement by respondents across both teams was that *information sharing is a valuable function of the case bust*. All respondents made the point that information sharing is necessary because AO is a team approach. Sharing information about risk was referred to frequently by respondents from both teams and was considered to be 'a critical part' of the process. Dan from team Y stated that knowledge is power and both he and Liam from team X referred to working without information on risk history as 'going in blind'. Sharing information about risk was perceived to have a protective function for staff and the dangers to staff of work within the community was emphasised by a number of respondents, for example:

> And you know I think sharing information and knowing information is really important because we could land ourselves in a risky situation when we go out to see patients. Its different if you're you know they are coming for outpatient appointments here because you have got security and stuff but for us if we are going out there and we don't know what the triggers are or what's you know what we need to look out for I think we're putting ourselves in a very dangerous so I think its really important that we do have these case busts. Yeah. (Laura)

The majority of staff from team X referred to information sharing as the primary function or key outcome of the case bust. Tom in team X described sharing information about risk, information he perceived as required by staff, as the main purpose of the case bust:

> *I: And what do you think is the main purpose of them, or the function of them?*

> T: Just to inform the team about the risk of the client, the, you know, what we need to be aware of really (Tom)

Information sharing was presented by this team as the means by which staff know how to work with a new client, a way to 'mitigate risk' with new service users and a valuable outcome in itself, for example:

> So yeah I'd say there is always an outcome even if the outcome is solely that you've shared information with more people so the team know the person better, know how to work with the person better, which would be valuable in itself (Kate)

In contrast both psychologists and participants from team Y wanted case busts to do more than facilitate the sharing of information. While they valued the information sharing function of the case bust they stated that there should be more emphasis in a case bust on understanding risk behaviours, for example:

> yeah you know if someone's history of arson do you know what I mean lets elaborate what was it how it happened rather than just you know saying yeah they've got a history of this, history of carrying knives you know history of violence lets you know, why has that happened (Laura)

This is an example of a theme that featured in team Y; *information sharing is necessary but not sufficient*. All participants from team Y and psychologists from both teams referred to information sharing as a key function but not necessarily the primary function of case busts: 'that's just the starting point isn't it I guess: information sharing' (Susan). They indicated that information sharing should be a basis for other processes

within the case bust such as formulation and planning intervention and not the end goal in itself, for example:

> It is important the information sharing but its having something useful that comes out of it you know that you feel like right well lets we've got a better plan lets try this kind of thing or lets do this, that's where I see the usefulness of it really because it feels wrong in a way if you just do it as an exercise that needs doing and then it just sort of closes it and you are not then doing anything from that sharing that information together having a formulation but having some action points from it really (Susan).

In both teams case busts were seen as particularly important for new cases and when there have been changes within the teams, for example:

> They happened in the old teams as well it was equally as important but I think because we have had a lot of change and a lot of new service users it's been massively important really. (Sarah)

Another key difference between the teams was that in team Y many respondents saw case busts as only relevant for new cases whereas in team X case busts were seen by the majority of respondents as relevant for both new and existing cases. There was a suggestion from staff in team Y that other more established team processes are considered sufficient by staff to meet the teams' needs over and above sharing information on new cases. The manager in team Y makes the point that organisational pressure to do case busts relates to risk and that the low incidence of 'serious untoward incidents' (SUI's) demonstrates that the team currently does well in managing risk as it currently operates:

I think the fact that we have a low incidence of SUI's em hopefully demonstrates that what we do we do quite well (Kate).

Katherine referred to 'ad hoc' discussions of challenging cases at morning meetings and stated that a more formal process for discussing challenging cases would 'put people off'. Liam stated that care planning meetings fulfil the need for further discussion of a clients' case after the initial case presentation.

Summary: The clearest agreement across both teams was in the value of sharing of information in the case bust, information about risk in particular. Respondents from team Y saw a value in case busts going beyond the sharing of information to also entail formulation and treatment planning. In the main case busts were seen as primarily relevant to new cases in team X but relevant for both new and existing cases in team Y.

Case busts are not a fully shared process

In line with the value placed on information sharing as a function of the case bust the key factor cited by respondents from both teams as influencing their participation in case busts was having knowledge of the client and as such believing that they have information to share about the client, for example:

> *I: And to what extent do you kind of personally participate in the case busts?*
> T: If I know the client then I will participate or ask questions
> I: Ok

> T: that's that's everybody…that's how much we are involved in the case bust. No I don't feel comfortable if I don't know the client very well to participate, no (Tom)

It was implied by respondents from both teams that participation over and above information sharing was limited, for example:

> I think em I think people know they can ask questions but whether they are encouraged to ask questions I'm not sure really. I think maybe its an expectation that people will ask questions but I actually think it's a very good point because not a lot of people do sometimes ask questions, which you'll find might be the same people all the while that tend to be a bit more vocal and ask but em in hindsight its probably something we need to improve on really (Sarah)

The perceived value of the case bust may be affecting participation. There was a suggestion that case busts are not perceived as a valuable or necessary process by all staff members in either team. Harry spoke about some staff feeling 'forced' into presenting at the case bust. Similarly Liam from team X indicated that some staff may have a similar view of case busts in team X:

> I think from what I hear of people say 'aw I've gotta do a case bust on this' people do see it sometimes as a bit of a grind, that it's just something that has to be done (Liam, team X)

Paula and Meghan suggested that differing perspectives or models may be contributing to a resistance to the case bust process: 'perhaps domination of particular models might get in the way' (Paula). Harry suggested that the 'attitude' of the staff member presenting at the case bust is a major factor determining the amount of preparation

done by that staff member for a case bust and stated that within the nursing profession there are 'old school' attitudes that mean that these types of processes are considered a 'waste of time' by some staff. John suggested that workers who are not psychiatrists or psychologists by profession are less inclined to see the value in processes like formulation. The fact that few explicit references to a psychosocial approach were made by respondents in either team when discussing the work of the AOT indicates that psychosocial interventions may not be a priority within the team. References to a psychosocial approach were more frequently made by staff in team Y but a psychosocial approach was referred to as an adjunct to medication treatment:

> Obviously medication is a big issue because em that's you know we can use various social interventions but medication is still principally the main tool that we use (Dan)

Collaboration with individuals outside of the staff team was limited in both teams, with information from client notes referred to most frequently as the *source of information* for case busts in addition to the information shared by workers with knowledge of the client. There was an indication that efforts were made in both teams to share the process with previous workers by inviting them to attend and share information when the client is a new case. This input was described as especially valuable. Some participants stated that they had asked clients for information to feed into case busts but this practice was presented as rare. Katherine who has worked with the AOT for over ten years stated that she has asked 'one or two' clients for information to feed into the case bust. Echoing the level of involvement of service users as a source of information very few participants had shared a formulation or aspects of a formulation from the case bust with the service user. A number of participants in both teams, but

particularly in team X, suggested that *it would be valuable to involve clients more in the process,* for example:

> *I: Is there other anything else you would suggest about the case busting, any way that it could be improved or..?*
> K: The only one I've thought of as we've sat here is discussing it more and giving them a copy after and I mean some you wouldn't be able to but using them yeah involving them more (Katherine)

Time constraints were cited as a barrier to increased collaboration with the service user and also the point was made that that the *decision to seek information or share a formulation would have to be made on a case-by-case basis*. Many participants believed that increasing collaboration would promote engagement but in contrast some also expressed concerns that sharing a formulation could threaten the engagement, for example:

I think you know we should be sharing the information with them so long as its not you know going to upset them or break you know break down the engagement (Liam).

Summary: Knowledge of information about the client was presented as a key factor dictating staff participation in the case bust. There was a suggestion that not all staff members see the case busts as valuable, a factor which may also affect participation. This may be due to differing attitudes or perspectives of individual staff members and also to the dominant culture within the AO teams. There were attempts made to share the process with previous workers but collaboration with the service user in regards to the case bust was limited. There did seem to be a support for increasing collaboration

with the service user but also some concerns about how to increase collaboration with clients without jeopardizing engagement.

Case busts are a process in need of structure and leadership

The *status of the case bust* differed between teams and the level to which it had become an established known aspect of team processes. It could be said that the teams were at different stages in terms of taking ownership of and defining the case bust process. In team Y the case busts was represented as a known process, staff stated that case busts are scheduled to occur weekly, and were clear on how to nominate clients for case bust. In contrast in team X the case bust had not been incorporated as a clearly defined team process as evidenced by the confusion of several staff members about which process the interviewer was asking about, for example:

> And the case busts.. because I get all these terms..they're the ones when we get the new clients? We have the ongoing sort of case management ones, is it particular ones? We've got various sorts of case busts… (Katherine)

The case busts were not occurring regularly in this team ('yeah so they are not like every month or something so' Tom) and the process for suggesting clients for case bust was unclear to staff: 'I think its em I don't know if there is, you are going to have to ask the manager if there is a formal process' (Diane).

The *structure* of the case bust process also differed between teams and the centrality of formulation to the process. Team Y respondents all stated that the 5 P's formulation tool was used as the structure for the case bust process. In contrast many participants

from team X believed that there was no standard structure for case busts and some indicated that a standard structure could be useful so that important information is not omitted. Respondents from team X were less definite about the role of formulation in the case bust than participants in team Y, stating that they 'think' it is included when discussing risk or 'should' be included. Diane stated that formulation does occur in case busts but in an unstructured and unnamed way. Pauline stated that formulation is not part of the case busts process at present but that she would like more emphasis on formulation within case busts.

One participant in an influential position within team X was concerned that standardization of the structure of the case bust would over-medicalise the process and 'blinker the way clinicians see the client' as ' person-centred service user' aspects of information such as strengths and interests would be lost. Participants from both teams were in agreement that there is currently an *overemphasis on risk and insufficient emphasis on strengths*. They indicated that information about risk dominates the information shared at present and Liam suggested that this emphasis on risk information could bias your view of the client in a negative way:

> I'd say another thing that should, could be included more in case busts is looking at someone's strengths. It does give you a worst case snapshot of someone (Liam)

However the view that using a standardized structure could reduce emphasis on strengths and over-medicalise the process conflicted with the view of both psychologists and of team members in team Y. They expressed the view that using a formulation tool to structure case busts helps to: 'move away from a medicalised way of

viewing things' (Paula). John suggested that it is a lack of focus in the case bust that precludes progression in the meeting to the consideration of protective factors, strengths, and also ideas for practice:

> I think risk if anything is slightly too dominant em but that comes back to this issue about the importance of it being clear the focus of the meeting so that you can move beyond kind of this itemising history towards thinking about more positive things like protective factors, people's strengths areas in the longer-term care plan that are perpetuating but you might think yeah I could come at it from that way so rather than focus specifically on the behaviour or whatever it is that you come up with different ideas about how you might deal with that (John).

John also referred to the process becoming 'lost' in discussion of extraneous detail when the purpose was to discuss risk. Several respondents from team Y agreed with John in suggesting that there was often *a lack of focus* in case busts and several also stated that the current formulation method in case busts is inadequate for comprehensively covering risk, for example:

I think the five P's if you if you study it or you know go into it fully that should cover all areas but we often em we perhaps sometimes we do miss some of the risk stuff (Dan)

John proposed that a formulation of risk specifically as opposed to the more all-encompassing formulation of the client would be more useful in understanding risk. Susan (the OT from team Y) and both team's psychologists expressed similar views, for example:

I: So it can adequately cover risk?

M: It can do if I guess again if you are clear from the beginning that you are trying to formulate risk because if you are not clear that you are just looking at those factors that are affecting the risk then it can be a bit of a mishmash (Meghan)

The majority of participants from team Y suggested that more directive facilitation has the potential to resolve the lack of focus and increase the consistency and coherence of the process. Harry suggested that the facilitator could guide the process, keeping the group focused, ensuring that planning practice is a key element of the case bust process and that the plans made are followed up. Clare, Dan and John explicitly stated that someone needs to take responsibility for the case bust process, to lead the process:

you know its important for somebody to take that responsibility for that, to have that consistency in terms of how its being done and structured (Clare)

These respondents suggested that the psychologist should take this role. Overall, the *role of psychology* in the case busts was not clearly understood by either team. Both psychologists referred to assisting with selection of cases for case bust and preparation and more tentatively to a role as facilitator of the case bust. Both psychologists spoke most usually in collaborative terms emphasising a joint working approach. Staff in team Y did refer to the role of the psychologist in organising and facilitating the case busts whereas there were few references made overall in team X to the role of the psychologist in the case bust. Two participants from team X referred to the psychologist having a role in facilitating case busts in the past but one of these participants also indicated that she did not believe it necessary for the psychologist to be involved in facilitating the case bust as it is 'natural' for care coordinators to take the

lead. Pauline in team X spoke of the value of the role of a previous psychologist in helping you understand people's difficulties but seemed unsure what role the new psychologist would hold within the team. Susan in team Y also referred to a role for psychology in helping staff understand client difficulties but spoke of the possibility that the psychologist might make the process 'a little too psychological' for staff.

Respondents from team Y suggested that the amount of preparation done for a case bust is another factor in the depth and coherence of the process, for example:

It can be a bit disjointed if people don't do the homework first maybe just throwing bits in and it's all over the place (Dan)

Susan stated that at times staff read information straight from a medical summary and that this practice does not engage the staff team in the process. Harry agreed that the perceived relevancy of the information shared effects staff interest or engagement in the case bust. Several staff cited *time constraints* as a barrier to preparation. Meghan, one of the psychologists, advocated increased preparation but expressed concern that asking for increased preparation will mean that case busts will not go ahead due to the constraints on staff time:

> my concern has always been that if you ask people to do a lot of preparatory work em and they don't have the time then the case bust may not go ahead because they haven't done that work (Meghan)

Support with preparation for the case bust was mentioned by a few staff from each team but was not seen as a given aspect of the psychologist's role within either team either, for example:

> *I: Ok, do people usually have any support with that preparation work or..?*
> S: I think some people have sat down with the psychologist and done bits but not, I think its mainly the care coordinators responsibility (Susan)

In both teams time constraints were referred to as a barrier to increased utilisation of psychology support with preparation for the case bust.

Summary: The teams differed in terms of the status of the case bust within team processes and the way case busts are run and structured. Within both teams there were perceived problems with regards to the structure of the case bust and the role of psychology in regards to the case bust was not clear in either team.

Case busts only have a clear consistent impact on defensive risk management practice

With the exception of Michael and Tom all staff members across both teams referred to the case bust as a source of multiple perspectives from the multidisciplinary team, these perspectives were presented as valuable by respondents and as a source of ideas for practice. In addition to facilitating access to a multidisciplinary perspective several participants from both teams also referred to case busts as having a role in reducing stress or anxiety for staff through the sharing of cases with the team, for example:

> Because our clients are complex you need to share them at times em because otherwise I think you'd kind of drown and stress levels would be higher and like I say you need different perspectives.
> (Pauline)

Respondents from both teams implied that there was increased empathy for the client following a case bust, an outcome they tended to credit to the sharing of information on client history.

Both psychologists saw developing a shared understanding as a key goal of the case bust. However there was some disparity between the teams in citing increased understanding of service user behavior as an outcome of the case bust. Respondents from team Y more frequently referenced increased understanding of client as an outcome case bust process, for example:

> It will help you understand why the person maybe where they are at now, some of the obstacles, some of the trauma in their life, some of I don't know their illness cycle as well, the risk as well. (Sarah)

Respondents from this team regularly referred to the value of formulation in increasing understanding. Harry explicitly credited the formulation element of the case bust process, using the 5 P's[3], with increasing understanding of client behaviour:

> 'As well as because we use the five P's for ours, but em that's quite in-depth sometimes and it focuses a lot on the reason why people do things..so yeah definitely, it definitely help you to understand their behaviours' (Harry)

[3] The five P's is a formulation tool. The categories are as follows: Presenting problems, predisposing factors, precipitating factors, perpetuating factors, protective factors (Johnstone & Dallos, 2006)

In team Y John alone stated that case busts do not increase his understanding of the client, stating that they are not 'sufficiently sharp' to do so.

