

A Thesis Submitted in Partial Fulfilment of the Registration for the Degree of  
Doctor of Clinical Psychology in the University of Birmingham

**Volume I: Research Component**

**Literature review – “What is it Like to Receive or Provide Psychological  
Interventions for Psychosis: A Qualitative Review”**

**Empirical paper – “The Experiential Impact of Hospitalisation in Early  
Psychosis”**

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## **Dedication**

I would like to dedicate my doctorate to the memory of my wonderful Step Dad, Kevin Wells. An amazing man, loved by many, who will be forever in our hearts.

## **Acknowledgements**

I would like to sincerely thank the participants who agreed to take part in this research and shared their experiences so openly.

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## **Overview**

This thesis is submitted in part fulfilment of the requirements for the degree of Doctorate of Clinical Psychology (Clin.Psy.D) at the University of Birmingham. The thesis contains reports of research and clinical work that have been undertaken during training.

Volume I of the thesis contains three research papers. The literature review examines what it is like to either receive or provide a psychological intervention for psychosis. This paper has been written in accordance with the guidelines for submission to the journal 'Clinical Psychology Review.' The word count for this paper is 9,523. The second paper is an empirical study, which considers the experiential impact of hospitalisation in early psychosis. This paper has been prepared in accordance with the guidelines for submission to the journal 'Journal of Mental Health' and has a word count of 8,356. Finally volume I contains the public domain briefing paper, which provides an overview of the empirical study.

Volume II contains five Clinical Practice Reports (CPR) completed over the course of training. The reports represent a range of clinical work carried out during placements in the specialties of Child and Adolescent Mental Health, Adult, Learning Disabilities and Older Adult. CPR1 presents a cognitive-behaviour and systemic formulation of a young boy with school anxiety. CPR2 reports a service evaluation of the Solihull Approach two-day training course. A single-case experimental design is presented in CPR3 which evaluates a cognitive-behavioural intervention with a man who has post-traumatic stress disorder. CPR4 is a case study of a young woman with learning difficulties who has low self-esteem. Finally, CPR5 was presented as an oral presentation and involved assessment, formulation, intervention and evaluation conducted with an older lady who had memory difficulties. The abstract of this work is presented here.

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**What is it Like to Receive or Provide Psychological Interventions for  
Psychosis?  
A Qualitative Review**

## **Abstract**

This qualitative review answers the question: *‘What is it like to receive or provide psychological interventions for psychosis?’* 10 articles are reviewed; all were felt to meet the standard criteria for methodological appropriateness in qualitative research. The review highlighted how some clients had positive experiences of the psychological intervention, feeling valued and respected. Elements found to potentially hinder the therapeutic relationship were specific therapy tasks; including setting homework and presenting longitudinal case formulations, whereas developing a shared task aided the therapeutic alliance. Psychosis was conceptualised predominantly as an ‘illness’, although psychological interventions have now progressed to address the distress associated with experiencing psychic phenomenon. There was one exception to the view of psychosis as an ‘illness’, where the clinician viewed psychosis as an ‘interpersonal disorder.’ Facilitators to change were identified as client and therapists having a shared understanding of what needed to change, and the client being able to move towards an ‘illness’ model. Barriers included the client not being able to ‘think logically’, not moving to a shared understanding and the absence of continuity. The discussion section also explores the issue of power and dominance of the cognitive behavioural model in treatments for psychosis. Clinical implications of the findings are generated along with questions for future research.

## **1. Introduction**

### 1.1 Why is this question important?

This review will answer the question: ‘*What is it like to receive or provide psychological interventions for psychosis?*’ This question is important for several reasons. Firstly, psychological interventions for psychosis have expanded over the past two decades and are now seen as a central part of treatments for psychosis (Chadwick et al, 1994; Garety *et al*, 2001; Morrison, 2001). Research has shown that psychological therapies such as Cognitive Behavioural Therapy (CBT) are effective for addressing distress in psychosis (Drury, Birchwood & Cochrane, 1996; Fowler, 1992; Haddock, Bentall & Slade, 1996; Kingdon & Turkington, 1991; Kuipers et al, 1997; Tarrier *et al*, 1993) and can lead to a reduction in number and severity of delusions and hallucinations when compared to standard care (Dickerson, 2000). It is important to note that CBT for psychosis has evolved over the past 10 years, with models now placing greater emphasis on the way people interpret events being central to their distress and disability, rather than the psychotic experiences themselves (Chadwick et al, 1994; Garety *et al*, 2001; Morrison, 2001). Developments in the field are fast moving and as such it is important to understand what it is like to experience CBT for psychosis, so new models can be developed to best meet the needs of people with distressing psychotic experiences. The National Institute for Health and Clinical Evidence (NICE) guidelines (2009) state that CBT should be offered to all people with schizophrenia. With NICE recommendations and an increase in the delivery of psychological interventions for psychosis it is essential to attempt to understand what it is actually like to receive and deliver such interventions for psychosis.

Secondly clients' perspectives on psychological interventions have received limited attention in psychotherapy research (Kuehl, Newfield & Joanning, 1990; Rennie 1994) and we have little understanding of the experiential impact of psychological interventions (Davidson, 2003; O'Toole *et al*, 2004). Understanding what it is like for clients will help to identify both helpful and unhelpful aspects of psychological interventions, and help to develop appropriate therapy approaches. Likewise, understanding what the experience is like for practitioners will help us to identify how best to train and support practitioners working within this field.

### 1.2 What will the review cover?

The review will focus on investigations conducted in the field of adult mental health (clients aged between 16 and 65 years old). It will focus on the experience of providing or receiving a psychological intervention for psychosis or psychotic phenomenon (e.g., hearing voices). Given the different conceptual models of schizophrenia, there are different ways to set the inclusion criteria for the review. Readers of the review are likely to be clinicians and therefore are likely to work with people who experience psychotic phenomenon, such as auditory hallucinations and delusions. It should be noted that not all participants in the research reviewed will have had a diagnosis of psychosis, but all will have experienced psychotic phenomenon.

## **2. Methodology**

### 2.1 Search strategy

Search terms to describe psychosis (schizophrenia), psychological interventions (including groups) and qualitative analysis were generated by the reviewer (see table 1 for search terms).

Terms identified were then used to search relevant medical and social science databases (these included PsycINFO, Web of Science, CINAHL, PILOTS, EMBASE and Ovid Medline). Additional sources included utilising the reference lists of published studies to generate more articles for analysis. Articles between the dates 1980 and 2010 were reviewed (the initial search was conducted from 1990 and revealed that the earliest article was from 2002; to ensure all possible articles were included the search was then completed from a decade before 1980). Table 1 displays the search process with articles identified at each stage.

Table 1. Search process

Search No.	Search Terms	Search Base	No. Articles Identified	No. Relevant
1	Psychosis (schizo*), psychotic, delusions, hallucinations, voices	PsycInfo, Ovid Medline, Cinal, Pilots, Embase	335463	-
2	Therapy, intervention, psychoeducation, treatment, group	PsycInfo, Ovid, Medline, Cinal, Pilots, Embase	8891735	-
3	Qualitative, experience, narrative, analysis, phenomenological, thematic	PsycInfo, Ovid, Medline, Cinal, Pilots, Embase	6038635	-
5	Psychosis and therapy intervention and qualitative	PsycInfo, Ovid Medline, Cinal, Pilots, Embase	152	7
4	-	References from obtained articles	7	3

**Total articles: 10**

## 2.2 Inclusion criteria

The following inclusion criteria were applied to articles searched:

- Research with a substantive qualitative component (at least 50% of the research)
- Psychological interventions (including group work, psychoeducation and individualised psychotherapy within any psychological orientation)
- Articles written from the perspective of the therapist and or the client



### 2.3 Exclusion criteria

The following exclusion criteria were applied to articles searched:

- Exercise-based interventions as these were not psychological in orientation
- Music therapy based interventions
- Family interventions for psychosis as the review focused on individual and group experiences and not that of families
- Interventions delivered to clients with a range of psychological difficulties
- Purely quantitative methodology

### 2.4 Identification of review methodology

For the review psychological interventions were defined as psychological therapy, psychoeducation or group interventions based on psychological approaches. The research papers reviewed included the experiences from both clients who were recipients of psychological interventions, and clinicians, who were delivering interventions. Some papers explored both client and therapist views and some were from one perspective only. Including the two positions of 'recipient' and 'provider' enabled the generation of a rich picture of the experience from different perspectives.

A qualitative approach was adopted for the review as this enabled conclusions to be drawn from both the summarising of primary studies and the contribution of the authors experience, existing theories and models. The strength of a qualitative review is therefore the opportunity to incorporate self-knowledge, reflective practice and the acknowledgement of shared phenomena (Jones, 2004). The author has provided psychological therapy for psychosis (both

within an individual and group setting) and as such had developed ideas and experiences directly relevant to the review.

### 2.5 Considerations of quality issues

Qualitative research employs a smaller sample (chosen for its special attributes) and the sample is analysed in depth. This is in contrast to quantitative investigations where large numbers of participants are sought and analysis is not in depth. With growing dissatisfaction in assessing qualitative research using criteria applied to quantitative investigations it is important when evaluating qualitative research to employ appropriate criteria (Smith, Flowers & Larkin, 2009). General guidelines for assessing qualitative research have been developed which offer an appropriate guide to assessing the quality of qualitative research. Yardley (2000) stipulates that any claims that a piece of research is of a high quality need to be legitimated by appropriate criteria relevant to methodology and to those people whose benefit the research was intended.

Yardley's (2000) criteria were used to assess quality issues in this review. Yardley presents four broad principles for assessing quality: 1). *Sensitivity to Context*: this incorporates many facets, including understanding of the context of theory, awareness of relevant literature and related empirical work, good grounding in the philosophy of the approach, awareness of the socio-cultural setting and consideration of the effects the researchers actions and characteristics have on the research. 2). *Commitment and Rigour*: Yardley argues that the concept of commitment encompasses prolonged engagement with the topic and the development of competence and skill. Rigour refers to the completeness of the data collection and analysis, completeness and plausibility of the interpretation. 3). *Transparency and*

*Coherence*: this relates to the clarity and cogency and the ‘fit’ between the research question and the philosophical perspective adopted and method of investigation. Finally 4). *Impact and Importance*: this is the idea that the ultimate value of a piece of research can only be assessed in relation to the objectives of the analysis (e.g., was it useful for the community it was intended for?) All articles were evaluated as appropriate for inclusion in the review. Appendix 1 has detailed quality assessments for each of the studies in this review. Table 2 displays the research papers.