In contrast respondents from team X made fewer explicit references to increased understanding as an outcome of the case bust, staff who spoke of increased understanding were non –committal and referred to this understanding as more incidental as a result of increased knowledge of client history, for example:

> But yeah because the predisposing gives you a lot of sort of historical stuff doesn't it that you might not perhaps have been aware of before if you are attending a session on somebody else's service user and that helps you sort of maybe understand where they are now and how they have arrived at where they are now (Kate)

Tom, when explicitly asked about the 5 P's by the interviewer, was unsure of the practical value of formulation using the 5 P[4]'s in understanding or managing risk:

> *I: And how well does the "5 p's" help you understand or manage risk?,. you mentioned risk..*
> *T:* I think it's probably there as a guideline maybe, but I think when you go and see the person it's a bit different, you face the situation that's in front of you, the "5 p's" goes at the back of your head really, you don't think of that then you deal with what you can see, so….maybe for presentation purposes the "5 p's" do apply but…it's difficult to say…(Tom)

As regards practice case busts were seen by staff in both teams as a way of highlighting risk factors, sharing responsibility for decisions about risk management, and as having a role in facilitating consistent risk management practice by the team: 'Again just reminds ourselves that you know of risk or of actually how we should be consistently working with someone' (Dan). While staff from both teams referred to risk management plans arising from the case bust it was implied that planning is not a given aspect of the case bust: 'maybe new plans sometimes you can get from that' (Pauline) and the risk management referred to was primarily of a defensive practice nature. The aim of which was presented most usually as minimisation of risk to staff in the community setting, for example:

> Yeah, covers the risk as well and what point you would go in twos and that's also included in the early warning signs at what stage would you start going in twos to somebody's house yeah would you not carry them in the car and all the sort of safety measures are and the you know.
> (Katherine)

In team X only the psychologist (Meghan), the psychiatrist (Michael) and the OT (Diane) made a clear link between case busts and practice other than defensive risk management practice. Megan and Michael spoke more in aspirational terms of the role the case bust 'should' take in informing wider practice. Michael stated that the case busts should make staff more comfortable with 'risk taking' in addition to practice with the aim of diminishing risk. No other respondents explicitly mentioned risk taking. There was no clear link specified between the case busts and the care planning process in this team. Two participants, one of whom had been with the team for over ten years, stated that they assumed that the case busts feed into the care plan but did not have

any direct experience of this being the case. Liam stated explicitly that he does not believe that there is currently any connection between the case bust and any other team processes:

> at the moment I think people only use a case bust for a case bust and then its gone, they don't use it for any other reason so it serves a purpose you've done it (Liam).

Staff within team Y made some references to practice (other than defensive risk management practice) arising from the case busts. Harry and Sarah both give specific examples of formulation-driven psychosocial interventions arising from the case bust, for example:

> And in the end we did, we did graded exposure but we did it in a CBT model in a much more organised way. And that was all after a case bust so. (Harry)

In team X a clear link was made by respondents between the case bust the care planning process, for example:

> Well I think the case busts can actually throw up or identify a specific need or a problem or a deficit em and you can also at the end of it you can actually identify not only the problem but actually the intervention. It can actually it can drive the intervention or identify the best way to intervene with someone or the best way to handle it. So that then would almost in itself would almost be a care plan you know it would actually identify the problem it would identify the best ways to intervene (Dan)

However the relationship to practice was presented as inconsistent in team Y. John stated that formulation and planning are not currently major elements of the case bust process in team Y either:

> And often my experience of case busts is that no we don't, kind of we have talked a lot which is good for information sharing but we haven't necessarily done much formulating and usually very very little planning. (John)

It was suggested that the implementation of the link between case busts and practice is dependant on the staff member coordinating the case, that plans are not always made in the case bust, and plans that are made are not always followed through, for example:

> I think there is sometimes a clear link but I think you see some case busts they share the information and it all closes down and that's it, but sometimes you see it and it goes somewhere, I don't know why is that...(Susan)

Summary: Case busts only appear to have a consistent impact on defensive risk management practice in both teams at present. Team Y seemed to be moving towards a closer relationship between case busts and practice but the relationship was presented as inconsistent.

Discussion

Risk was a motivating factor in the implementation of AO teams in the UK. As such the case bust process, a process that seeks to improve work with risk, has been the main focus of this study. The Department of Health risk management best practice guidelines

(Department of Health, 2007) emphasize positive risk management, collaboration with the service user and a strengths-based approach. This is in line with other recent policy documents recommending a recovery-orientation in mental health services (Department of Health, 2011; Division of Clinical Psychology, 2013). This study indicates that the case busts are a process in need of further development in each of the AO teams studied in order to align them with these recommendations.

It was clear that case busts were serving an information sharing function within both teams, a function valued by all participants. Sharing information on risk was presented as a priority by both teams. This is most likely due to the perceived protective nature of information about risk to staff working within the community setting with this client group. In both teams it was suggested that sharing information on risk dominates the process and that there is insufficient emphasis on client strengths. In both teams participation in case busts was largely dictated by knowledge of information about the client supporting the interpretation that information sharing is perceived by staff to be a key function of the case bust. There were however differences in the way that the two teams studied understood the case bust and its functions. Participants in team X were more inclined to see information sharing as the main function of the case bust whereas both psychologists and participants from team Y saw the potential for the case bust to do more than share information, viewing information sharing as a basis for other processes in the case bust such as formulation and treatment planning. The view in team X that case busts were a process more relevant for new cases may be a factor as it would be reasonable to assume that information sharing is a key requirement for new cases.

It could be said that, as a team process, the case bust was at a different stage of development in each team. While in practice neither team seemed to have successfully consistently moved beyond an emphasis on sharing information that informed defensive risk management practice in team Y there was more progression towards a psychologically informed case bust that serves additional functions beyond information sharing. Formulation was presented as more central to the case bust process in team Y. Literature on formulation in teams that suggests it has multiple benefits, both for clients and staff (see Division of Clinical Psychology, 2011 for a review). This study provides further support for the value of team formulation as participants from team Y were more inclined to report a broader range of outcomes from the case bust including increased understanding of the service user and psychosocial interventions. However, there appeared to be little emphasis on positive risk taking in either team and collaboration with the service user was presented as minimal in both teams, despite support for increasing collaboration. Roberson and Collinson (2011) suggested that positive risk taking is considered a gamble without organisational coherence and support and participant concerns about how to increase collaboration without jeopardising engagement in this study may indicate that participants have a similar view of collaboration with the service user.

The majority of respondents did suggest a need for increased coherence in the case bust process. Participants from team X suggested that the process could benefit from a standard structure and participants from team Y suggested that the consistency and focus of the process could be improved. Both psychologists and several respondents from team Y suggested that formulating risk specifically in case busts has the capacity to more clearly practice. Leadership was also identified by several respondents in team Y as an important consideration for the case busts. They spoke of

someone taking responsibility for the process and offering direction and many participants suggested that the psychologist should take this role. If case busts are to be a psychologically informed process with formulation at its core it makes sense for psychology to take the lead as formulation has been described as a defining skill of the profession of clinical psychology (Kinderman, 2001). The clinical psychology leadership framework lists 'Lead on psychological formulation within your team' as one of the roles of the qualified psychologist (Skinner & Toogood, 2010). The role of psychologists with regards to the case bust was not clearly understood by respondents in this study and respondents did not consider psychologists to have a clear leadership role in case busts. In a recent study of clinical psychologists' use of formulation in multidisciplinary work Christofides and colleagues found that clinical psychologists were more inclined to share psychological hypotheses informally by 'chipping in' during team discussions as opposed to through explicit means (Christofides et al., 2012). A number of reasons were given for this approach including the culture within the team and stage of development of the clinical psychologists' role or identity within the team.

The status of the case bust in the team may be a factor in the different stage of development of the case bust within the teams. In team Y the case bust was a regular established part of team processes whereas in team X the case bust was not presented as a fully incorporated known process. The adoption of new innovations by complex organisations is not a straightforward process and there are reported to be many factors that have an influence (Greenhalgh et al., 2004). Among these factors is the perception of the innovation as valuable or having a clear advantage and the compatibility of the innovation with existing values, norms and perceived needs of the service (Greenhalgh et al., 2004). In this study there was an indication that not all staff see a clear value or advantage of the case bust process and that the process may not be

perceived by all to be entirely compatible with team values and norms. Historically AO teams have favoured medical interventions (Priebe, 2003) and it is only relatively recently that psychological approaches have been promoted and the discipline of psychology specified as an essential member of the AO multidisciplinary team (Aitken, 2007). If psychosocial interventions are not a priority for individual workers or within team culture this may impact on the perceived need for psychologically informed team processes. Time constraints were referred to frequently by staff as a barrier to processes that could potentially improve the case bust such as increased preparation, utilization of psychology support and increased collaboration with the service user but this may reflect the low service priority that psychologically informed processes or recovery-oriented work have at an organisational level within the teams at present. There is evidence to suggest that using formulation in multidisciplinary teams is in itself a systemic intervention, a way of shifting cultures toward more psychosocial perspectives (Onyett, 2007). It is possible that the regularity of case busts in team Y and the emphasis on formulation has had a role in shifting the culture in this team towards greater receptivity to a psychosocial model.

Conclusion and implications for practice

Shetty (2010) states that in order to improve their effectiveness AO teams need to move to a greater focus on recovery and rehabilitation and adopt a strong strengths-based approach. Case busts provide a forum for multidisciplinary work with risk but need to develop past an emphasis on processes that support defensive risk practices and adopt an approach that has the capacity to inform recovery-oriented work that includes positive risk taking. A shared team risk formulation approach using a model such as those suggested by Meaden and Hacker (2011) or Whomsley (2010) has the

potential to fulfil these objectives while also increasing the consistency and focus of the process. In order to further emphasise a recovery orientation and avoid viewing the service user in primarily negative terms a broader focus in team formulation processes incorporating person level and problem level formulation could also be considered (Meaden & Hacker, 2011). A shared formulation approach must be a multidisciplinary process and support is required at the level of the individual and the team for it to be fully adopted. Crucially the introduction of a formulation approach must supported by influential members of the team (Lake, 2008). Increased coherence and focus combined with clearer links to practice may increase the perceived value of the process to staff thus increasing support and commitment to the process. Psychologists are in a position to offer psychoeducation, support and leadership in case busts but taking up a leadership role within multidisciplinary teams may not be a straightforward proposition for clinical psychologists. The means by which to provide leadership in case busts needs to be considered by psychologists in consultation with the peers and AO team colleagues as part of developing their role within the AO team. Pipon-Young et al., (2010) recommend a robust supervision structure to support clinical psychologists in developing their roles within AO teams.

Strengths and limitations

This study explores the perspectives of a multidisciplinary group of clinicians within two AO teams. The focus on two specific teams offers a picture of the experience within these AO teams, how transferable these findings are to other teams requires further investigation. The use of template analysis allowed for a larger sample thus giving a broader picture of how case busts are understood and experienced by clinicians from various disciplines across two teams. While the spread of disciplines represented was a

strength of the study as the multidisciplinary perspective within the AO team was represented a more homogenous sample could have allowed for a deeper exploration of the case bust as experienced by a particular discipline.

The interpretation of the data may have been influenced somewhat by the position of the researcher. As a psychology student and psychotherapist the researcher ascribes to a psychosocial perspective and is biased toward considering formulation an essential process in working clinically with clients with mental health difficulties.

APPENDICES

Appendix 1: Mid-placement review form – placement 1.

Student Name	Maeve Lynch
[redacted]	
Study Advisor	n/a
Overall aim or title of the placement	To assist [redacted] psychotherapy service in designing an empirical study of inner (psychic) change and outcomes for clients of the service.

Mid-placement Review Form – Placement 1

Primary objectives	**Progress against objectives** - *please categorise as either:* a) on course to achieve b) behind but plans in place to enable catch up c) changed objective (please add to list)	**Comments**
To carry out a review of the relevant literature	c) a)	This objective has become more focused. A full systematic literature review is not required at this point. The review of relevant literature is to be written up in the format of items A6-10 of the DClinPsy ethics form (see attached).
To explore study design and methodology	c) a)	To be covered as part of the ethics form items A6-A10 (see attached)

To collect details of as many relevant measurement tools of outcomes and internal change as possible and to investigate the procedure and practical considerations for using these tools. This is with a view to aiding in the assessment of feasibility/practicality for use by clinicians in the [redacted] Psychotherapy service as part of their routine assessment process.	a)	This work is ongoing and forms part of the preparatory work for the document based on items A6-A10 of the Ethics form. Meetings with my clinical supervisor and her colleague are ongoing discussing the feasibility of the use of various sourced measures of psychic change for research at [redacted]
To write an ethics proposal for the study and submit through IRAS	c)	This objective has changed to completion of Ethics form items A6 – A10 on the attached form as a basis for a full ethics proposal in the future.
Secondary Objectives		
To develop my skills in performing a thorough and replicable literature search	a)	My level of knowledge and skill has improved. It has been necessary with this project to think creatively as regards literature searching. As much of the psychoanalytic literature is published on specialist sites it has been necessary to go outside the mainstream sites such as Psycinfo and Medline when sourcing literature to specialist sites such as PEP web

		(Psychoanalytic Electronic Publishing).
To develop my knowledge of research methodology and my skill in designing feasible research including applying for ethics approval	a)	As the bulk of my work to date has involved reviewing available empirical research my knowledge of research methodology is growing. I am also much more familiar with requirements to be met when applying for ethics approval.
To develop my academic writing skill	c)	This is more a generic objective and less specifically applicable to this placement.
To develop my understanding and knowledge of psychodynamic psychotherapy theory and practice	a)	This has been a substantial element of the work to date as it was necessary to develop my knowledge of psychoanalytic theory and practice in order to begin to work towards the primary objectives. The area is complex and a basis of psychoanalytic theory was essential in order to be in a position to understand the research in the area particularly in terms of the way psychic change has been conceptualised and operationalised.
To explore the options for a summer research project with [redacted] Psychotherapy service	a)	Discussions have taken place. The project may be at too early a stage to apply for ethics thereby ruling out the possibility of a related preliminary study as a summer project in 2013.

For the supervisor - Overall, do you have any concerns that the student will not achieve the overall aim of the placement? No

For the student - Overall, do you have any concerns that you might not achieve the overall aim of the placement? No

Any other comments

The objectives of the placement have evolved as the placement has progressed. The project was at an early stage, the research area is complex, and there were many additional aspects that needed to be considered in designing the study. As such it transpired that the original objectives were not realistic or even the most valuable contributions to make to the project at this time considering the timeframe of the placement.

As such it has been decided that a key objective of this project is to review and understand the different ways of conceptualising and operationalising psychic structure with a view to being in a position to select a method that fits with the [redacted] theoretical orientation and is practical to incorporate without serious service disruption or excessive demands on valuable clinician time. This method will then be the key element around which other aspects of the methodology, which will all need consideration in their own right, can be built. The new objectives, which centre on an overview of rationale and methodology for the study in the form that is used in an ethics proposal, seem more realistic and ultimately more valuable to the project at this stage. I feel that the work will continue to be a challenge with a big learning curve but that I am on track to achieve the new objectives.

Appendix 2: An evaluative annotated bibliography – Inner change study

Title

Exploration of studies investigating psychic change/structural change in personality as an outcome of Psychoanalytic Psychotherapy: an evaluative annotated bibliography.

Rationale

The current emphasis on evidence-based treatment for mental health problems has intensified the search for reliable ways to measure the efficacy of psychotherapy. There is a drive to go beyond measurement of the symptom level of change to measure more lasting structural changes that indicate a capacity for growth that continues to develop after treatment has ended.

There is divergence within the psychoanalytic literature on the structure of personality and the nature of personality change and there is no widely accepted instrument to measure personality change. There are however numerous psychodynamically oriented instruments that purport to measure psychic structure.

[redacted] Psychotherapy service intend to carry out a prospective study that includes the investigation of internal or psychic change as an outcome of psychodynamic psychotherapy. As the development and validation of an instrument to measure internal change is time-consuming and costly [redacted] have elected to restrict the selection of instruments to those that already exist and have an existing evidence suggesting their reliability and validity as measures of psychic change. The use of an existing measure will also increase generalisability of the findings of the [redacted] study to other outcome studies. This bibliography contributes to the design of this study by reviewing approaches to empirically investigating psychic change as an outcome in psychodynamic psychotherapy.

Search Strategy

The specific question that guided this investigation was *"How has psychic change been conceptualised and measured as an outcome of psychoanalytic/psychodynamic psychotherapy in empirical studies to date?"*

The literature search database used was Psycinfo/OVID – entries between 1806 and November week 3 2012. This search was repeated on the Web of Science.

The literature search databases used were PSYCINFO, MEDLINE, EMBASE, and Web of Science all entries occurring between 1987 and November Week 2 2010.

The following strategy was used:

A. Subject search "Analytical Psychotherapy" or "Psychoanalysis" or "Psychodynamic psychotherapy" or "Psychodynamics" (all terms exploded)

B. Keyword search "Psychodynam*" or "Psychoanaly*" or psychodynam* adj3 Psychotherapy.

C. Combine A and B using OR

D. Subject search "psychotherapeutic outcomes" or "mental health program evaluation" or "treatment effectiveness evaluation" or "treatment outcomes" or "psychological assessment" (all terms exploded)

E. Keyword search (psychotherapeutic or psychotherapy) adj3 outcomes) or mental health program* evaluation or treatment) adj3 outcomes) or treatment) adj3 (effectiveness or efficacy)).

F. Combine D and E

G. Subject search "personality development" or "personality change" (all terms exploded)

H. Keyword search “personality development” or “personality change” or psychic or intrapsychic or structural) adj3 change)

I. Combine G and H. using OR

J. Combine C F I using AND

Results = 248

Further limits applied: articles must be in the English language and from peer reviewed journals = 150 results

Duplicates removed = 145 results

The remaining titles and abstracts were filtered using the following exclusion criteria:

1. The paper does not report on an empirical study that uses a psychodynamically oriented measure of personality or psychic structure as an outcome measure (excluded n= 124)

2. The study is a retrospective or follow-up study (e.g. LeuzingerBohleber, Stuhr, Ruger, & Beutel, 2003). and Grande et al., 2009)

3. The paper is not available for download on Psycinfo/Web or Science and cannot be sourced from PEP-web (the Psychoanalytic Electronic Publishing Website – accessed through supervisor) (excluded n=4)

In order to increase the scope of the search the reference lists of included studies were also examined and any additional studies that had the potential to contribute to the review (i.e reports of empirical outcome studies that include a measure of personality structural change) were also included when they could be accessed from peer reviewed journals and were

available for download (n=4). Studies that were sourced in this way are marked with an asterix (*) (n = 4).

Bibliography

The papers are grouped according to basic conceptual similarities.

1. Alpher, V.S., Henry, W.P., Strupp, H.H. (1990) Dynamic Factors in Patient Assessment and Prediction of Change in Short-term Dynamic Psychotherapy. *Psychotherapy: Theory, Research, Practice, Training., 27*(3), 350-361.

A study investigating the contribution of client intrapsychic characteristics to treatment outcomes in short-term dynamic psychotherapy. A heterogenous group of outpatients (N=32), all with a history of impairment in interpersonal functioning affecting intimate relationships, sexual behaviour or work. The Rorschach, applied using the comprehensive system[1] is used at assessment to assess quality of object relations using Blatt's method (1976 a, b). The suitability for Dynamic Process Scale (CDPS; Thackrey, Butler, & Strupp, 1985), scored on data from a semi-structured assessment interview the authors call the interpersonal interview, is used to assess suitability for short-term psychodynamic psychotherapy. The authors report that the interpersonal interview focuses on the systematic exploration of current and past relationship patterns. Outcome measures include a measure of symptomatic functioning -the Symptom Check List-90-revised (SCL-90-R**;** Derogatis, 1977)[3], The Global Assessment of Functioning Scale (GAS; APA, 1987) and the Structured Analysis of Social Behaviour-intrex (SASB; Benjamin, 1974, 1984)[4]. SASB is used in this context to measure changes in intrapsychic organisation. These measures are assessed pre and post treatment and the reader is told that information from the SASB is used to determine the clients' "self-directed, dynamic self-concept" at best and at worst. The study commences with 32 patients

and has full-data sets for 25 patients available for analysis. Only the CDPS was significantly related to symptomatic outcome as measured by the SCL-90-R. The SASB is responsive to change and there is a medium strength correlation with overall outcomes as assessed by the other outcome measures. Developmental level variables on the Rorschach were the best predictors of introject change. The treatment period short (25 sessions) with no follow-up as such no conclusions can be drawn as to whether treatment effects evidenced by the SASB were transient or sustained.

2. Abraham, P., Lepisto, B., Lewis, M., Schultz, L., & Finkelberg, S. (1994). An Outcome Study: Changes in Rorschach Variables of Adolescents in Residential Treatment. *Journal Of Personality Assessment*, 62(3), 505. (*)

This study uses the Rorschach protocols to assess the personality structure of young adults, all diagnosed with psychiatric disorders (N=50, 15 – 17 yrs old) pre and post 2 years of residential psychiatric treatment. The treatment programme includes the following: twice weekly individual and group psychotherapy, family therapy, education and therapeutic milieu. The sample was randomly selected from the population of in-patients at the treatment facility who all complete the Rorschach protocols as part of routine assessment procedure. The study does not use a control or comparison group. 20 of the 50 study sample Rorschach protocols were selected at random and re-rated by a second rater with good inter-rater reliability reported. The authors report that there was evidence of change in 19 of the 32 indices. No information is provided on who is applying and assessing the Rorschach protocols but it is unlikely given that the Rorschach protocols are used as part of routine assessment procedure that they could be unaware of the clients' status as regards pre/post treatment. Additional symptomatic or behavioral indices of outcome are not used.

3. Fowler, J. C., Ackerman, S. J., Speanburg, S., Bailey, A., Blagys, M., & Conklin, A. C. (2004). Personality and symptom change in treatment-refractory inpatients: Evaluation of the phase model of change using rorschach, TAT, and DSM-IV axis V. *Journal of Personality Assessment, 83*(3), 306-322.

An investigation of the phase model of change during psychotherapy (Howard, 1993, 1996). Participants (N = 77) are in-patients with psychiatric conditions that are severe and treatment-refractory and there is a high level of co-morbidity between Axis I and Axis II disorders in the sample. They are in treatment (psychodynamic psychotherapy in conjunction with family therapy and insight-oriented groups) for an average of 16 months. A battery of tests, administered by postdoctoral psychology fellows, is used at assessment and again 16 months later. The tests are as follows: the Wechsler Adult Intelligence scale[6], the DSM-IV rating scales[7]; the Rorschach protocols scored using the Mutuality of Autonomy Object Relations Scale (MOA)[8], the Boundary Disturbance and Thought Disorder Scale (BDS)[9] and scored for Aggressive Ideation; The Thematic Apperception Test (TAT)[10] scored using The Social Cognition and Object Relations Scale (SCORS; Westen, 1995)[11]. All Rorschach measures are scored by the first author and a selection of these by a second independent rater, inter-rater reliability was in the excellent range for Rorschach. The TAT was scored with SCORS by four raters trained for 10 hours. Reliability for the SCORS scales in this study ranged from good to excellent. In this study both the Rorschach and the four of the eight scales of SCORS demonstrated significant improvement with small to medium effect sizes indicating their responsiveness to change. The largest effect size for the SCORS was on the Complexity of Representations scale (.46). The authors suggest that the fact that not all scales of the SCORS showed an improvement may indicate that different aspects of personality functioning change at different rates. The rates of change in object relations as assessed by the Rorschach was found to be roughly the same as for object relations as

assessed by the SCORS however an absence of a correlation between SCORS and Axis V of the DSM and the high correlation between Axis V and DSM for the Rorschach suggests that the measures may not be measuring exactly the same constructs.

4. Blatt, S.J. & Shahar (2004) Psychoanalysis – With Whom, for What and How? Comparisons with Psychotherapy. J Am Psychoanal Assoc, 52, 393.

This paper reports on a re-analysis of the data from the long running Menninger Psychotherapy Study (Wallerstein, 1986). The study compares the data from patients in two treatment groups: Supportive-expressive Psychotherapy (SEP) and Psychoanalysis (PSA). The measures of psychic change used in the Menninger study were Rorschach protocols and the authors re-score this data from 33 patients with methods designed to examine the level of object representation in Rorschach protocols– Concept of the Object on the Rorschach (COR) and Mutuality and Autonomy Scale (MOA). When combined these methods assess aspects of differentiation, articulation, integration and relatedness in mental representations. These methods did not exist when the study was first carried out, they are the same scoring methods used in the above study by Fowler et al. (2004) on Rorschach protocols. The methods evaluate change in these protocols using the COR and MOA from pre-treatment to post-treatment. They also review patient clinical material and classify patients as either 'Introjective' or 'Anaclitic'. The authors find a statistically significant treatment effect on quality of object relations as assessed by these methods and also an interaction between patient characteristics (anaclitic/introjective), type of treatment and change in mental representations. They found that overall level introjective patients improved more in PSA whereas overall those classified as Anaclitic did better in SEP when assessed using these intrapsychic outcome measures.

5. Price, J. L., Hilsenroth, M. J., Callahan, K. L., Petretic-Jackson, P. A., & Bonge, D. (2004). A pilot study of psychodynamic psychotherapy for adult survivors of childhood sexual abuse. *Clinical Psychology & Psychotherapy*, *11*(6), 378-391.

This naturalistic study uses SCORS[11] (Westen, 1995) as a measure of structural personality structural change over the course of short-term psychodynamic psychotherapy (mean treatment length 26 sessions) of a small sample of patients (N=33) seeking treatment for Axis I and Axis II disorders. For the purposes of data analysis the authors divide the participants into two groups, a group of patients who have experienced childhood sexual abuse and a group who have not, as they are interested in the differential effects of psychodynamic psychotherapy on these groups. The authors use semi-structured clinical interviews that include history taking, history of past and current relationships, mental state examination and the eliciting of information for a diagnosis according to DSM-IV criteria. Further measures used were the Abuse Dimensions Inventory (ADI) [12], SCL-90-R to assess symptoms, a Social Adjustment Scale (SAS), SCORS[11] (Westen, 1995), and patient and therapist rated measures of alliance. SCORS was rated on patient relational narratives by treating clinicians and by external raters who viewed tapes of therapy sessions. Measures are completed at session 3 and post-treatment. The CSA sample used in the final analysis is small (n= 12). It is reported that the CSA group showed significant improvement on all measures of symptomology and general well-being. Of interest in this review is the report that the hypothesis that the CSA group would show improvement in personality functioning is partially supported, three of the eight scales of the SCORS (AFF, AGG, SE) showed a significant change over the course of the treatment for the CSA group with moderate to large effect sizes . No data is offered for the non CSA group except to say that rates of change between the two groups were comparable.

6. Kuutmann, K., & Hilsenroth, M. J. (2012). Exploring in-session focus on the patient-therapist relationship: Patient characteristics, process and outcome. *Clinical Psychology & Psychotherapy, 19*(3), 187-202.

This study has a broader remit than is of interest to the specific question in this review. The researchers explore the relationship between patient (N=76) pre-treatment personality pathology and interpersonal style, process and outcomes in a study of psychodynamic psychotherapy treatment. Of interest is the inclusion of a psychodynamically oriented measure of personality structure, SCORS[11], as an outcome measure. Independent raters (PhD graduate clinicians trained in the use of SCORS) made SCORS ratings on verbally expressed relational episodes and self-statements from the evaluation sessions and from the last two sessions of treatment. As only the one scale of SCORS is found to be correlated with focus on the patient-therapist relationship early in treatment (AFF), the key area of interest in this study, the researchers report the pre to post difference in this variable only. They report a significant change in this SCORS scale from pre to post treatment with a large effect size.

7. Levy, K.N.; Meehan, K.B.; Kelly, K.M.; Reynoso, J.S.; Weber, M.; Clarkin, J.F.; Kernberg, O.F. (2006) Change in attachment patterns and reflective function in a randomized control trial of transference-focused psychotherapy for borderline personality disorder. *Journal of Consulting and Clinical Psychology*, Vol 74(6),1027-1040.

This paper reported on a study comparing three treatments for Borderline Personality Disorder (BPD): *transference-focused psychotherapy* (TFP); Dialectical Behaviour Therapy (DBT); and a supportive psychodynamic therapy (SFT). 90 adults, predominantly women, are randomized to the three treatment conditions; treatment is manualised in all cases. The focus of this paper is on specific change mechanisms during these treatments. Levy and colleagues investigate the hypothesis that change in attachment organization and in reflective

function, as operationalised by The Adult Attachment Interview (AAI)[13] and the Reflective Function Scale (RFS)[14] is the primary mechanism by which patients with BPD improve in treatment. Both measures are scored by trained coders. Overall RF, attachment coherence, and security of attachment all increased significantly as a function of treatment group in this study. TFP outperforms the other treatments in the study in terms of increases in attachment coherence and security and in terms of increases in reflective function. The only treatment that was found to have an effect on attachment organization is the TFP condition. In the TFP condition 1/22 treatment completers are classified as securely attached at time 1 and 7/22 are classified as securely attached at time 2. Treatment was one year in duration which may be a short time period as regards structural change in personality and results should be considered in this light. This study offers support for the use of both the AAI and the RF scale as characterological outcome measures. The study does not report on symptom outcomes for the participants or compare symptom outcomes with changes in AAI and RF so the relationship between these personality measure changes and symptomatic outcomes are not available to the reader.

8. Blatt, Sidney J.; Stayner, David A.; Auerbach, John S.; Behrends, Rebecca S. (1996) Change in object and self-representations in long-term, intensive, inpatient treatment of seriously disturbed adolescents and young adults. *Psychiatry: Interpersonal and Biological Processes,* Vol 59(1), 82-107. (*)

This study investigates psychic change in 40 in-patient adolescents (mean age 17.5), with a range of DSM-IV diagnoses, by examining changes in content and cognitive-structural dimensions of mental representations over a treatment period of 12 months. They compare these changes with level of psychological functioning as independently assessed through clinical reports of these individuals over the same time period. Treatment is multi-faceted but

primarily psychodynamically oriented. All participants are asked at the start of treatment and at 6-month intervals thereafter over the treatment period to describe self and significant figures in their life – mother, father and therapist. The structure and content of these descriptions are rated using the Differentiation-Relatedness Scale (DRS)[15], a Conceptual level Scale[16] and Qualitative-Thematic Scales 11**.** The degree of ambivalence expressed in each description and the length of the description was also evaluated. Descriptions given at the start of treatment and at the end of treatment are used in analysis, these are scored by independent judges blind to patient identity and GAS score. The Global Assessment Scale (GAS), rated by an independent judge on clinical case material, is used to assess overall clinical functioning at intake and discharge. The findings are broadly supportive of Blatt's theory of the centrality of these mental representations in psychic structure as they indicate that there is a relationship between structural features of descriptions and clinical functioning at intake and also clinically significant changes in functioning were associated with changes in the structure and content of mental representations in the sample. A highly significant relationship was found between the level of clinical functioning at intake and the degree of differentiation-relatedness in the description of self and a significant negative correlation was found between clinical functioning at intake and conceptual level of descriptions of both parents. Highly significant relationships were also found between improvement in clinical functioning and increases in differentiation-relatedness of the descriptions of all four figures. A significant relationship was also found between the degree of articulation in the descriptions of significant others and clinical improvement. The findings imply a unique role for the mental representation of Father as increased conceptual level of the description of Father was correlated with clinical improvement whereas increased conceptual level of the other descriptions did not and the qualitative changes linked with clinical improvement differed for the description of Father and for other descriptions. Increases in the level of

benevolence ascribed to descriptions of therapist correlated significantly with clinical improvement as did a tendency to describe Mother as warmer whereas in the description of Father clinical improvement was associated with changes in the opposite direction. The authors suggest that taken together their findings indicate that the effect of therapy may be to facilitate the disengagement from a more intense involvement with parents and the establishment of more reciprocal relationships with therapist and mother and to facilitate greater separation or individuation from father.

9. Harpaz-Rotem, I., Blatt, S.J (2005) Changes in Representations of a Self-Designated Significant Other in Long-Term Intensive Inpatient Treatment of Seriously Disturbed Adolescents and Young Adults *Psychiatry*; 68, 3. (*)

An extension of the study by Blatt et al. (1996) discussed above. The authors, studying the same treatment population as Blatt et al. (1996), i.e adolescent in-patients receiving multifaceted psychodynamically oriented treatment, asked participants (N = 40) to describe self, Mother, Father, therapist and a significant other of their choice at intake and 6 month intervals during their treatment. Descriptions of self, Mother, Father and Therapist from the beginning and at the end of their course of treatment are analyzed using the DRS[15] and developmental progression in the selection of a significant other is analyzed using the The Significant Other Scale (SOS)[16]. Clinical functioning was assessed using GAS ratings made on clinical case reports. Their findings corroborate those of Blatt et al (1996) indicating the utility of the concept of differentiation-relatedness in assessing psychic structure as clinical improvement over the course of treatment assessed using GAS is significantly associated with increases in differentiation-relatedness in the all descriptions. Using a regression model the authors find that changes in the differentiation-relatedness of description of self and self-

designated significant other are the most closely associated with changes in clinical functioning and that changes in these variables significantly predict changes in clinical functioning independent of changes in other variables. This study provides further evidence for the utility of the concept of mental representations in representing a key aspect of psychic structure and for the concept of differentiation-relatedness in these mental representations for assessing change in psychic structure.

10. Lindgren, A., Werbart, A., & Philips, B. (2010). Long-term outcome and post-treatment effects of psychoanalytic psychotherapy with young adults. *Psychology and Psychotherapy-Theory Research and Practice, 83*(1), 27-43.

A naturalistic study investigating outcomes and maintenance of gains for young adults (N= 131, 18-25 yrs) who are treated with individual or group psychodynamic psychotherapy. Presenting problems included depression, anxiety, interpersonal difficulties and low self-esteem. Self-reported personality disorders were found in 31% of the sample. Average treatment duration is reported as 19 months but there is a large range (range = 1-55, SD = 13.8). Symptomatic functioning is assessed using SCL-90, Self-rated health scale (SRH)[17], and the Global Assessment of Functioning Scale (GAF)[18]. The primary outcome measures used were the SCL-90 and The Inventory of Interpersonal Problems (IIP)19 but the study also includes The SASB and the DRS as secondary outcome measures, measuring object relations i.e measures of psychic structure. The ratings for the DRS were based on data from the Object Relations Inventory (ORI)[21]. The authors report that all participants were interviewed pre-therapy and again at treatment termination and at follow-up 1.5 years post-treatment. All DRS ratings were made by a group of trained raters and there was good inter-rater reliability in this study. Gender, treatment duration, treatment format and patient-rated

and therapist-rated alliance are all investigated as potential predictors or moderators of change during treatment. Significant changes were found in eight of the nine outcome variables (3 symptom measures, the IIP, SASB-2 factors and DRS-3 descriptions) between intake and termination and in all outcome measures between intake and follow-up. The exception was change in differentiation-relatedness score of the description of Mother which was significant between intake and follow-up but not during the treatment or follow-up period separately. Effect sizes for the intake to follow-up period for measures of psychic structure were in the medium to large range. Measures of object relations changed least over the treatment period but continued to develop over the period between termination and follow-up. Alliance was the only factor found to significantly moderate outcome.