**Table 2. Descriptive table of research papers**

<b>Title</b>	<b>Author(s)</b>	<b>Year</b>	<b>Journal</b>	<b>Sample Size</b>	<b>Research Setting</b>	<b>Country Research Conducted</b>
Factors in outcome of cognitive-behavioural therapy for psychosis: Users’ and clinicians’ views	<i>McGowan, Lavender &amp; Garety</i>	2005	Psychology & Psychotherapy Theory, Research and Practice	4 Therapists (clinical psychologists)  8 clients (7 received therapy as outpatients, 1 as inpatient)	3 therapists employed in NHS community rehab service  1 therapist in NHS acute inpatient ward	England
CBT for psychosis: A qualitative analysis of clients’ experiences	<i>Messari &amp; Hallam</i>	2003	British Journal of Clinical Psychology	5 clients (4 inpatients and 1 outpatient)	Inpatient mental health ward & CMHT (NHS)	England
Building bridges to observational perspectives: A grounded theory of therapy processes in psychosis	<i>Dilks, Tasker &amp; Wren</i>	2008	Psychology and Psychotherapy : Theory, Research and Practice	6 psychologist-client pairs	NHS outpatient services	England
Clients’ experience of case formulation in cognitive behavioural therapy for psychosis	<i>Pain, Chadwick &amp; Abba</i>	2008	British Journal of Clinical Psychology	13 therapist-client pairs	NHS therapy services (linked acute wards and	England

					community teams	
Impact of case formulation in cognitive behavioural therapy for psychosis	<i>Chadwick, Williams &amp; Mackenzie</i>	2003	Behaviour Research and Therapy	13 therapist-clients pairs	NHS therapy services (linked acute wards and community teams)	England
Patients' Experiences of Homework Tasks in Cognitive Behavioural Therapy for Psychosis: A Qualitative Analysis	<i>Dunn, Morrison &amp; Bentall</i>	2002	Clinical Psychology and Psychotherapy	10 clients	NHS Early Intervention in Psychosis Service	England
Patients' perspectives on what works in psychoeducational groups for schizophrenia	<i>Sibitz, Amering, Gossler, Unger &amp; Katsching</i>	2007	Social Psychiatry, Psychiatric Epidemiology	10 clients (focus group)	Community service for people with psychosis (free)	Austria
More than just a place to talk: Young people's experiences of group psychological therapy as an early intervention for auditory hallucinations	<i>Newton, Larkin, Melhuish &amp; Wykes</i>	2007	Psychology and Psychotherapy : Theory, Research and Practice	8 clients	NHS outpatient services	England
Beyond countertransference : Therapists' experiences in clinical relationships with patients diagnosed with schizophrenia	<i>Laufer</i>	2010	Psychosis	5 psychoanalytic clinicians	Private outpatient therapy services	America
Group person-based cognitive therapy for distressing voices: Views from the hearers	<i>Goodliffe, Hayward, Brown, Turton &amp; Dannahy</i>	2010	Psychotherapy Research	18 clients	NHS adult outpatient services	England

## 2.6 Identification of themes and development of preliminary syntheses

The main aim of the review was to answer the question; *What is it like to receive or give psychological interventions for psychosis?* and this question was addressed in Chapter 1. 8 further sub questions were initially developed and then refined through discussions with a supervisor. This resulted in 3 sub-chapters which are addressed in this review (please see appendix 2 for the process of question refining). The sub-chapters in this review are;

- *Chapter 2: What is understood to help or hinder therapeutic engagement and what blocks or aids are there to the therapeutic alliance?*
- *Chapter 3: How is psychosis conceptualised by professionals and understood by clients?*
- *Chapter 4: What are understood to be the facilitators and barriers to change?*

The influence of power in the experience of both delivering and receiving psychological interventions is explored throughout each of the chapters. Each chapter explores the phenomenon from client and the therapist's perspectives. Client and therapist perspectives have been explored together to help build a picture of the therapy process and the experience of psychological interventions from different viewpoints.

Throughout the review, the terms 'clinician' and 'therapist' are used to describe the person delivering the therapeutic intervention. The terms 'patient' and 'client' are used to describe the recipient of the intervention. The terms used in the review reflect the term chosen by the original authors in their research paper, to keep as close to the data as possible. The terms

‘psychosis’ and ‘schizophrenia’ are used to describe the psychological condition under review, and again, terms used reflect those chosen by the original authors.

## 2.7 Review format

Chapters 1 to 4 will both summarise and synthesise the content of the research papers in a descriptive way, without reflection. Quotations will be used throughout the chapters to illustrate the authors’ claims and to bring the participants’ voices into the description. Quotes will not be taken out of the context in which the authors originally used them to illustrate their analysis.