11. Vermote, R., Lowyck, B., Luyten, P., Vertommen, H., Corveleyn, J., Verhaest, Y., . . . Peuskens, J. (2010). Process and outcome in psychodynamic hospitalization-based treatment for patients with a personality disorder. *Journal of Nervous and Mental Disease, 198*(2), 110-115.

12. Vermote, R. Lowyck, B., Luyten, P., Verhaest, Y., Vertommen, H., Vandeneede,B., Corveleyn, J., & Peuskens, J. (2011) Patterns of Inner Change and Their Relation with Patient Characteristics and Outcome in a Psychoanalytic Hospitalization-Based Treatment for Personality Disordered Patients. Clinical *Psychology and Psychotherapy Clin. Psychol. Psychother*. 18, 303–313.

As the two studies cited above report on the same data set they will be discussed together. Vermote and colleagues investigate internal change in individuals (N=44) with personality disorder over the course of 12 months of psychoanalytically-informed hospital-based treatment and at follow-up three months post-treatment. In an approach firmly grounded in

psychodynamic theory they formulate a three-dimensional model of personality organization, a model they hope will transcend research purposes by its capacity to inform psychodynamic treatment. The model of personality structure is composed of three aspects: felt safety or security, the capacity for mentalization, and object relations. They conceptualise mentalisation in terms of both the concept of reflective function and using the Bion concept of mentalisation as they see these concepts as two different dimensions of mentalisation. An independent researcher assesses these aspects of personality organization by scoring a selection of validated scales on the Object Relations Interview (ORI: Blatt, 1998; Harpez-Rotem and Blatt, 2005). Felt safety or security is measured using the Felt Safety Scale (FSS)[23]. The reflective function dimension of mentalisation is assessed using the RFS and the Bion conceptualization of mentalisation is operationalised using the Bion-grid scale (BGS)[24]. Object relations is assessed using the DRS. The DRS scale and the RF scale were originally designed to be scored on the AAI but Vermote uses the ORI interview (having done preliminary studies) instead as scoring on the ORI is less time-consuming and therefore more practical for research purposes. The authors identify two distinct clusters of patients with different patterns of change in personality organization over the course of treatment, one cluster showing a fluctuating pattern of change and the other a more stable pattern of change in these personality variables. Findings indicate a significant change in both DRS and FS over the treatment period with a medium effect size for DRS and a large effect size for FS. They find that changes in DR and FS are correlated with improvements in levels of personality functioning and reductions in symptoms, but reflective functioning is not. They find that linear changes in DR and FS predicted improved outcomes but changes in reflective function did not. As the authors suggest it this could indicate that the RFS as scored on the ORI is not as sensitive to change in trait reflective function which would make sense in the context of the scope for free reflection in the AAI as compared to the ORI or

could indicate that development of RF does not follow a simple linear trend. The authors report that most patients continue psychotherapy treatment over the 12 month follow-up period (78%) but there are no further significant gains in self and object relations or felt safety over this period, the authors suggest that this may indicate a "ceiling effect".

13. Vinnars, B., Thormahlen, B, Gallop, R., Noren, K., Barber, J.P. (2009) Do personality problems improve during psychodynamic supportive-expressive psychotherapy? Secondary outcome results from a randomized controlled trial for psychiatric outpatients with personality disorders. *Psychotherapy: Theory, Research, Practice, Training*, Vol 46(3), p. 362-375.

This study compares manualized time-limited supportive-expressive psychotherapy (SEP) and non-manualized community delivered psychodynamic treatment (CDPT) in the treatment of Personality Disorder (PD). The authors comment on the paucity of studies assessing outcomes beyond a symptom level and aim to contribute to the evidence base by including measures to assess what they consider to be the core aspects of PD: personality and interpersonal functioning. 156 participants all with a diagnosis of personality disorder were randomized to the two treatment conditions. Treatment with SEP was one year duration in most cases and was open-ended for CDPT, mean number of treatment sessions attended between intake and follow-up did not differ significantly between the two groups (average 26 sessions). The outcomes measures used were The Karolinska Psychodynamic Profile (KAPP)[25], the Psychological Mindedness Scale (PMS)[26], the circumplex version of the Inventory of Interpersonal Problems (IIP-C) and the Karolinska Scale of Personality (KSP)[27]. Data for KAPP was collected using a semi-structured interview at three time points: intake, post treatment in the case of SEP (1 year), and follow-up (2 years) in both cases. Only the results for the first factor of the KAPP are used, a factor the authors report has been found to

correspond with quality of object relations and ego strength. As there is only KAPP data from both groups from intake and follow-up only these time-points are used in analysis. Due to attrition there is data on these variables for only a little over half of the participants (57%). Findings indicated that ego functions and object relations as assesses by KAPP improved significantly between intake and follow-up, with a large effect size. Significant change was also found on the IIP over the treatment phase but not between termination and follow-up. Significant improvements in Neuroticism and increases in levels of agreeableness were found in both treatment groups over the treatment periods. A significant interaction with treatment was found as regards change in personality traits as assessed by the KSP in the termination to follow-up phase with only the CDPT group evidencing a change in Neuroticism over this period. Overall the number of patients achieving recovery in the study was small, the authors surmise that a one-year treatment many not be sufficient to expect improvement to a normal range of functioning in this treatment population.

14. Bond, C & Perry, J.C. (2004) Long-Term Changes in Defense Styles With Psychodynamic Psychotherapy for Depressive, Anxiety, and Personality Disorders. Am J Psychiatry; 161:1665–1671. (*)

A naturalistic study investigating changes in defensive functioning over the course of Psychodynamic Psychotherapy treatment and the relationship between changes in defensive functioning and changes in symptomatology. The relationship between the therapeutic alliance and defensive functioning was also of interest. The study uses a heterogenous group of participants (N=53), diagnoses included personality disorder, depressive disorder and anxiety disorders. Treatment was offered for 3 years and follow-up was 3-5 years, 29 subjects complete treatment. Patients had 10 hours of research interviews and questionnaires prior to commencing the study. The California Psychotherapy Alliance Scale was

administered at sessions 3, 5, 7, 9 and 11. Research assistants met participants every six months to administer: the DSQ, the Hamilton Depression rating scale (HDRS)[29], and the SCL-90-R. Initial symptom levels correlated with defensive functioning score with high score being associated with fewer symptoms. The authors divide participants into two groups (high and low) based on the position of their original DSQ scores relative to the clinical cutoff score for the DSQ. No clear pattern of change in defenses was discernible over the first 2 years of treatment. Between assessment point one and the final assessment point the following changes were noted: significant improvement for the maladaptive defense style (style 1) and the self-sacrificing defense style (defense style 3) for the high scoring group with large and medium effect sizes respectively, no changes in image distorting (style 2) or adaptive (style 4); significant rise in the scores for defense style 3 for the low scoring group (effect size 0.51); and an improvement in styles 1 and 2 and overall defensive functioning for the group as a whole (effect size 0.43). Changes in defense style scores were correlated with symptomatic change and changes in defense styles added substantially to the prediction of variance in the three outcome measures and the authors conclude that changes in defensive functioning appear to predict changes in symptomatic change.

15. Drapeau, M., De Roten, Y., Perry, C. J., Despland, J. (2003) A Study of Stability and Change in Defense Mechanisms During a Brief Psychodynamic Investigation. *The Journal of Nervous and Mental Disease*. Issue: Volume 191(8).

The DMRS (Perry, 1990) is used to code transcripts from four sessions of an ultra-brief (4 session) psychodynamic intervention. The participants are a heterogenous group of patients (N=61) with various psychiatric diagnoses. The DMRS is scored on the transcripts from each session and examined for changes in the overall number of defenses utilized and the overall

defensive functioning from session to session. The overall defensive functioning score and the use of obsessional defenses (intellectualization specifically) increased from session 1 to 4. The number of defenses being utilized decreased between session 1 and 4 and the use of narcissistic defenses (devaluation and idealization) also decreased between sessions one and four. Mature level defenses fluctuated over the four session treatment but had returned to initial levels by the fourth session. The authors suggest that the finding may reflect state as opposed to trait changes in defensive functioning and that these changes may be linked to the therapeutic process. They point to the need for caution when assessing defensive functioning as an outcome of psychotherapy as depending on the methods used for data collection results may reflect state and not trait changes in defensive functioning.

16. Lopez Moreno, C.M., Schalayeff, C., Acosta, S.R., Vernego, P., Roussos, J., Dorfman Lerner, B. (2005) Evaluation of psychic change through the application of empirical and clinical techniques for a two-year treatment: a single case study. *Psychotherapy Research*, 15:3, 199-209.

An evaluation of a single case over 2 years of non-manualised psychodynamic psychotherapy with the aim of illuminating the process of psychic change. The author uses a broad definition of psychic change which includes symptoms, defensive functioning, quality of interpersonal relationships, self-esteem, widening of consciousness as a result of increased capacity for reflexivity and elaboration, and increased ability of expressing pleasant and unpleasant affect. Methods used to explore the process of psychic change are both empirical and clinical. Of interest in this review are the instruments utilized to assess psychic change which are as follows: the SCL-90-R, the Core Conflictual Relationship Theme (CCRT) and the authors own instrument Differential Elements for a Psychodynamic Diagnostic (DEPD).

The DEPD is used by the therapist and the supervisor at 6 monthly intervals to make inferences about psychic structure. The CCRT and the SCL-90-R are applied at the same intervals. All clinical and empirical data are discussed between the clinical and investigative team at regular clinical meetings over the course of treatment. While the DEPD and the CCRT demonstrate the capacity to produce rich and interesting data in this study it is evident that they are most appropriately used as tools to understand the process of psychotherapy rather than as outcome measures. The data collected using the DEPD shows a change over the course of the two years of therapy with a decrease in indicators of inferior or medium level psychic functioning and an increase in indicators of a superior level of psychic functioning. The data collected using the CCRT indicates that the core conflictual theme identified originally becomes less pervasive over the course of treatment, but there is no change in two of the three components of the core conflictual theme. Symptoms are below average at the start of treatment and increased at the end of treatment, an outcome that the author links to life events occurring for the client at the time.

17. Hoglend, P., Bogwald, K., Amlo, S., Marble, A., Ulberg, R., Sjaastad, M. C., . . . Johansson, P. (2008). Transference interpretations in dynamic psychotherapy: Do they really yield sustained effects? *American Journal of Psychiatry, 165*(6), 763-771.

This study seeks to investigate the long-term effects of the use of transference interpretations in Psychodynamic Psychotherapy. The authors randomly assign participants (n=100) to Dynamic Psychotherapy treatment with mild-moderate use of transference interpretations (n=52) or Dynamic Psychotherapy without transference interpretations (n=48) for one year of treatment. Participants are assessed in a 2 hour videotaped dynamic assessment interview, based on the work of Malan (1976) and Stifneos (1992). Three clinicians rated each videotaped assessment interview using the Quality of Object Relations Scale and the

Psychodynamic Functioning Scales (PFS), no clinician rated their own patient. Quality of object relations was examined as a potential moderator of treatment effects in the study with the hypothesis that patients with more mature object relations would benefit more from therapy with transference interpretations than without. Three clinical raters, blind to treatment group, re-rated participants using the PFS again at 1 year, 2 years and 4 years after the start of therapy. Patients also completed the Inventory of Interpersonal Problems (IIP-C) at each of the time points to measure self-reported interpersonal problems. In this study the PFS appears sensitive to treatment effects. Both treatment conditions demonstrated a capacity to produce significant improvements on both outcome measures during treatment and also during the follow-up period with moderate effect sizes. QOR seemed to have a moderating effect on the relationship between transference interpretations and outcomes as rated on the PFS for the participants with a low QOR initially. Participants with a high QOR score did equally well in both conditions whereas participants with a low QOR score seemed to benefit most from Dynamic Psychotherapy with transference interpretations, this effect was sustained over the follow-up period. Both treatment conditions produced significant changes in interpersonal problems as measured by the IIP-C and QOR did not have a moderating effect on the effect of transference interpretations on this outcome variable.

18. Ulberg, R., Hogland, P., Marble, A., Johanansson, P. (2012) Women Respond More Favorably to Tranference Intervention Than Men: A Randomized Study of Long-term Effects. *The Journal of Nervous and Mental Disease*, Vol 200(3), p 223 – 229.

The study investigates whether there is a gender difference in response to transference interpretations in psychodynamic psychotherapy. A heterogeous group of participants (N=100) were randomly assigned to receive dynamic psychotherapy with or without transference interpretations and the effect of Quality of Object Relations is controlled for.

PFS and the IIP-C are used as outcome measures. Significant changes occur on the PFS during the one year treatment period and over the 3 year follow-up period. No significant effects are using the IIP-C as the outcome variable, the authors suggest that this may be due to the fact that self-report measures may capture more transient effects which diminish in longer term investigations. When QOR is controlled a significant gender difference in response to transference interpretations is found on this primary outcome measure with women appearing to respond better to this intervention.

19. Taylor, D., Carlyle, J., McPherson, S., Rost, F., Thomas, R., & Fonagy, P. (2012) Tavistock Adult Depression Study (TADS): a randomised controlled trial of psychoanalytic psychotherapy for treatment-resistant/ treatment-refractory forms of depression. *BMC Psychiatry, 12*, 60.

An effectiveness study of psychoanalytic psychotherapy with patients with treatment-resistant/refractory forms of depression. The study aims to investigate both the effect of the treatment on immediate symptoms and the long-term effectiveness of the treatment in preventing relapse. The treatment period is 18 months with a target of 60 sessions and the follow-up period is two years, the TAU group are followed up for 3.5 years. An RCT using a community 'treatment-as-usual' (TAU) group. The Hamilton depression rating scale is used as the primary outcome measure. A pilot study of two cases was carried out before commencing the study proper. As regards assessing personality change the authors report that they aim to study progression/development in psychological and interpersonal functions, no detail is given as to how this aim will be realised. This assessment is done in the context of their assessment procedure - 'The Tavistock Dynamic Interview'. An assessment interview with clinical functions which draws on validated psychodynamic and attachment

based interviews including the Adult Attachment Interview (AAI; Main), the Current Relationships Interview (CRI) and the Quality of Object Relating Scale (QOFS). This interview is carried out at the participants' entry into the trial and then two years later (post-treatment) and at each time point a request is made for a recent dream and earliest childhood memory. The authors report that descriptions made at each time-point will be used by independent judges to categorize participants as responders, intermediate or non-responders and this categorization will be correlated with treatment outcome and quantitative outcome data. No information is provided on how exactly this will be done.

Conclusions:

It may initially appear that personality structure and personality change have been conceptualised in different ways by different groups of researchers. A closer look however reveals some overlap in many of the conceptualisations of personality structure. There seems to be a tacit agreement that a key aspect of personality structure is object relations. With the exception of the two studies that have measured defensive functioning and the two studies utilizing the PFS all of the studies have used instruments that operationalise object relations. This concept has been operationalised in different ways, some studies have added additional instruments to measure theorised additional aspects of core personality structure such as felt safety and mentalisation in the case of the study by Vermote and colleagues. The emphasis on object relations as a core feature of personality structure is not surprising as it echoes the theory of a range of prominent theorists of personality development from Melanie Klein (1932, 1935) onwards.

The studies that measure this concept also provide some evidence that object relations is subject to change over the course of psychodynamic psychotherapy and that these changes are correlated with other assessed outcomes of psychodynamic psychotherapy.

The most long-standing of the methods used to assess object relations are the scales that are scored based on material from the Rorschach protocols. Older projective measures such as the Rorschach have fallen out of fashion due to debate as to the quality of the evidence indicating reliability and validity as methods of assessing psychic structure. The inter-rater reliabilities reported in the studies above are acceptable but in all but one of the studies the Rorschach protocols are used as part of assessment procedure and not as an outcome measure. The exception is the study by Abraham and colleagues, they use Rorschach protocols pre and post treatment, however there is insufficient information offered to judge the potential influence of researcher bias and there are no comparisons made with other outcome measures meaning that it is difficult to judge the validity of the Rorschach protocols as an outcome measure based on this study.

The most commonly occurring measure of object relations in this review is the DRS. The DRS is assessed on the Object Relations Interview seems to have the most consistent support as regards reliability, sensitivity to change, and the type of relationship with other outcome measures that theory would predict for a measure of psychic structure. The studies reviewed above indicate that the DRS is a consistently responsive measure of change in internalised mental representations. Three of the studies that utilize this measure are with an adolescent or young adult population which could lead to questions about the generalisability of their findings to an adult population however the study by Vermote and colleagues is with an adult population and reports equally persuasive findings using this measure.