## 3. Results

### Chapter 1: What is it like to receive or provide a psychological intervention for psychosis?

#### What is it like to receive a psychological intervention for psychosis – client perspective?

##### *3.1 Feeling experiences have been listened to and being seen as ‘human’*

Messari and Hallam (2003) explored client and therapist experiences of therapy for psychosis. Clients in the research identified a ‘*friendship discourse*.’ All clients bar one talked about experiencing therapy as ‘*the meeting of two equal human beings*’, and a space to talk openly about difficulties and ‘*get things off their chest*.’ Describing the experience as ‘*getting things off their chest*’ suggests that therapy may be one of the few places where people can express themselves and talk about their experience of psychosis. McGowan, Lavender & Garety (2005) investigated factors in the outcome of CBT for psychosis from both client and clinician perspective. Clients in this research identified important positive, ‘non-model

specific' experiences of therapy, the most common being '*having difficult experiences listened to and taken seriously.*' In the Messari & Hallam (2003) research, clients experienced personal connections between themselves and therapists which were experienced as positive. Clients also felt therapists provided '*emotional support*' and allowed them '*dignity.*' Client 3 stated:

*...when I see the psychologist, it's as though they're responding to the human being that's in his own dilemma.*

The participant felt like a '*human being*' with a '*dilemma*', rather than someone who is '*bad.*' Participants in this study also talked about therapists having an interest in their experiences and feeling respected. Client 5 stated:

*...he [the therapist] is listening to my belief system, he's taking it seriously.*

The client talked about not being made to feel '*stupid*', '*crazy*' or '*irrational*' for having a different belief system to that of the therapist and felt the therapist understood where their beliefs had come from and how they had developed.

Newton *et al* (2007) investigated young people's experience of group psychological therapy for auditory hallucinations. One participant in the research described their experiences of the group as enabling her to feel '*less isolated and lonely*' following hearing other's stories.

### *3.2 Reciprocal 'helping' and therapy as an 'educational process'*

The idea that the intervention or therapist could help reduce 'distress' was documented in the Messari & Hallam study. Several clients experienced the therapist as a 'healer' who was able to make them feel 'better.' Dilks, Tasker & Wren (2008) investigated therapy processes in psychosis. They found that after psychological intervention clients experienced more confidence:

*[I] feel more confident in my abilities. Nothing's really stopping me. It's just how I feel inside. So he's [therapist] made me feel a more confident, able person in that way.*

The Messari and Hallam research generated the theme of an 'educational discourse.' All but one of their participants described their experience of the psychological intervention (individual CBT) as a process of learning about oneself and exploring alternative ways of seeing things. Education was experienced by recipients as a way to 'normalise' experiences and explain them within a framework of 'normal' cognitive processes, one participant stated:

*He [therapist] goes into detail of how...there's a whole scale of people who, you know, people under stress can hear things and people have a, you know, just a strong belief about something, you know, not only schizophrenic or mentally ill.*

In the Messari & Hallam (2003) research one participant compared their experience of the psychological intervention to that of the medical establishment. They drew a distinction between the educational, respectful 'convincing' process of therapy and the coercive management style of the medical establishment.



Goodliffe *et al* (2010) investigated group cognitive therapy for distressing voices. The authors found that the participants experienced the group as a positive environment which challenged their negative appraisals of themselves, one participant stated:

*It wasn't until we were in the group that we started to realise that you haven't done anything bad. You know? But all of them were saying, "Yeah, well, I must have done something to make me have these voices" [...]. We can't all be evil. We can't all be wrong.*

### *3.3 Experience of the therapist working from a different frame of reference & not being neutral*

Some participants reported being aware that their therapist was working from a different frame of reference (ill narrative verses the alternative psychotic explanation). Several participants in the Messari & Hallam research felt their therapist was trying to ‘convince’ them that their experiences were not true. In ‘building bridges to observable perspectives’ (Dilks *et al*, 2008) the authors reflect on how the psychologists appeared to be continually lending alternative observational perspectives to the client, enabling the client to consider different perspectives to explain their experiences.

Messari and Hallam (2003) found that two clients in their research were aware of their therapists’ position regarding their psychotic experiences, even when they were trying to appear ‘open minded.’ A key technique in CBT is the therapist appearing open minded (Nelson, 1997) and adopting the attitude of ‘independent objective discussant’ (Fowler *et al*, 1995). This allows therapists to employ the ‘Colombo technique’ (Fowler *et al*, 1995) where

therapists apologise for being so confused about it all, and carefully question clients to gain details of the sequences of events. It appears that clients may be aware of this technique and know that the therapist's neutrality isn't genuine.

### *3.4 The experience of specific therapeutic techniques*

Pain, Chadwick & Abba (2008) investigated experiences of case formulation in cognitive behavioural therapy for psychosis. They found the experience of case formulation was different for different clients, with some viewing it as a positive experience and some a negative experience. One client who found the case formulation helpful stated that *'having it sort of written down in a different form was very helpful'*. One client who did not find the case formulation helpful stated *'I don't actually understand why I do a lot of the things I do, I still don't know.'* Four Participants in the research expressed both negative and positive comments about case formulation, suggesting their experience of this technique was mixed.