In the Vermote study the researchers have tried to go beyond measurement of one core construct when operationalising personality change. The Vermote study is the most ambitious as he seeks to measure all aspects of a multi-level model of personality organization. His results are promising for use of the DRS on the ORI, a replication of other findings with this measure. The findings for other measures used are more equivoval as regards the application of the RFS to the ORI. This is to be compared with the results achieved by Levy with the RFS applied to the AAI, the interview that the RFS was designed to be used with.

The second most commonly used instrument is the SCORS. The outcomes using this measure in the studies reviewed are not as compelling as those achieved using the DRS. In the study by Fowler and colleagues there is change in 3 of the 8 scales of SCORS over the course of psychotherapy treatment with small to medium effect sizes. These finding could be due to the size of the sample used in the analysis which is likely to have reduced statistical power in this study and the treatment period is short in terms of measuring structural change. The only scale of SCORS that demonstrated a significant effect in both the study by Price and the study described above by Fowler and colleagues is (SE) Self-Esteem, although the scale with the largest effect size in the study by Price and colleagues AFF (Affective quality of representations) trends towards significance in Fowler's study.

Initially outcomes with the SASB show significance however one of the studies is of short duration with no follow-up and the second study that utilises this measure doesn't evidence any change during the follow-up period. There are concerns with the sole use of self-report measures to assess psychic structure as self-report can be influenced by response bias and in

the case of assessing psychic structure may restrict data collected to consciously accessible material. Also it has been suggested that they may be less sensitive to detecting change (Cousineau & Shedler, 2006).

Two studies measure defensive functioning as a core aspect of the structure of personality. This is not surprising as over the last few years there has been growing empirical support for the theory that defensive functioning is related to adaptive behavior (Hentschel and Ehlers, 1993; Perry, 1993; Valliant, 1992, 1993). Concerns as regards the sensitivity and susceptibility to bias of self-report measures also shed some doubt on the use of the DSQ as an outcome measure. In the study by Bond and colleagues it cannot be ascertained either whether defensive change caused symptom change or vice-versa, or whether in fact changes in both were caused by another variable/s. Also the long follow-up period could be seen as a weakness as various life events could have influenced outcome. The results are also called into question by the fact that there was no discernable pattern of change in defensive functioning over the first two years of treatment. The over-dependence on self-report measures including self-report of defensive functioning could also be seen as a methodological weakness of this study, the originators of the DSQ admit that the scale measures conscious defensive functioning. To measure the mainly conscious aspect of a process that is theorized to be largely unconscious seems partial. Perry and Hogland (1998) suggest that "subjective distress may distort conscious derivatives of actual defensive processes" (p 529) and caution against using self-report as the sole method of assessing defensive functioning. The study by Drapeau utilizes a clinican scored method of assessing defensive functioning and they report some changes in defensive functioning over the short period of study however defensive functioning returns to intial levels by the end of the short treatment period and the authors themselves admit that flutuations may be changes in state defensive functioning due to the engagement in the process of psychotherapy.

The PFS and the KAPP seem to be the most comprehensive measures of those reviewed. There is evidence of good psychometric properties of the KAPP to date (see Levy et al., 2012 for a review), however it has only been used by the developer (Robert Weinryb) in studies to date and in the study by Vinnars there is a reference to years of training being provided by the developer prior to the study and also ongoing training during the study to reduce rater drift. This makes the measure potentially costly and time-consuming to incorporate into a routine clinical setting in the NHS. In addition the study discussed in this review that uses the KAPP does not provide adequate support for its use as an outcome measure as only as there were issues with missing data in this study so scores on one factor from intake to follow-up for a little over half of participants are available for analysis. With such a long follow-up and without any control group there is no way of ascertaining whether the changes on the KAPP are related to treatment at all or indeed whether there was something significantly different about the 57% of participants that contributed data at follow-up.

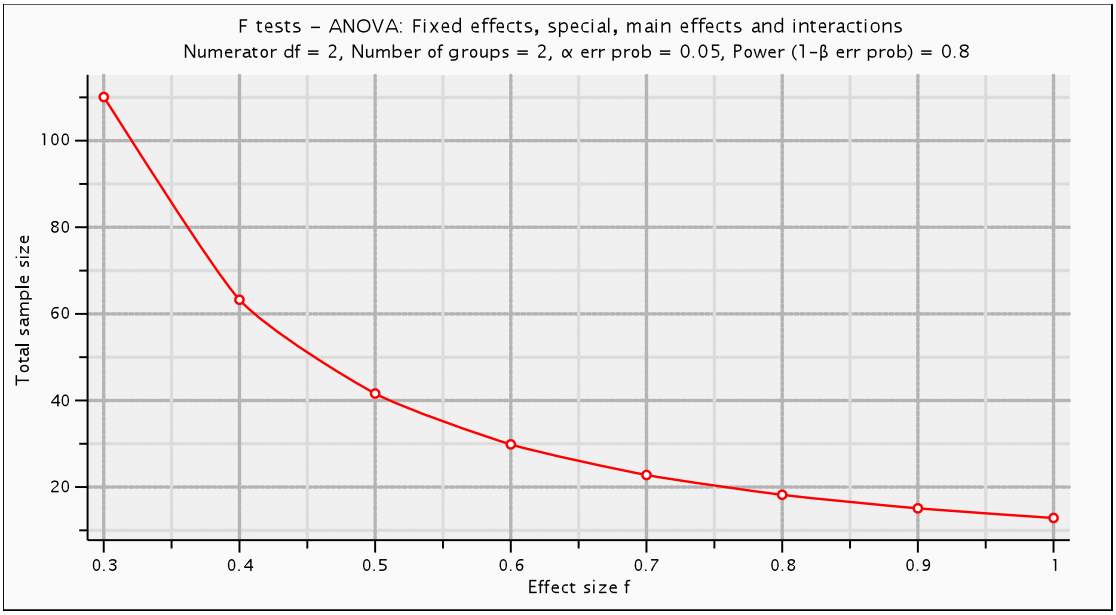
The studies reviewed indicate that the PFS has potential but it yet to be used by researchers other than those that developed the measure and so there is no data to suggest that other researchers less familiar with the measure would be able to achieve similar outcomes. In addition the above studies do use other methods to assess outcome investigating the relationship between this measure and other outcome measures such as has been explored in other studies.

The study by Moreno using the CCRT as an outcome measure suggests that the CCRT is not valid for use in the proposed context (i.e as outcome measure in an empirical study), this is supported by the absence of other studies using the measure in this way.

Overall this review suggests that the most promising outcome measure for assessing change in the structure of personality over the course of Psychodynamic Psychotherapy treatment is the DRS.

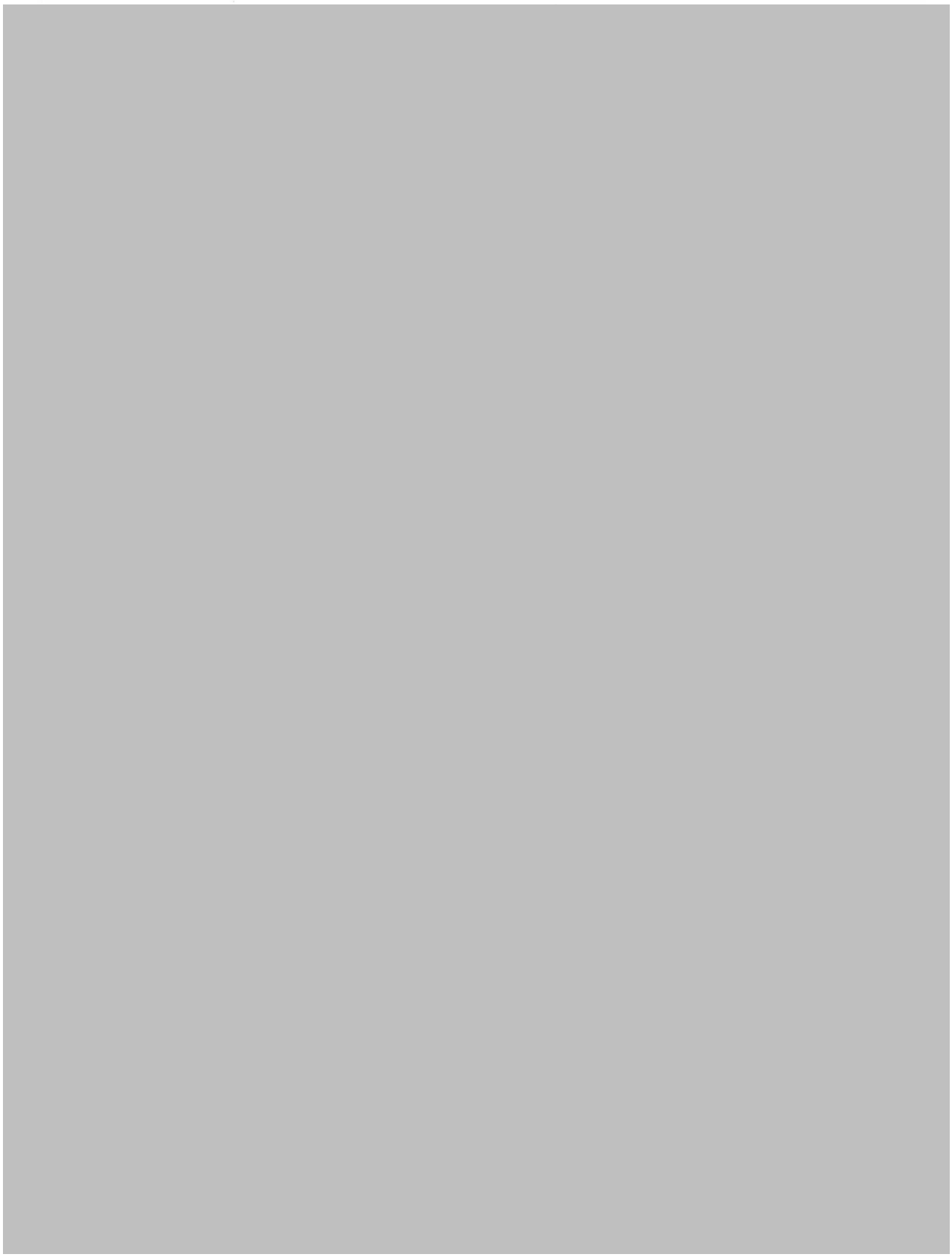
Appendix 3: Power Analysis

Using Cohen's (1988) conventions for describing effect sizes as small, medium or large, the proposed study would require approximately 432 participants in order to identify a small experimental effect, 158 participants in order to show a medium experimental effect and 62 participants to show a large experimental effect (power = 0.80; alpha = 0.05 two-tailed; Mixed ANOVA with Pre/Post as the within subjects factor and treatment condition as the between subjects factor). The relationship between sample size and effect size sis shown in the figure below.



Accordingly, a sample size of between 20-25 participants per treatment group would be able to detect a medium to large effect size with a power of 0.8, and would constitute a reasonable balance between precision and clinical utility.

Appendix 4: Confirmation of ethical approval



Appendix 5: Participant information sheet

UNIVERSITY OF BIRMINGHAM

College of Life and Environmental Sciences

School of Psychology

Participant Information Sheet

Evaluation of the use of the shared case formulations in Assertive Outreach Teams in Birmingham: Interviews with NHS staff

You are invited to take part in a service evaluation interview. Before you agree to participate, it is important that you understand the purpose and nature of the interview.

<u>What is the purpose of this evaluation?</u>

This study intends to explore the use of case busts in Assertive Outreach Teams in Birmingham city, to understand staff perceptions of the strengths and weaknesses of the approach as it is being currently used and to make recommendations for improvements based on this data.

<u>Why have I been chosen to take part?</u>

You have been asked to take part as you have been identified as a member of BSMHFT staff who has had the opportunity to participate in case busts.

<u>Do I have to take part and what will happen if I do?</u>

No, participation is completely voluntary and if you decide not to take part this will not affect you in any way. If you do decide to take part, I will ask you to sign a consent form, but if you change your mind later, you are free to withdraw at any time during the interview. You are also free to withdraw you data for up to two weeks after the research interview.

<u>What will happen to me if I take part?</u>

You will be interviewed about your experiences of case busts. The focus of these interviews will be on the process of case busts only and will not focus on individual service users. This will include questions on how the process works in your opinion, what you find helpful about it, and what you feel could be improved. Interviews will be carried out individually and will involve recording on an audio device. Recordings will be deleted within 12 months after recording and transcriptions will be disposed of after 10 years.

University of Birmingham Edgbaston Birmingham B15 2TT United Kingdom
T: +44 (0)121 414 4932 F: +44 (0)121 414 4897 W: www.birmingham.ac.uk

Will my taking part in the study be kept confidential?

If you join the study, the interview will be recorded and transcribed before recordings are deleted. When the interview is transcribed, you will be allocated a pseudonym so that you are not personally identifiable. Transcriptions will be kept confidential and stored in a password protected, encrypted database, and will only be accessible to the research team. Some quotes may be used in an internal presentation and report within the University, but no quotes will be used that could identify an individual.

What if there is a problem?

It is unlikely that taking part in this study will cause any problems, but if you have a complaint about any aspect of the way in which you have been approached or treated during the course of the study, you can either contact myself (Maeve Lynch) directly, my academic supervisor Michael Larkin, or Alan Meaden.

What will happen to the results of the service evaluation?

The data will be used for research purposes, presented in an internal presentation within the University and in a written report to form part of a Masters thesis.

Who has reviewed the study?

This study has been reviewed by University of Birmingham Research Ethics Committee.

What happens next?

I will give you at least 24 hours to decide if you would like to take part in this research study, participants who are willing to take part will be asked to sign a consent from. If you would like any further information about this study, please contact Maeve Lynch, (contact details can be found on the top of the page).

Thank you for considering taking part in this research and taking the time to read this information sheet.

Appendix 6: Consent form

[APPENDIX C]

UNIVERSITY OF BIRMINGHAM
College of Life and Environmental Sciences
School of Psychology

CONSENT FORM

Evaluation of the use Case Busts in Assertive Outreach Teams

I confirm that I have read and understood the Information Sheet and have had the opportunity to consider the information and ask questions. ☐

I understand that participation is voluntary and that I will receive a copy of my Transcript. I have been asked to notify the researcher if I see anything which I believe is inaccurate or any sections that I wish not to be quoted directly. I understand that I will be given until two weeks after the research interview to provide feedback to the researcher after which it will be assumed that I wish to remain in the study. ☐

I understand that data collected during the study will be stored on the University Computer network (which is password protected). ☐

I understand that data will be used for research purposes, and that it will form part of an Masters in Research thesis. ☐

I agree to take part in this study. ☐

……	……	.....
YOUR NAME	Signature	Date
……	……	.....
RESEARCHER'S NAME	Signature	Date

When completed: 1 copy for participant, original copy to be retained in research file.

University of Birmingham Edgbaston Birmingham B15 2TT United Kingdom
T: +44 (0)121 414 4932 F: +44 (0)121 414 4897 W: www.birmingham.ac.uk

Appendix 7: Indicative topic guide

Indicative Topic Guide

Evaluation of the use of the shared case formulations in Assertive Outreach Teams in Birmingham.

Thank you for agreeing to meet with me. This interview should take about 30-40 minutes. We will be discussing your experiences of the use of 'case busts' in your Assertive Outreach Team, what you find helpful about the process, and any changes that you feel could be made. The focus of this interview is the process of the shared formulation approach and not on individual case. I ask that you do not use the real names of service users in any examples you chose to give to illustrate your points.

Opening questions:

- What is your job role? What does this involve?
- Which assertive outreach team/s do you work with?
- How long have you worked with this team?

Service context:

- Thinking through your caseload, can you describe the typical client that you work with?
- What sorts of problems come up for your service users?

Case busts

- Can you tell me a little about your experience of the case bust?
- What is the main purpose/function of the case bust in your opinion?
- What do you want to get out of a case bust?
- What are the elements of the formulation framework that is usually used?
- Are these elements sufficient in your opinion to cover/include important considerations for the client group? For example risk. Are all elements relevant at different stages of treatment i.e. commencing treatment, maintenance/relapse, exiting treatment?
- Are there additional elements or alternative formulation frameworks that you would suggest?
- To what extent do you participate in the formulation process and what is the nature of your participation? Does anything interfere with your participation in the process?
- How is it decided which clients/cases are brought to case busts within your team?

Impact on practice

- What do you see as the link between case busts and practice?
- How is your practice influenced by the case bust sessions?
- What is the relationship between the case busts and care planning?

Future directions

Aside from the things that you have mentioned so far, is there anything that you would like to see changed/any improvements you could suggest that would strengthen the process of case busts?

Do you have any other comments on your experiences of the case bust process?

Thank you for your time.