Another technique used in cognitive therapy is the setting of 'homework' tasks, by the therapist. Dunn, Morrison & Bentall (2002) investigated clients' experiences of homework tasks. Several participants felt they were *'lazy'* when not motivated for psychological therapy or completing the homework:

*When I first came I thought what's the point of therapy, I just couldn't be bothered I was just too lazy.*

The client experienced their difficulty and lack of motivation at the start of therapy as their own failing (*'I was just too lazy'*), rather than the failing of the therapist or service, or it not

being the right time for a psychological intervention. Many clients also felt their 'failure' to complete the homework was due to their 'bad' memory, once again attributing failure to an internal characteristic. Homework tasks were also experienced as a burden for some:

*The anger sheets were very difficult I was thinking gosh what a lot to do.*

In the Goodliffe *et al* (2010) research, specific cognitive therapeutic techniques were taught and practiced by group members. One technique was examining the evidence for and against the negative thoughts about voices. One group member stated how she had utilised the technique:

*Last week the voices said that when I go to bed to sleep my [family members] were going to kill me [...] And then I woke up and thought "No, they didn't kill me, the voices were wrong." So it proved a point that the voices can be wrong at times.*

The participant therefore had a positive experience of utilising this technique.

### *3.5 Being in a homogenous group and feeling empowered*

In their research Goodliffe *et al* (2010) described the formation of the group identity. They found that for some members of the group the group intervention provided their first experience of being part of a homogenous group (people with mental health difficulties). Participants felt being part of such a group helped them to discuss their experiences with others who understood their difficulties.

Sibitz *et al* (2007) investigated what worked in a psychoeducational group for schizophrenia. Several participants in this research stated they felt a sense of encouragement and empowerment following the group intervention. One participant stated:

*'You don't feel like being at someone's mercy so much. You can do something for yourself – so that is great, namely a mental strength.'*

What is it like to deliver a psychological intervention for psychosis – provider perspective?

### *3.6 Having work endorsed & validated*

Chadwick, Williams and McKenzie (2003) investigated the impact of case formulation in CBT for psychosis. Therapists in this study reported finding it powerful and validating to have clients endorse their case formulation; this also made therapists feel more hopeful about the therapy. Therapists also stated that this validation increased their confidence that CBT was an appropriate therapy for their clients. Having their case formulation validated by clients appeared to have a personal impact on therapists.

### *3.7 A transformative experience and learning from the client*

Laufer (2010) investigated therapists' experiences of their relationships with clients diagnosed with schizophrenia when working within a psychodynamic framework. Therapists talked about providing therapy to individuals with psychosis as a transformative experience where the therapists went through a personal change, one therapist stated:

*My ex-patient and I have both been transformed...my learning of her resulted in an expansion of myself, my "I"... I grew as a consequence of treating her.*

The therapists in the Laufer (2010) study also talked about the experience of learning something new: that 'life makes sense', 'what it means to fear death', 'fallibility', 'humility' and 'what is important'. Therapists talked about the human condition:

*What we keep learning about is what does it mean to be human. Just how profoundly afraid of dying all of us are. It's something the patients taught me.*

*Well, what you learn, not just about yourself, but about the human condition, is that everything is laid bare, like what's important, what's not important.*

### *3.8 Therapists experience of specific therapeutic approaches*

Messari and Hallam (2003) investigated client and therapist experiences of therapy for psychosis. All therapists in their sample felt that CBT was a collaborative educational process where clients actively participate in making sense of their experiences. All therapists also experienced '*CBT as a modification of patients' paranoid beliefs*' and talked about '*leading patients in a particular direction*' in order to '*convince*' them to change their beliefs. Messari and Hallam (2003) suggest the discourse of '*modification*' suggests a less collaborative approach than the educational process discussed by therapists as the modification goal was the therapists 'ultimate agenda' and that was not discussed explicitly with clients.

One therapist in the research talked about their implicit way of challenging their clients' beliefs as '*slightly false*', as they had explicitly agreed with the client to explore both the options of '*this is true*' and '*I am ill*,' however the therapist described their aim as trying to promote the '*I am ill*' discourse.

### *3.9 Chapter Summary*

This chapter has explored what it was like to receive or deliver a psychological intervention for psychotic experiences. Clients experienced being listened to, respected and seen as human. Clients also experienced interventions as educational but also something they could contribute to (e.g., sharing their experiences with others). In group interventions clients felt part of the group and for some this was their first experience of feeling similar to others. Clients highlighted that they were aware of the therapist not being neutral, and that therapists had their own agenda (trying to convince clients that their experiences were part of an illness).

Clinicians felt positive when their work was validated, and one format for achieving this was via case formulation. Some clinicians experienced a transformation when delivering therapy and learnt from their patients. Clinicians employing cognitive-behavioural therapy felt their approach was collaborative, even though they had a specific agenda.

## **Chapter 2: What is understood to help or hinder therapeutic engagement and what blocks or aids are there to the therapeutic alliance?**

### What is understood to help or hinder client engagement in the intervention?

#### *4.1 Engagement within the context of a group intervention*

Newton et al (2007) investigated young people's experiences of group psychological therapy for auditory hallucinations. Group members identified the group as being supportive, particularly as group members had similar experiences and so were able to understand what each other was encountering. The role of facilitators was identified as an important factor within the group, particularly as they encouraged the young people to use their expertise to help each other and share experiences. One technique identified as helpful was the therapist using Socratic dialogue to help group members identify effective coping resources. A supportive group, good facilitators and psychological techniques all helped to engage clients in the intervention.

Goodliffe *et al* (2010) found that for most people in their research their initial reason for joining the therapy group was as they wanted to meet other people who had a similar experience to them; participants hoped this would develop their social network.

#### *4.2 Engagement within the context of therapy (influence of establishment)*

Having described the experience of receiving or providing psychological interventions for psychosis, it is important to also consider the context in which psychological interventions occurs. One of the themes generated by Messari & Hallam's (2007) study in an inpatient setting was '*CBT participation as compliance with the powerful medical establishment.*'

Clients experienced their participation in therapy as an expression of their co-operation with the medical establishment and as such a possible means of discharge:

*I hope it helps me to get discharged...because I'm doing things I'm supposed to do*

Some clients also appeared to not understand the purpose of the psychological sessions, seeing them as an 'interview' for the therapist's own purposes and enjoyment.

#### *4.3 Questions unanswered*

There was very little information on engagement throughout all of the research papers. There was no discussion of the impact which engagement had on the overall therapy or intervention experience. There was little consideration given to the client's motivation when deciding to engage (or not) in the psychological intervention, aside from those outlined in section 4.2. How engagement is actually understood by both the client and the therapist was not considered in any paper.

#### What is understood to block or aid the therapeutic alliance?

#### *4.4 The development of a shared task*

McGowan, Lavender and Garety (2005) investigated factors in the outcome of CBT for psychosis. The research identified differences between those clients who made progress in therapy and those who didn't. One therapist identified a reason for their client making progress as they had developed a shared-goal to work towards in therapy:

*It was clear that he was thinking things in between times and he knew why I was there and roughly the focus of what we were doing and why I was asking those questions*



Messari & Hallam (2003) investigated clients' experience of CBT for psychosis. Several clients in this investigation described their experience of therapy as a '*collaborative enterprise*' where therapists and clients worked together to '*achieve common goals.*' Clients talked about having agency and responsibility to use the therapists' services for their own benefit.

#### *4.5 The importance of the relationship*

In the Messari & Hallam (2003) study, clients felt the therapist took them seriously; this enabled them to trust the therapist. In '*building bridges to observational perspectives,*' (Dilks *et al*, 2008) the authors identified that a main therapy activity was the '*doing relationship*' which they defined as a '*reciprocal process of the psychologist and client working together in creating and experiencing a confiding context.*' The authors also found that the therapist demonstrating concern related to clients feeling cared about, and also related to clients building up trust in the therapist and valuing the self (being respected and respecting self).

#### *4.6 Impact of specific therapeutic tasks*

In the Messari and Hallam research (2003), two clients talked about their experience of belief modification, a technique used in CBT to challenge client's beliefs about their illness. Clients experienced being in control of the process because they retained the right to disagree with therapists:

*I'm open minded about what the conclusion is going to be. [...] Maybe, at the end, I still think that these things are real, whether he says or not*

Pain, Chadwick and Abba (2008) investigated clients' experience of case formulation. They found that two clients (out of 13) felt that using case formulation made the therapeutic relationship worse, two clients felt it didn't make a difference and seven felt it had a positive effect on the relationship. Chadwick, Williams and Mackenzie (2003) also investigated the impact of case formulation in CBT for psychosis. The authors reported that therapists in their sample felt case formulation increased a sense of alliance and collaboration with their clients.

#### *4.7 Questions unanswered*

There is little information throughout the papers regarding how the therapeutic relationship was developed in the first instance. Likewise no paper specified how the therapeutic relationship was maintained. In the Pain, Chadwick and Abba (2008) research no explanation was given as to why the case formulation specifically helped or hindered the therapeutic relationship.

#### *4.8 Chapter Summary*

This chapter identified factors helpful in engagement within individual therapy and group interventions. It also highlighted that it was developing a shared task and having a good relationship aided the therapeutic alliance with specific therapy tasks potentially blocking the alliance. From the research reviewed it was evident that there were gaps in the data regarding engagement and therapeutic alliance.

### **Chapter 3: How is psychosis conceptualised by professionals and understood by clients?**

#### *5.1 Understanding psychosis within an illness model*

McGowan, Lavender and Garety (2005) investigated factors in the outcome of CBT for psychosis. One therapist described how their client was able to move on as he had moved towards an 'illness' model:

*When I first started to see him [he had] a vaguely supernatural explanation. He's ended up with more of an illness model.*

Sibitz et al (2007) investigated patients' perspectives on what works in psychoeducational groups for schizophrenia. In the research, the authors talk about '*patients*' who have a '*diagnosis of schizophrenia*' and who are '*suffering from a disease.*' Using these terms of reference suggests the author's view of schizophrenia is within a medical framework.

#### *5.2 'I am ill,' client's perception of psychosis as a 'disease'*

Messari and Hallam (2003) investigated clients' experience of CBT for psychosis. They identified an '*I am ill*' discourse amongst their participants. They reported how participants varied in the implication of this discourse. One client presented themselves as in need of medication and psychological therapy for their general well-being. Another participant drew on the discourse very tentatively and identified therapy as introducing the idea they were '*sick*':

*Well, it [sessions] makes me think that er possibly I'm sick.*

Another participant in their investigation described themselves in terms of their diagnosis '*I'm a schizophrenic*' and stated that they needed to '*take medication.*' The authors also found that three participants switched between their beliefs that '*this is truly happening*' and that '*I am ill.*' There was ambivalence about one or the other discourse suggesting clients were aware of their status as patients, but also held onto their other beliefs about their psychotic experiences.