Appendix 8: Case Busts in AOT initial template

1. What is a case bust?

    1.2 Describing a case bust

        1.2.1 Confusion over what a case bust is

        1.2.2 Describing the format of a case bust

            1.2.2.1 Team X – variable

            1.2.2.2 Team Y – emphasis on information sharing, not enough emphasis on formulation/planning

    1.3 How are clients allocated for case bust

    1.4 Desired uses/outcomes – to use to deal with stuckness/complex cases

2. Organisational change – CB is a means to manage this change

3. Cultures and practices

    3.1 What determines if a case is brought to case bust – new case/risk

    3.2 How are clients allocated for case bust – timetabled/new cases/risk

    3.3 Frequency – variable between teams

    3.4 Preparation – variable, onerous, no clear support structure available, responsibility falls on care coordinator

    3.5 Facilitation – lacking and desired, would provide structure and focus

    3.6 Service user involvement – minimal, good reception when attempted, could be increased with certain clients

4. Structure

    4.1 How are case busts structured?

        4.1.1 Not aware of any standard structure

        4.1.2 5 P's

    4.2 Perceptions of the structure used

        4.2.1 Need for a standardised structure

        4.2.2 5 P's useful

4.2.3 Additional elements need to be added to cover strengths and risk

3.3 Does the structure used cover risk adequately? Conflicting views – 5 p's has the potential to cover risk adequately depending on how it is used

5. Perceived Value

5.1 Case bust is a means to share information – particularly information on risk

5.2 Case bust is multi-disciplinary working – aids the team approach

5.2 Reduces stress/anxiety by sharing responsibility- supportive function

5.4 Case bust increases understanding – leading to increased empathy/tolerance of client behaviour & improved practice

5.3 Managing risk – CB is a means to share information and plan to manage risk – CB increases the safety of staff and clients

6. Link between case bust and practice

6.1 Case bust and care planning

6.2 Case bust and documentation

6.3 Case bust and day-to-day practice

7. What gets in the way of an effective case bust process?

7.1 Time constraints

7.2 Staff attitudes

7.3 Lack of perceived value

8. Psychologists role within the process

8.1 Organising

8.2 Facilitating

8.3 Aiding with preparation

Appendix 9: Case Busts in AOT – final template

1. Information sharing with the team as a valued function of the case bust
    1.1. Sharing information is important as AOT is a team approach
    1.2 Sharing information is particularly important for new clients
    1.3 Type of information considered valuable/important
        1.3.1 Sharing information on risk is key
        1.3.2 Historical information is valuable
            1.1.3.2.1 Information on risk history is critical
        1.3.3 Information on strengths is important
            1.3.3.1 Overemphasis on risk and insufficient emphasis on strengths
    1.4 How important is this function?
        1.4.1 Information is protective for staff working in community settings
            1.4.2 Info sharing is the key function of the case bust and an outcome in itself
            1.4.3 Info sharing is necessary but not sufficient
2. Case busts as limited reaching their full potential as a means of understanding risk
    2.1 Case busts are about understanding
        1.2.1 Increased understanding as a result of case bust currently
            1.2.1.1 Increased understanding linked to the use of formulation
        1.2.2 Increased understanding may be an incidental occurance
        1.2.3 No increase in understanding as a result of the case bust
        1.2.4 Case bust increases empathy
            1.2.4.1 Empathy as a result of new understanding
            1.2.4.1 Empathy as a result of new information
    2.2 Formulation is a function of the case bust
        2.2.1 Formulation may be an aspect of the case bust
        2.2.2 The value of formulation in the case bust
            2.2.2.1 Formulation should be the basis for intervention
            2.2.2.2 Formulation has limited impact
        2.2.2 Formulation as a shared team process
        2.2.4 Generic or all encompassing formulation
        2.2.5 Specific risk formulation
            2.2.5.1 Specific risk formulation is more useful
            1.2.5.2 Specific risk formulation occurring outside the case bust

3. Case busts inform team defensive risk management practice but have an unreliable impact on wider practice

- 3.1 Case busts are a source of multiple perspectives from the multidisciplinary team
- 3.2 Case busts have a supportive function for staff
- 3.3 Informing practice
  - 3.3.1 Ideas for practice
  - 3.3.2 Case busts facilitate a consistent team approach
    - 3.3.2.1 Defensive risk management
    - 3.3.2.2 Positive risk management/risk taking
  - 3.3.3 The case bust should inform practice
  - 3.3.4 A clearer link to practice is made, examples of formulation driven practice
    - 3.3.4.1 Link presented as inconsistent
    - 3.3.4.2 Support for a clearer link between case bust and practice
  - 3.3.5 No impact on practice other than defensive risk management practice
  - 3.3.5 Relationship between case bust and care plan
    - 3.3.5.1 Relationship seen by staff between case bust and care planning
    - 3.3.5.2 No clear link/tenuous/uncertain relationship between case bust and care planning

4. Limited collaboration with the service user

- 4.1 Sources of information for case busts
- 4.2 Service user is a source of information
- 4.3 Formulation/aspects of the formulation shared with service user
- 4.4 Increase involvement of service user
  - 4.4.1 Sharing information with a client is not straightforward
  - 4.4.2 Time constraints as a barrier

5. Current status of the case bust within the teams

- 5.1 What is a case bust? – team X only
- 5.2 Frequency
  - 5.2.1 infrequent – team x
  - 5.2.2 weekly – team y
- 5.3 Allocation of clients to case bust
  - 5.3.1 Type of client considered appropriate for case bust –new/existing
  - 5.3.2 How are clients allocated for case bust?
    - 5.3.2.1 Team X: no clear system staff are aware of, limited staff involvement

5.3.2.2 Team Y: clear system, staff know how to suggest clients for case bust

5.4 Structure

2.4.1 no clear structure that staff are aware of/variable

2.4.1.1 Standardization of the structure opposed

2.4.2 Team Y: 5 P's

2.4.2.1 Alternative to the medical model

5.5 Preparation

2.5.1 Level of preparation varies

2.5.2 Preparation is seen as a key factor in determining the quality of the case bust

2.5.3 Time constraints as a barrier to increased preparation

5.6 Case busts perceived to be of variable quality

5.6.1 Lack of focus

5.6.2 Quality of information shared varies

5.7 Facilitation

5.7.1 Someone needs to take responsibility/lead

6. Perceived value of the case bust

6.1 Case busts are just something you have to do

6.2 The value is variable

6.3 Factors influencing participation -staff attitudes/perspectives

6.4 Case busts are not required – other processes meet the teams needs

7. The role of psychology

6.1 As seen by the psychologists

6.2 As seen by other staff

4.3.1.1 Psychologist should lead the process

6.3 Relationship to a psychosocial model within the teams

Appendix 10: Theme frequencies table: functions of the case bust

	Me X	Mi X	Ka X	Di X	Li X	Pa X	Ka X	To X	Pa Y	Jo Y	Su Y	Cl Y	Sa Y	Ha Y	Da Y	La Y
1.Information sharing with the team is a function of the case bust	6	7	14	4	14	3	13	5	3	12	10	5	7	6	14	7
1.1 Sharing information is nb as AOT is a team approach	2	0	2	1	1	1	1	1	0	1	0	2	2	0	1	1
1.2 Sharing information particularly relevant for new clients	1	0	2	0	7	1	7	0	0	4	0	1	1	0	5	3
1.3 Sharing information on risk is key	2	3	4	2	5	1	4	1	0	1	2	3	4	2	4	3
1.4 Information on client history is key information	3	4	2	1	2	1	7	2	0	0	2	3	2	2	1	0
1.5 Information is protective	0	1	0	0	1	0	3	0	0	0	0	0	0	0	3	2
1.6 Info on protective factors is nb	0	0	3	0	1	1	1	0	1	1	0	0	0	0	0	0
1.7 Info sharing is the key function of the case bust	0	0	5	0	4	0	3	2	0	0	0	0	0	0	0	0
1.8 Info sharing is necessary but not sufficient	0	0	0	0	0	0	0	0	1	4	4	0	1	1	1	0

2 Case busts involve formulation	9	3	3	4	1	2	0	2	15	9	11	6	5	4	2	1
2.1 Formulation relates to risk	1	4	2.	0	2	2	0	0	2	4	5	2	2	1	0	0
2.2 Formulation should be the basis for intervention	4	0	0	0	0	0	0	0	3	10	10	3	1	0	0	1
2.3 Formulation as a shared process	3	0	0	0	0	0	0	0	5	1	4	2	1	0	0	0
2.4 Formulation should be specific	1	1	1	0	0	0	0	0	3	2	2.	0	0	0	0	0
2.5 Formulation is understanding	0	0	1	4	0	4*	0	0	3	1	2	1	3	1	0	0
3. Case busts are about understanding	1	1	1	1	0	0	1	2	2	0	4	3	3	2	0	1
3.1Increased understanding as a result of case bust currently	1	1	1	1	0	0	1	2	2	0	4	3	3	2	0	1
3.2 No increase in understanding as a result of the case bust	0	0	0	0	1	0	0	1	0	1	0	0	0	0	0	0
4 Case busts are an opportunity for MDT working	1	0	1	2	2	3	1	0	1		1	1	2	0	3	1
5 Case busts have a supportive function for staff	1	0	0	0	0	1	0	0	1	0	2	0	0	0	1	0

6 Case busts have a function in terms of practice	9	3	5	8	4	4	7	4	7	6	10	14	14	7	17	4
6.1 Case busts are a source of ideas for practice	1	0	3	2	4	2	1	0	3	1	2	2	3	2	4	1
6.2 Case busts facilitate a consistent team approach	6	0	1	5	0	2	2	3	2	3	5	2	3	2	6	1
6.3 Case bust facilitates defensive risk management	0	1	1	0	0	0	4	1	0	1	1	3	4	2	3	2
6.4 A clearer link is made, examples of formulation driven practice	2	2	0	1	0	0	0	0	2	1	2	7	4	1	3	0
6.5 No clear link/tenuous link between case bust and care plan	0	1	1	1	3	0	2	4	0	0	0	0	2	0	1	0

Appendix 11: Example of a code: 1.4.3 Info sharing is necessary but not sufficient

I think the outcomes you know the actual recommendations and the things that we are going to do should be I don't know perhaps be more formalised because otherwise you know you sit down there and yes you gain information and you ideas but unless, unless its actually, unless its drives the care plan or it drives the em the intervention I think it will get forgotten. I don't know how we formalise that I don't know but. (Dan)

My suspicion is that all of the case busts will focus or non-presentational case busts for new patients will focus around risk, I think risk if anything is slightly too dominant em but that comes back to this issue about the importance of it being clear the focus of the meeting so that you can move beyond kind of this itemising history towards thinking about more positive things like protective factors, people's strengths areas in the longer-term care plan that are perpetuating but you might think yeah I could come at it from that way so rather than focus specifically on the behaviour or whatever it is that you come up with different ideas about how you might deal with that and again that requires a bit of preparation I think and people being ready to kind of go forward with something (John)

I think in case busts sometimes you can spend about 99 percent of the time sharing information but very little time actually getting into discussions about well what will that actually mean about what we might do tomorrow or if we have a call from them next week are we any clearer about what we are going to do. And often my experience of case busts is that no we don't, kind of we have talked a lot which is good for information sharing but we haven't necessarily done much formulating and usually very very little planning (John)

I think there is something to do with understanding why you want the whole team to come together and being quite clear about that and then I think that you know should influence, I don't think it does, but I think it should influence the critical information you need to share at the beginning in terms of peoples ability to participate and also directing them towards where you want a particularly fresh look or a kind of eh you want to share peoples different feelings about something (John)

we are only here for an hour, you've got to hit the ground running maybe you know first ten, fifteen minutes share critical information but then we've got to move on to you know be using the rest of the time constructively to discuss x y or z (John)

I think there is sometimes a clear link but I think you see some case busts they share the information and it all closes down and that's it, but sometimes you see it and it goes somewhere (Susan)

that's just the starting point isn't it I guess. Information sharing.. (Susan)

I think that its always good to have something that comes out of the five P's, in my mind that really important, yeah thinking about what's useful and where is it going to take you, apart from sharing information and understanding. (Susan)

it is important the information sharing but its having something useful that comes out of it you know that you feel like right well lets we've got a better plan lets try this kind of thing or lets do this, that's where I see the usefulness of it really because it feels wrong in a way if you just do it as an exercise that needs doing and then it just sort of closes it and you are not then doing anything from that sharing that information together having a formulation but having some action points from it really (Susan)

its not just about looking at risk its thinking about how you can work with them slightly differently so it can be useful not just looking at the risk formulation but looking at you know new ways of working with people like kind of action, that's what I find really useful (Susan)

I think we need to make sure that this is set really that its part of the weekly plan that we have this case bust because it's a good time for staff really to have I won't say supervision its not supervision but it's a good time for staff to have that time where they think and they re-evaluate their care with a service user and re-evaluate their interventions and you know what's the best way forward really. But also I think its

important to em for staff to realise that the case bust can be and is very useful in the formulation of the care plan and the risk assessment so in actual fact by attending these and by working on them more its giving staff more knowledge more confidence to work in this manner (Sarah)

yeah you know if someone's history of arson do you know what I mean lets elaborate what was it how it happened rather than just you know saying yeah they've got a history of this, history of carrying knives you know history of violence lets you know, why has that happened (Laura)

And like I said because I tend to use case busts when I have a specific issue em so I like to come away from it with an outcome or an action plan to tackle that em because I think otherwise you are just having a discussion about someone's history and while that can be helpful its a lot more helpful if you can come away from it with some fresh ideas. But again that's only helpful if its all done in a SMART way, if its all actually going to be followed up because equally I've seen action plans be made that never get chased up and just fall into the ether and that's that. But again that's about individual care coordinators taking responsibility (Harry)

The case bust I think is very helpful it supports the team approach and I suppose the teams risk management processes so where it helps I think is it helps to share information with the team as a whole about peoples histories risk em you know so everybody is aware of what the key kind of areas of risk are em I mean what it also helps with is we try to link that in with care planning process so it helps us as a team to actually as a team develop a management strategy in terms of managing specific risks or as simply as you know if there is information that we haven't got it identifies where those gaps are where we might need to do further work to try and find out more information around a specific area em and it helps to feed into the you know the routine care planning process as well you know in terms of what areas of need em do we need to address em as a priority em you know to help the person in their recovery process but also I suppose its very much about the risk management process too (Clare)

I feel the case busting process is a really important part of this kind of work. It what attracted me to this role anyway hearing about the opportunity for you know developing shared formulations with a team. Yeah I think the process is particularly important in terms of everyone in the team having a good shared understanding of what the persons presenting problems are em what the things that might be maintaining the problem or em understanding em what's contributed to the persons difficulties and I guess it helps to move away from a very medicalised model of viewing things so to have a bit more of an understanding of the persons narrative really as to how they've got to where they are now so how they've got here and what's maybe preventing them from moving to where they want to be as well in terms of the recovery. (Paula)

REFERENCES

Abdel-Hamid, M., Lehmkämper, C., Sonntag, C., Juckel, G., Daum, I., & Brüne, M. (2009). Theory of mind in schizophrenia: The role of clinical symptomatology and neurocognition in understanding other people's thoughts and intentions. *Psychiatry Research, 165*(1), 19-26.

Abu-Akel, A., & Khalid, A. (2004). 'Theory of mind' in violent and non-violent patients with paranoid schizophrenia. *Schizophrenia Research, 69, 46–53.,* (69), 46-53.

Abu-Akel, A. (1999). Impaired theory of mind in schizophrenia. *Pragmatics & Cognition, 7*(2), 247-282.

Adolphs, R. (2001). The neurobiology of social cognition. *Current Opinion in Neurobiology, 11*(2), 231-239.

Aitken, P. (2007). *Mental health policy implementation guide: Liason psychiatry and psychological medicine in the general hospital.* UK: Royal College of Psychiatrists.

Allen, J. G., & Fonagy, P. (2006). *The handbook of mentalization-based treatment. UK:* John Wiley & Sons.

Ambady, N., Hallahan, M., & Rosenthal, R. (1995). On judging and being judged accurately in zero-acquaintance situations. *Journal of Personality and Social Psychology, 69*(3), 518.

Andreasen, N. C., Arndt, S., Alliger, R., Miller, D., & Flaum, M. (1995). Symptoms of schizophrenia: Methods, meanings, and mechanisms. *Archives of General Psychiatry, 52*(5), 341.

American Psychiatric Association. (1987). *Diagnostic and statistical manual of mental disorders* (rev.) Washington. Dc: Author.

Barber, J. P., Luborsky, L., Crits-Christoph, P., & Diguer, L. (1995). A comparison of core conflictual relationship themes before psychotherapy and during early sessions. *Journal of Consulting and Clinical Psychology, 63*(1), 145.

Baron-Cohen, S., Jolliffe, T., Mortimore, C., & Robertson, M. (1997). Another advanced test of theory of mind: Evidence from very high functioning adults with autism or asperger syndrome. *Journal of Child Psychology and Psychiatry, 38*(7), 813-822.

Baron-Cohen, S., Leslie, A. M., & Frith, U. (1985). Does the autistic child have a "theory of mind"? *Cognition, 21*(1), 37-46.