### *5.3 Therapists going against the 'status quo' - positives of schizophrenia*

In '*Beyond countertransference: Therapists' experiences in clinical relationships with patients diagnosed with schizophrenia* Laufer (2010), offers a different perspective of schizophrenia. The author describes how he viewed schizophrenia as an interpersonal disorder rather than a biological one. Laufer uses the word '*dissenter*' to describe taking this alternative view point. The American paper is written in the context of a strong acceptance of schizophrenia as a biological disorder within the USA. The author also referred to people with schizophrenia as being '*like us*', and this is one reason why therapy is not advocated in the USA (as a psychodynamic defence, as the idea that people with psychosis are similar to ourselves is threatening).

Laufer (2010) outlines how he will be looking for positive aspects of having schizophrenia and positives of providing psychological therapy for people who have schizophrenia. He described people as '*schizophrenic*' rather than having '*schizophrenia*' and asserted:

*The distinction is an important one for this paper. To be schizophrenic it to perceive the world from the point of view of a particular position, rather than to be rendered insane by a disease process.*

Laufer described how four out of the five therapists referred to schizophrenia as a '*human condition*', even though this term was not used by the interviewer. The research also found therapists stated they had gained knowledge and/or transformed while in the therapeutic relationship, with their patients.

#### *5.4 Psychosis as 'psychological' distress*

Newton *et al* (2007) take the position that 'schizophrenia' is not a disease and that this conceptualisation has enabled a shift in the way we respond to the distress caused by psychosis. They described the move from diagnosis and treatment to a move towards problem solving and developing formulations and interventions where the client is central to the process.

Participants in the Goodliffe *et al* (2010) study described how their understanding of voices and their belief of either being '*cured*' or '*living in misery*' had changed following the group, and they now considered the idea of '*coping*' with the voices:

*I wasn't expecting to be able to cope with the voice still there. I wasn't expecting to, just be in control. I was expecting to either have the voice or not have the voice.*

Along with the idea of coping, participants in this research also developed an understanding of how the experience of hearing voices had affected them. The authors found that a pivotal aspect of this process was re-evaluating their sense of personal identity with the voices as part of themselves, one participant stated:

*I am not the illness. I am a person with a certain illness.*

It appeared that participants in this research moved from a ‘cure’ model, within which medication was the solution, to a model of understanding and accepting the self and the voices. The authors suggest that participants appeared to develop a sense of agency which allowed them to define the self in ways which were not determined by the voice.

### *5.5 Changing clients’ conceptualisations of psychosis*

In the Sibitz *et al* (2007) investigation participants who undertook a psychoeducation group for schizophrenia talked about the group dismantling the prejudices they had towards people with mental health difficulties, one participant said:

*It was good to meet other young people who are completely normal and have a psychosis*

Another group member stated she had to correct her belief that ‘*the mentally ill stay in bed all day.*’ Similarly in the Goodliffe *et al* (2010) investigation into a therapy group for people who heard voices, participants talked about having a different opinion about mental health and what was ‘*normal,*’ one participant stated:

*I’m just surprised that everyone was so normal [...] I thought if they seemed alright, they looked, you know, normal, perhaps I did as well.*

## 5.6 Chapter Summary

This chapter explored conceptualisations of psychosis. Psychosis was either conceptualised by professionals as an illness (disease) or as a different way of being. A psychological understanding of psychosis has led to a shift in focus from treating ‘symptoms’ to developing psychological formulations and working with the distress people experience. Group interventions provided participants with the opportunity to dispel some of their prejudices around mental illness.

## **Chapter 4: What are understood to be the facilitators and barriers to change?**

### What are the facilitators for change?

#### *6.1 A change understanding*

McGowan, Lavender & Garety (2005) investigated factors in the outcome of CBT for psychosis. They found that having a joint understanding of what needed to change was facilitative. The therapist may understand the change process in CBT as attempting to change clients’ beliefs about their symptoms, which in turn will reduce distress. A client may see the change in therapy as the process which changes their understanding of their experiences, the authors therefore found that having a joint goal and understanding of the aim of therapy was facilitative for change.

#### *6.2 Moving towards a shared model/understanding and ‘letting go’*

McGowan, Lavender and Garety (2005) found that one facilitator for clients making progress in therapy (as judged by the therapists in the study), was ‘*moving to new and disregarding old*

*understanding.*' Within this category therapists talked about the client needing to move towards a '*less distressing*' understanding of their difficulties and beginning to see their experiences within an illness model rather than having a psychotic explanation.

Therapists in the research also identified the importance of clients being able to '*think clearly to aid understanding.*' One therapist talked of how when the client's '*thinking was clearer he [could] understand it in terms of a kind of stress/vulnerability interaction.*' Another therapist in this study talked about the client being able to use the therapists' explanations to aid clarity of thought:

*And yet there was a sense in which the way I was there was almost a kind of cognitive prosthesis. That I was doing the thinking for him and he could attach my thinking to his thinking.*

A client in this study described how change occurred when they were able to eliminate other explanations and ended up with just one explanation (being able to shift their views to that of the therapist). The authors suggested that clients being able to engage with the therapists model of reality appeared to be contingent on leaving more distressing explanations behind and meant clients could 'progress' in therapy. The authors found that clients '*letting go*' of the distressing belief was key, not just the clients ability to consider alternative explanations.