Bazeley, P. (2009). Editorial: Integrating data analyses in mixed methods research. *Journal of Mixed Methods Research, 3*(3), 203-207.

Behere, R. V., Venkatasubramanian, G., Arasappa, R., Reddy, N. N., & Gangadhar, B. N. (2011). First rank symptoms & facial emotion recognition deficits in antipsychotic naïve schizophrenia: Implications for social threat perception model. *Progress in Neuro-Psychopharmacology and Biological Psychiatry, 35*(7), 1653-1658.

Bellack, A. S., Schooler, N. R., Marder, S. R., Kane, J. M., Brown, C. H., & Yang, Y. (2004). Do clozapine and risperidone affect social competence and problem solving? *American Journal of Psychiatry*, *161*(2), 364-367.

Bell, M., Bryson, G., & Lysaker, P. (1997). Positive and negative affect recognition in schizophrenia: A comparison with substance abuse and normal control subjects. *Psychiatry Research, 73*(1), 73-82.

Benjamin, L. S. (1984). Principles of prediction using Structural Analysis of Social Behavior (SASB). In Zucker, R. A., Aronoff, J. & Rabin, A. J. (eds.), Personality and the prediction of behavior New York: Academic.

Benjamin, L. S. (1974). Structural analysis of social behavior. Psychological Review, 81, 392–425.

Bentall, R. P. (2004). *Madness explained: Psychosis and human nature.* UK: Penguin.

Bentall, R. P., Corcoran, R., Howard, R., Blackwood, N., & Kinderman, P. (2001). Persecutory delusions: A review and theoretical integration. *Clinical Psychology Review, 21*(8), 1143-1192.

Bentall, R. P., Kinderman, P., & Kaney, S. (1994). The self, attributional processes and abnormal beliefs: Towards a model of persecutory delusions. *Behaviour Research and Therapy, 32*(3), 331-341.

Bentall, R., & Kinderman, P. (1998). Psychological processes and delusional beliefs: Implications for the treatment of paranoid states. Wykes, T. (Ed); Tarrier, N. (Ed); Lewis, S. (Ed), (1998). Outcome and innovation in psychological treatment of schizophrenia. , (pp. 119-144). Hoboken, NJ, US: John Wiley & Sons Inc, ix, 291 pp.

Bentall, R., Jackson, H., & Pilgrim, D. (1988). Abandoning the concept of 'schizophrenia ': Some implications of validity arguments for psychological research into psychotic phenomena. *British Journal of Clinical Psychology, 27*(4), 303-324.

Birmingham and Solihull Mental Health Foundation Trust. (2009). BSMHFT external action plan. Retrieved 11/02, 2014, Retrieved from http://www.bsmhft.nhs.uk/about-us/news/news-archives-2009/independent-inquiry-into-the-care-and-treatment-of-glaister-earle-butler/

Blatt, S. J. (1995). Representational structures in psychopathology. . In D. Cicchetti, & S. Toth (Eds.), *Rochester symposium on developmental psychopathology: Vol. 6. emotion, cognition, and representation* (pp. 1-33). Rochester: University of Rochester Press.

Blatt, S. J. (1974). Levels of object representation in anaclitic and introjective depression. *The Psychoanalytic Study of the Child, Vol 29 10, 1974, 7-157.*

Blatt, S. J. (1991). A cognitive morphology of psychopathology. *The Journal of Nervous and Mental Disease, 179*(8), 449-458.

Blatt, S. J., & Auerbach, J. S. (2003). Psychodynamic measures of therapeutic change. *Psychoanalytic Inquiry, 23*(2), 268-307.

Blatt, S. J., & Auerbach, J. S. (2003). Psychodynamic measures of therapeutic change. *Psychoanalytic Inquiry, 23*(2), 268-307.

Blatt, S. J., Ford, R. Q., Berman, W., Cook, B., & Meyer, R. (1988). The assessment of change during the intensive treatment of borderline and schizophrenic young

adults. *Psychoanalytic Psychology, 5*(2), 127.

Blatt, S. J., Stayner, D. A., Auerbach, J. S., & Behrends, R. S. (1996). Change in object and self-representations in long-term, intensive, inpatient treatment of seriously disturbed adolescents and young adults. *Psychiatry: Interpersonal and Biological Processes, , Vol 59(1), Feb 1996, 82-107.*

Blatt, S. J., Wein, S. J., Chevron, E. S., & Quinlan, D. M. (1979). Parental representations and depression in normal young adults. *Journal of Abnormal Psychology, 88*(4), 388.

Bornstein, R. F., & O'NEILL, R. M. (1992). Parental perceptions and psychopathology. *The Journal of Nervous and Mental Disease, 180*(8), 475-483.

Braun,V. & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77-101.

Brüne, M., & Schaub, D. (2012). Mental state attribution in schizophrenia: What distinguishes patients with "poor" from patients with "fair" mentalising skills? *European Psychiatry, 27*(5), 358-364.

Brüne, M. (2005). "Theory of mind" in schizophrenia: A review of the literature. *Schizophrenia Bulletin, 31*(1), 21-42.

Caspar, F. (1995). *Plan analysis: Toward optimizing psychotherapy.* Hogrefe & Huber Publishers.

Chiesa, M., Fonagy, P., Bateman, A. W., & Mace, C. (2009). Psychiatric morbidity and treatment pathway outcomes of patients presenting to specialist NHS psychodynamic psychotherapy services: Results from a multi-centre study. *Psychology and Psychotherapy-Theory Research and Practice, 82*(1), 83-98.

Christofides, S., Johnstone, L., & Musa, M. (2012). 'Chipping in': Clinical psychologists' descriptions of their use of formulation in multidisciplinary team working. *Psychology and Psychotherapy: Theory, Research and Practice, 85*(4), 424-435.

Clarkin, J. F., Foelsch, P. A., Levy, K. N., Hull, J. W., Delaney, J. C., & Kernberg, O. F. (2001).

The development of a psychodynamic treatment for patients with borderline personality disorder: A preliminary study of behavioral change. *Journal of Personality Disorders, 15*(6), 487-495.

Cohen, A. S., Nienow, T. M., Dinzeo, T. J., & Docherty, N. M. (2008). Attribution biases in schizophrenia: Relationship to clinical and functional impairments. *Psychopathology, 42*(1), 40-46.

Combs, D. R., Penn, D. L., Wicher, M., & Waldheter, E. (2007). The ambiguous intentions hostility questionnaire (AIHQ): A new measure for evaluating hostile social-cognitive biases in paranoia. *Cognitive Neuropsychiatry, 12*(2), 128-143.

Corcoran, R., & Kaiser, S. (2008). Persecutory delusions and theory of mind: Longstanding debates and emerging issues. *Persecutory Delusions: Assessment, Theory, and Treatment,* 207-222.

Corcoran, R. (2000). Theory of mind in other clinical conditions: Is a selective 'theory of mind'deficit exclusive to autism. *Understanding Other Minds: Perspectives from Developmental Cognitive Neuroscience,* 391-421.

Corcoran, R., & Frith, C. D. (2003). Autobiographical memory and theory of mind: Evidence of a relationship in schizophrenia. *Psychological Medicine, 33*(5), 897-905.

Corcoran, R., Mercer, G., & Frith, C. D. (1995). Schizophrenia, symptomatology and social inference: Investigating "theory of mind" in people with schizophrenia. *Schizophrenia Research, 17*(1), 5-13.

Corcoran, R., Rowse, G., Moore, R., Blackwood, N., Kinderman, P., Howard, R., . . . Bentall, R. P. (2008). A transdiagnostic investigation of 'theory of mind'and 'jumping to conclusions' in patients with persecutory delusions. *Psychological Medicine, 38*(11), 1577-1583.

Costello, C. G. (1994). Two dimensional views of psychopathology. *Behaviour Research and Therapy, 32*(4), 391-402.

Couture, S. M., Penn, D. L., & Roberts, D. L. (2006). The functional significance of social

cognition in schizophrenia: A review. *Schizophrenia Bulletin, 32*, S44-S63.

Crits-Christoph, P., Barber, J. P., Snyder, C., & Ingram, R. (2000). Long-term psychotherapy. *Handbook of Psychological Change: Psychotherapy Processes & Practices for the 21st Century.Hoboken, NJ: John Wiley & Sons,* , 455-473.

Cuesta, M. J., & Peralta, V. (1995). Cognitive disorders in the positive, negative, and disorganization syndromes of schizophrenia. *Psychiatry Research, 58*(3), 227-235.

Department of Health. (1999). National service framework for mental health. UK: Crown HM Government.

Department of Health. (2007). *Best practice in managing risk.* United Kingdom: Crown HM Government.

Department of Health. (2011). *No health without mental health*. UK: Crown HM Government.

Derogatis, L. R. (1977). SCL-90: Administration, scoring, and procedures manual-I for the revised version. Baltimore, MD: Clinical Psychometric Research.

Division of Clinical Psychology. (2011). *Good practice guidelines on the use of psychological formulation.* UK: British Psychological Society.

Division of Clinical Psychology. (2013). *Clinical psychologists and assertive outreach.* (Briefing paper No. 21). UK: The British Psychological Society.

Dudley, R., John, C. H., Young, A., & Over, D. (1997). Normal and abnormal reasoning in people with delusions. *British Journal of Clinical Psychology, 36*(2), 243-258.

Edwards, J., Jackson, H., & Pattison, P. (2002). Emotion recognition via facial expression and affective prosody in schizophrenia: A methodological review. *Clinical Psychology Review, 22*(6), 789-832.

Evans, John Mellor-Clark, Frank Margison, Michael Barkham, Kerry Audin, Janice Connell, Graeme McGrath, Chris. (2000). CORE: Clinical outcomes in routine evaluation. *Journal of Mental Health, 9*(3), 247-255.

Fairbairn, W. R. D. (1952). *Psychoanalytic studies of the personality* Psychology Press.

Fett, A. J., Viechtbauer, W., Dominguez, M., Penn, D. L., van Os, J., & Krabbendam, L. (2011). The relationship between neurocognition and social cognition with functional outcomes in schizophrenia: A meta-analysis. *Neuroscience & Biobehavioral Reviews, 35*(3), 573-588.

Fiszdon, J. M., & Reddy, L. F. (2012). Review of social cognitive treatments for psychosis. *Clinical psychology review, 32(8), 724-740.*

Foerster, A., Lewis, S., Owen, M., & Murray, R. (1991). Pre-morbid adjustment and personality in psychosis. effects of sex and diagnosis. *The British Journal of Psychiatry, 158*(2), 171-176.

Francis, R., Hennigan, B., Metcalfe, L., Makuvachuma-Walker, D., & and Ndegwa, D. (2009). *Report of the independent inquiry into the care and treatment of mr glaister earle butler*. *Birmingham: The West Midlands Strategic Health Authority.*

Frith, C. D. (1992). *The cognitive neuropsychology of schizophrenia* Psychology Press.

Frith, C. D. (2004). Schizophrenia and theory of mind. *Psychological Medicine, 34*(03), 385-389.

Frith, C. D., & Corcoran, R. (1996). Exploring 'theory of mind'in people with schizophrenia. *Psychological Medicine, 26*(03), 521-530.

Galderisi, S., Maj, M., Mucci, A., Cassano, G. B., Invernizzi, G., Rossi, A., . . . Pini, S. (2002). Historical, psychopathological, neurological, and neuropsychological aspects of deficit schizophrenia: A multicenter study. *American Journal of Psychiatry, 159*(6), 983-990.

Garety, P., Hemsley, D., & Wessely, S. (1991). Reasoning in deluded schizophrenic and paranoid patients: Biases in performance on a probabilistic inference task. *The Journal of Nervous and Mental Disease, 179*(4), 194-201.

Grande, T., Dilg, R., Jakobsen, T., Keller, W., Krawietz, B., Langer, M., . . . Rudolf, G. (2009). Structural change as a predictor of long-term follow-up outcome. Psychotherapy

Research, 19(3), 344-357.

Green, M. F., Penn, D. L., Bentall, R., Carpenter, W. T., Gaebel, W., Gur, R. C., . . . Heinssen, R. (2008). Social cognition in schizophrenia: An NIMH workshop on definitions, assessment, and research opportunities. *Schizophrenia Bulletin, 34*(6), 1211-1220.

Greenhalgh, T., Robert, G., Macfarlane, F., Bate, P., & Kyriakidou, O. (2004). Diffusion of innovations in service organizations: Systematic review and recommendations. *Milbank Quarterly, 82*(4), 581-629.

Greig, T. C., Bryson, G. J., & Bell, M. D. (2004). Theory of mind performance in schizophrenia: Diagnostic, symptom, and neuropsychological correlates. *The Journal of Nervous and Mental Disease, 192*(1), 12-18.

Grube, B. S., Bilder, R. M., & Goldman, R. S. (1998). Meta-analysis of symptom factors in schizophrenia. *Schizophrenia Research, 31*(2), 113-120.

Hammersley, M. (1992). *What's wrong with ethnography?: Methodological explorations.* Psychology Press.

Happé, F. G. (1994). An advanced test of theory of mind: Understanding of story characters' thoughts and feelings by able autistic, mentally handicapped, and normal children and adults. *Journal of Autism and Developmental Disorders, 24*(2), 129-154.

Hardy-Baylé, M., Sarfati, Y., & Passerieux, C. (2003). The cognitive basis of disorganization symptomatology in schizophrenia and its clinical correlates. *Schizophrenia Bulletin, 29*(3), 459-471.

Harpaz-Rotem, I., & Blatt, S. J. (2005). Changes in representations of a Self–Designated significant other in Long–Term intensive inpatient treatment of seriously disturbed adolescents and young adults. *Psychiatry: Interpersonal and Biological Processes, 68*(3), 266-282.

Harrington, L., Siegert, R., & McClure, J. (2005). Theory of mind in schizophrenia: A critical review. *Cognitive Neuropsychiatry, 10*(4), 249-286.

Hooker, C. I., Tully, L. M., Verosky, S. C., Fisher, M., Holland, C., & Vinogradov, S. (2011). Can I trust you? negative affective priming influences social judgments in schizophrenia. *Journal of Abnormal Psychology, 120*(1), 98.

Horowitz, M. J. (1994). Configural analysis and the use of the role–relationship models to understand transference. *Psychotherapy Research, 4*, 184-196.

Jacobson, E. (1964). The self and the object world. Oxford, England: International Universities Press. (1964). v 250 pp.

Janssen, I., & Versmissen, D.a campo, JA, myin-germeys, I., van os, J. and krabbendam, L. 2006. attributional style and psychosis: Evidence for an externalizing bias in patients, but not in individuals at high risk. *Psychological Medicine, 36*, 771-778.

John, C., & Dodgson, G. (1994). Inductive reasoning in delusional thought. *Journal of Mental Health, 3*(1), 31-49.

Johnstone, L., & Dallos, R. (2006). Introduction to formulation. *Formulation in Psychology and Psychotherapy: Making Sense of people's Problems,* 1-16.

Kapur, S. (2003). Psychosis as a state of aberrant salience: A framework linking biology, phenomenology, and pharmacology in schizophrenia. *American Journal of Psychiatry, 160*(1), 13-23.

Kendell, R., & Jablensky, A. (2003). Distinguishing between the validity and utility of psychiatric diagnoses. *American Journal of Psychiatry, 160*(1), 4-12.

Kendler, K., Myers, J., O'Neill, F., Martin, R., Murphy, B., MacLean, C., . . . Straub, R. (2000). Clinical features of schizophrenia and linkage to chromosomes 5q, 6p, 8p, and 10p in the irish study of high-density schizophrenia families. *American Journal of Psychiatry, 157*(3), 402-408.

Kernberg, O.Object relations theory and clinical psychoanalysis, 1976. *Jason Aronson, New York,* 247-258.

Kernberg, O., F. (1983). Object relations theory and character analysis. *Journal of the American Psychoanalytic Association, 31*, 247-271.

Kerr, S. L., & Neale, J. M. (1993). Emotion perception in schizophrenia: Specific deficit or further evidence of generalized poor performance? *Journal of Abnormal Psychology, 102*(2), 312.

Kinderman, P. (2001). Changing causal attributions. In P. Corrigan, & D. Penn (Eds.), *Social cognition and schizophrenia* (pp. 195--215). Washington, D.C.: American Psychological Association.

Kinderman, P., & Bentall, R. P. (1996). A new measure of causal locus: The internal, personal and situational attributions questionnaire. *Personality and Individual Differences, 20*(2), 261-264.

Kinderman, P., & Bentall, R. P. (1997). Causal attributions in paranoia and depression: Internal, personal, and situational attributions for negative events. *Journal of Abnormal Psychology, 106*(2), 341.

Kinderman, P., Sellwood, W., & Tai, S. (2008). Policy implications of a psychological model of mental disorder. *Journal of Mental Health, 17*(1), 93-103.

King, N. (2012). Doing template analysis. *Qualitatve Organizational Research: Core Methods and Current Challenges,* 426-450.

King, N., Cassell, C., & Symon, G. (2004). Using templates in the thematic analysis of texts. *Essential Guide to Qualitative Methods in Organizational Research,* 256-270.

Klein, M. (1933). The Psycho-Analysis of children. *The Sociological Review, 25*(3), 296-298.

Klein, M. (1933). The Psycho-Analysis of children. *The Sociological Review, 25*(3), 296-298.

Klein, M. (1935). A contribution to the psychogenesis of manic-depressive states. *The International Journal of Psychoanalysis, Vol 16, 1935, 145-174.*

Kline, J. S., Smith, J. E., & Ellis, H. C. (1992). Paranoid and nonparanoid schizophrenic processing of facially displayed affect. *Journal of Psychiatric Research, 26*(3), 169-182.

Kohler, C. G., Bilker, W., Hagendoorn, M., Gur, R. E., & Gur, R. C. (2000). Emotion recognition deficit in schizophrenia: Association with symptomatology and cognition. *Biological Psychiatry, 48*(2), 127-136.

Kohut, H. (1971). *The analysis of the self.* New York: Int.

Kurtz, M. M., & Richardson, C. L. (2012). Social cognitive training for schizophrenia: A meta-analytic investigation of controlled research. *Schizophrenia Bulletin, 38*(5), 1092-1104.

Langdon, R., Davies, M., & Coltheart, M. (2002). Understanding minds and understanding communicated meanings in schizophrenia. *Mind & Language, 17*(1-2), 68-104.

Langdon, R., Ward, P. B., & Coltheart, M. (2010). Reasoning anomalies associated with delusions in schizophrenia. *Schizophrenia Bulletin, 36*(2), 321-330.

Leichsenring, F., & Leibing, E. (2003). The effectiveness of psychodynamic therapy and cognitive behavior therapy in the treatment of personality disorders: A meta-analysis. *American Journal of Psychiatry, 160*(7), 1223-1232.

Leuzinger-Bohleber, M., Stuhr, U., Ruger, B., & Beutel, M. (2003). How to study the quality of psychoanalytic treatments and their long-term effects on patients well-being: A representative, multi-perspective follow-up study. The International Journal of Psychoanalysis, 84(2), 263-290.

Levy, K. N., Blatt, S. J., & Shaver, P. R. (1998). Attachment styles and parental representations. *Journal of Personality and Social Psychology, 74*(2), 407.

Lewis, S. F., & Garver, D. L. (1995). Treatment and diagnostic subtype in facial affect recognition in schizophrenia. *Journal of Psychiatric Research, 29*(1), 5-11.

Liddle, P. F. (2001). *Disordered mind and brain: The neural basis of mental symptoms.* RC Psych Publications.

Lincoln, T. M., Mehl, S., Kesting, M., & Rief, W. (2011). Negative symptoms and social cognition: Identifying targets for psychological interventions. *Schizophrenia*

Bulletin, 37(suppl 2), S23-S32.

Lindgren, A., Werbart, A., & Philips, B. (2010). Long-term outcome and post-treatment effects of psychoanalytic psychotherapy with young adults. *Psychology and Psychotherapy: Theory, Research and Practice, 83*(1), 27-43.

Luborsky, L., & Crits-Christoph, P. (1990). In Duncan Cartwright (ed) Understanding Transference: The Core Conflictual Relationship Theme Method. New York: Basic Books.

Luborsky, L., Diguer, L., DeRubeis, R. J., & Schmidt, K. A. (1997). A core battery of measures of depression and principles for their selection. In Strupp, Hans H. (Ed); Horowitz, Leonard M. (Ed); Lambert, Michael J. (Ed), (1997). *Measuring patient changes in mood, anxiety, and personality disorders: Toward a core battery* (pp. 283-300). Washington, DC, US: American Psychological Association, xvi, 544 pp.

Magnavita, J. J. (2004). The relevance of theory in treating personality dysfunction. Handbook of Personality Disorders, 56.

Malla, A., Norman, R., Williamson, P., Cortese, L., & Diaz, F. (1993). 3 syndrome concept of schizophrenia - a factor-analytic study. *Schizophrenia Research, 10*(2), 143-150.

Mancuso, F., Horan, W. P., Kern, R. S., & Green, M. F. (2011). Social cognition in psychosis: Multidimensional structure, clinical correlates, and relationship with functional outcome. *Schizophrenia Research, 125*(2), 143-151.

Marks, I. (1994). Psychotherapy--a luxury the NHS cannot afford? unevaluated or inefficient approaches are hard to justify. *BMJ (Clinical Research Ed.), 309*(6961), 1071-1072.

Marshall, M., Gray, A., Lockwood, A., & Green, R. (1998). Case management for people with severe mental disorders. *Cochrane Database of Systematic Reviews, 2*

Marshall, M., & Lockwood, A. (1998). Assertive community treatment for people with severe mental disorders. *Cochrane Database of Systematic Reviews, 2*.

Martin, J. A., & Penn, D. L. (2002). Attributional style in schizophrenia: An investigation

in outpatients with and without persecutory delusions. *Schizophrenia Bulletin, 28*(1), 131-141.

Mayer, J. D., Salovey, P., Caruso, D. R., & Sitarenios, G. (2003). Measuring emotional intelligence with the MSCEIT V2. 0. *Emotion, 3*(1), 97.

McAdam, M., & Wright, N. (2005). A review of the literature considering the role of mental health nurses in assertive outreach. *Journal of Psychiatric and Mental Health Nursing, 12*(6), 648-660.

McDonald, S., Flanagan, S., & Rollins, J. (2002). *The awareness of social inference test.* Bury St Edmonds, UK: Thames Valley Test Company.

McKay, R., Langdon, R., & Coltheart, M. (2005). Paranoia, persecutory delusions and attributional biases. *Psychiatry Research, 136*(2), 233-245.

Meaden, A. (2010). 3 making assessment and outcomes meaningful. *Reaching Out: The Psychology of Assertive Outreach,* , 64.

Meaden, A., & Hacker, D. (2011). *Problematic and risk behaviours in psychosis: A shared formulation approach.* London: Routledge.

Meddings, S., Shaw, B., & Diamond, B. (2010). Community psychology. In C. Cupitt (Ed.), *Reaching out: The psychology of assertive outreach.* London: Routledge.

Mehl, S., Rief, W., Mink, K., Lüllmann, E., & Lincoln, T. M. (2010). Social performance is more closely associated with theory of mind and autobiographical memory than with psychopathological symptoms in clinically stable patients with schizophrenia-spectrum disorders. *Psychiatry Research, 178*(2), 276-283.

Menzies, D., Dolan, B., & Norton, K. (1993). Are short term savings worth long term costs? funding treatment for personality disorders. *Psychiatric Bulletin, 17*(9), 517-519.

Morgan, S. (2000). Risk-making or risk-taking. *Openmind, 101*, 16-17.

Morgan, S. (2004). Positive risk-taking: An idea whose time has come. *Health Care Risk Report, 10*, 18-19.

Mueser, K. T., Bellack, A. S., Morrison, R. L., & Wixted, J. T. (1990). Social competence in schizophrenia: Premorbid adjustment, social skill, and domains of functioning. *Journal of Psychiatric Research, 24*(1), 51-63.

Nelson, A. L., Combs, D. R., Penn, D. L., & Basso, M. R. (2007). Subtypes of social perception deficits in schizophrenia. *Schizophrenia Research, 94*(1),139-147.

Onyett, S. (2007). Working psychologically in teams. *Leicester: BPS/NIMHE.*

Penn, D. L., Sanna, L. J., & Roberts, D. L. (2008). Social cognition in schizophrenia: An overview. *Schizophrenia Bulletin, 34*(3), 408-411. doi:10.1093/schbul/sbn014

Penn, D., Corrigan, P., Bentall, R., Racenstein, J., & Newman, L. (1997). Social cognition in schizophrenia. *Psychological Bulletin, 121*(1), 114-132. doi:10.1037/0033-2909.121.1.114

Perlick, D., Stansy, P., Mattis, S., & Teresi, J. (1992). Contribution of family, cognitive and clinical dimensions to long-term outcome in schizophrenia. *Schizophrenia Research, 6*(3), 257-265.

Perry, J. C., Banon, E., & Ianni, F. (1999). Effectiveness of psychotherapy for personality disorders. *American Journal of Psychiatry, 156*(9), 1312-1321.

Persons, J. B. (1989). *Cognitive therapy in practice: A case formulation approach* Norton New York.

Phillips, L. D., & Edwards, W. (1966). Conservatism in a simple probability inference task. *Journal of Experimental Psychology, 72*(3), 346.

Pickup, G. J., & Frith, C. D. (2001). Theory of mind impairments in schizophrenia: Symptomatology, severity and specificity. *Psychological Medicine, 31*(02), 207-220.

Pinkham, A. E., Brensinger, C., Kohler, C., Gur, R. E., & Gur, R. C. (2011). Actively paranoid patients with schizophrenia over attribute anger to neutral faces. *Schizophrenia Research, 125*(2), 174-178.

Pinkham, A., Penn, D., Perkins, D., & Lieberman, J. (2003). Implications for the neural

basis of social cognition for the study of schizophrenia. *American Journal of Psychiatry, 160*(5), 815-824.

Pipon-Young, L., Cupitt, C., & Callanan, M. (2010). Experiences of clinical psychologists in assertive outreach teams: A delphi survey. *Clinical Psychology Forum,* (212), 17-18, 19, 20, 21.

Pogue-Geile, M. F. (1989). The prognostic significance of negative symptoms in schizophrenia. *The British Journal of Psychiatry,*

Pogue-Geile, M. F., & Zubin, J. (1987). Negative symptomatology and schizophrenia: A conceptual and empirical review. *International Journal of Mental Health, 16*(4), 3-45.

Pousa, E., Duñó, R., Brébion, G., David, A. S., Ruiz, A. I., & Obiols, J. E. (2008). Theory of mind deficits in chronic schizophrenia: Evidence for state dependence. *Psychiatry Research, 158*(1), 1-10.

Premack, D., & Woodruff, G. (1978). Does the chimpanzee have a theory of mind? *Behavioral and Brain Sciences, 1*(04), 515-526.

Priebe, S., & Turner, T. (2003). Reinstitutionalisation in mental health care. *BMJ (Clinical Research Ed.), 326*(7382), 175-176.

Ramon, S., & Tew, J. (2005). Approaches to risk in mental health. A multidisciplinary discourse. *Social Perspectives in Mental Health,* 184-199.

Randall, F., Corcoran, R., Day, J., & Bentall, R. (2003). Attention, theory of mind, and causal attributions in people with persecutory delusions: A preliminary investigation. *Cognitive Neuropsychiatry, 8*(4), 287-294.

Ritchie, J., Dick, D., & Lingham, R. (1994). *Report of the christopher clunis inquiry. North* West Thames Regional Health Authority, *London.*

Robertson, J. P., & Collinson, C. (2011). Positive risk taking: Whose risk is it? an exploration in community outreach teams in adult mental health and learning disability services. *Health, Risk & Society, 13*(2), 147-164.

Robinson, D., Woerner, M., & McMeniman, M. (2004). Symptomatic and functional recovery from a first episode of schizophrenia or schizoaffective disorder. *American Journal of Psychiatry, 161*(3), 473-479.

Rosenthal, R., Hall, J. A., DiMatteo, M. R., Rogers, P. L., & Archer, D. (1979). *Sensitivity to nonverbal communication: The PONS test.* Johns Hopkins University Press Baltimore.

Ryan, P., & Morgan, S. (2004). *Assertive outreach.* Churchill Livingstone.

Salokangas, R. K., Honkonen, T., Stengård, E., & Koivisto, A. (2002). Symptom dimensions and their association with outcome and treatment setting in long-term schizophrenia. results of the DSP project. *Nordic Journal of Psychiatry, 56*(5), 319-327.

Sarfati, Y., Hardy-Baylé, M., Besche, C., & Widlöcher, D. (1997). Attribution of intentions to others in people with schizophrenia: A non-verbal exploration with comic strips. *Schizophrenia Research, 25*(3), 199-209.

Sarfati, Y., Hardy-Baylé, M., Brunet, E., & Widlöcher, D. (1999). Investigating theory of mind in schizophrenia: Influence of verbalization in disorganized and non-disorganized patients. *Schizophrenia Research, 37*(2), 183-190.

Sarfati, Y., & Hardy-Baylé, M. (1999). How do people with schizophrenia explain the behaviour of others? A study of theory of mind and its relationship to thought and speech disorganization in schizophrenia. *Psychological Medicine, 29*(3), 613-620.

Schenkel, L. S., Spaulding, W. D., & Silverstein, S. M. (2005). Poor premorbid social functioning and theory of mind deficit in schizophrenia: Evidence of reduced context processing? *Journal of Psychiatric Research, 39*(5), 499-508.

Schneider, F., Gur, R. C., Gur, R. E., & Shtasel, D. L. (1995). Emotional processing in schizophrenia: Neurobehavioral probes in relation to psychopathology. *Schizophrenia Research, 17*(1), 67-75.

Schulte, D. (1997). Dimensions of outcome measurement. *Measuring Patient Changes in Mood, Anxiety, and Personality Disorders,* 57-80.

Sergi, M. J., Rassovsky, Y., Widmark, C., Reist, C., Erhart, S., Braff, D. L., . . . Green, M. F. (2007). Social cognition in schizophrenia: Relationships with neurocognition and negative symptoms. *Schizophrenia Research, 90*(1-3), 316-324.

Sergi, M., Rassovsky, Y., Nuechterlein, K., & Green, M. (2006). Social perception as a mediator of the influence of early visual processing on functional status in schizophrenia. *American Journal of Psychiatry, 163*(3), 448-454. doi:10.1176/appi.ajp.163.3.448

Shean, G., Murphy, A., & Meyer, J. (2005). Social cognition and symptom dimensions. *The Journal of Nervous and Mental Disease, 193*(11), 751-755.

Shean, G., & Meyer, J. (2009). Symptoms of schizophrenia and social cognition. *Psychiatry Research, 170*(2-3), 157-160.

Shetty, A. (2010). Assertive community treatment teams. *The British Journal of Psychiatry : The Journal of Mental Science, 196*(1), 77-8; author reply 78-9.

Skinner, P. & Toogood, R. (2010). *Clinical psychology leadership development framework.* Leicester: British Psychological Society.

Smith, J. A. (1995). Semi-structured interviewing and qualitative analysis. *Rethinking Methods in Psychology,* 9-26.

Sprong, M., Schothorst, P., Vos, E., Hox, J., & Van Engeland, H. (2007). Theory of mind in schizophrenia meta-analysis. *The British Journal of Psychiatry, 191*(1), 5-13.

Stern, D. N. (2000). Interpersonal world of the infant: A view from psychoanalysis and development psychology Basic books.

Thackrey, M., Butler, S. F.,& Strupp, H. H. (1985). Measurement of patient capacity for dynamic process. Paper presented at the annual meeting of the Society for Psychotherapy Research, Evanston, IL.

Thompson, A., Papas, A., Bartholomeusz, C., Nelson, B., & Yung, A. (2012). Externalized attributional bias in the ultra high risk (UHR) for psychosis population. *Psychiatry research, 206(2), 200-205.*

van't Wout, M., van Dijke, A., Aleman, A., Kessels, R. P., Pijpers, W., & Kahn, R. S. (2007). Fearful faces in schizophrenia: The relationship between patient characteristics and facial affect recognition. *The Journal of Nervous and Mental Disease, 195*(9), 758-764.

Vauth, R., Rusch, N., Wirtz, M., & Corrigan, P. (2004). Does social cognition influence the relation between neurocognitive deficits and vocational functioning in schizophrenia? *Psychiatry Research, 128*(2), 155-165.

Ventura, J., Thames, A. D., Wood, R. C., Guzik, L. H., & Hellemann, G. S. (2010). Disorganization and reality distortion in schizophrenia: A meta-analysis of the relationship between positive symptoms and neurocognitive deficits. *Schizophrenia Research, 121*(1), 1-14.

Ventura, J., Wood, R. C., & Hellemann, G. S. (2013). Symptom domains and neurocognitive functioning can help differentiate social cognitive processes in schizophrenia: A meta-analysis. *Schizophrenia Bulletin, 39*(1), 102-111.

Ventura, J., Wood, R. C., & Hellemann, G. S. (2011). Symptom domains and neurocognitive functioning can help differentiate social cognitive processes in schizophrenia: A meta-analysis. *Schizophrenia Bulletin, 39*(1), 102-111.

Vermote, R., Lowyck, B., Luyten, P., Verhaest, Y., Vertommen, H., Vandeneede, B., . . . Peuskens, J. (2011). Patterns of inner change and their relation with patient characteristics and outcome in a psychoanalytic hospitalization-based treatment for personality disordered patients. *Clinical Psychology & Psychotherapy, 18*(4), 303-313.

Whomsley, S. (2010). 4 team case formulation. *Reaching Out: The Psychology of Assertive Outreach,* London: Routledge.

Winnicott, D. W. (1965). The relationship of a mother to her baby at the beginning. *The Family and Individual Development,*15-20.