Dilks, Tasher & Wren (2008) investigated therapy processes in psychosis. One process they identified was '*negotiating shared understandings.*' This was defined as the therapist and client negotiating a shared view during the course of a conversation through dialogue. The



authors found this negotiation led to the opening up of new possibilities for thinking, feeling or acting in relation to areas of distress. One client in the research felt this was a joint process:

*It's like finding the answers together. Do you see what I mean? Resolving it together. Like he'll [psychologist] help you, he'll come up with an idea, you say 'Well not really, that doesn't work for me, that [other idea] might do' and he somehow channels it in. You don't actually have the answer but it takes two of you to find it.*

### 6.3 Continuity and 'holding on'

McGowan, Lavender & Garety (2005) found that in the group of clients considered to have progressed in therapy 'continuity in therapy' was important. One therapist described how his client had continuity:

*He remembered things I was saying and considered them between times.*

The authors suggest that the ability to 'hold on' to the therapy (e.g., content and things discussed) was an indicator of being able to progress and succeed within a CBT framework. Related to this is the author's finding that those clients who progressed in therapy were able to both identify and operationalise the changes they felt had occurred during therapy (i.e. say what the changes were and how they worked).

#### 6.4 Education & therapeutic techniques

Dunn, Morrison & Bentall (2002) investigated clients' experiences of homework tasks. Four clients in this investigation outlined how they felt the homework tasks were a help in therapy as it helped them gain a greater understanding and facilitated client's ability to challenge thoughts. Client number 3 said:

*I've learnt how to think about everything different...I'd achieved something that I didn't think I could do... If they say something weird to me and I think it's weird I know it's just a coincidence you know as if I'm the professional.*

Dilks, Tasher & Wren (2008) found that clients in their study felt being able to process distress was facilitated by the client and psychologist structuring distressing experience in a conversational account. This allowed distress to become the object of observational activities. One client felt this helped them to act differently outside of the therapy context:

*Since talking with Louise [psychologist] I've now understood that some of the thoughts that have been at the back of your mind...has affected you in such a way that it was affecting human relationship...and affect your outlook about life and positive way of doing things...when such thoughts try to cross um in my mind and say 'oh you've been through this, you've been through that', [I] kind of dismiss it, unlike before when I would spend time thinking about it.*

In Chadwick, Williams and McKenzie's study into the impact of case formulation in CBT for psychosis they found that therapists felt their case formulations increased their understanding of the client's problems.

### *6.5 Group Interventions*

#### *I: Increasing social interactions and feeling understood*

Sibitz *et al* (2007) investigated patients' perspectives on what works in psychoeducational groups for schizophrenia. Participants in their study felt the group had led to a reduction of isolation and increased social interaction and better coping. Particularly important was getting to know people who also had schizophrenia (learning that other people had similar problems) and hearing how others dealt with the problems they experienced. Participants identified that getting '*emotional support and understanding*' from other group members was key in facilitating positive change.

Newton *et al* (2007) investigated people's experience of a therapy group for auditory hallucinations. One theme which emerged from their analysis was '*a place to explore shared experiences.*' This included important elements such as a 'safe' place to talk, a place which was 'normalising and destigmatising', 'learning from and helping others and 'the role of the facilitators.' Like in the Sibitz *et al* (2007) study, participants interviewed by Newton *et al* identified the primary utility of the group as providing a place they can share experiences, one participant said:

*I was talking to people who have similar experiences to myself, so it was quite helpful to understand and see the similarities between cases – which was quite remarkable how similar it was*

The young people who attended the group also felt they preferred to talk to people with similar experiences to themselves and they reported that had positive consequences (e.g., reducing isolation and loneliness). One participant also stated meeting other voice hearers meant they no-longer felt ‘crazy’ as they knew other people had the same problem. Participants also felt that peers with similar difficulties were more able to understand and empathise with their difficulties than their family or friends and this meant they were more able to provide them with more meaningful support. This was also the finding by Goodliffe *et al* (2010). In this research, participants highlighted the importance of being able to share experiences with others similar to themselves. Like in the Newton *et al* (2007) investigation, the authors found participants valued the group environment as it provided normalisation and validation for their experiences.

## *II: Influence of facilitators*

Participants in Goodliffe *et al*'s (2010) investigation felt the facilitators prioritising their views (not the views of ‘experts’) allowed them to feel valued and supported within the group. Sibitz *et al* (2007) found that participants felt the ‘openness of the group facilitator’ was also key for the group intervention, as was the information being presented from professionals, which was important for orientation and self-management.

### *III: Feeling Safe and Contained*

Participants in Goodliffe's research felt the group was 'safe' and containing and that meant they were able to share experiences. One participant talked about the structure of the group being important to achieve the feeling of safety:

*Sometimes there might only be two or three of you, and other times there would be lots of you, and it's very difficult because you don't know how many. Whereas with this group you know how many there are all the time. And you get to know each other well.*

### *III: The group itself*

Goodliffe *et al* (2010) found that actually being in the group format itself helped had a beneficial effect for decreasing the power of voices. The authors found that during the course of the group, members described a change in the way they perceived themselves in relation to their voices. Participants felt that by listening to other group members and making their opinions a priority, authority was shifted away from the voices

### *V: Stage of Recovery*

A finding from Newton *et al* (2007), which appeared to facilitate change, was having group members at different stages of recovery. Some group members seemed to benefit from observing the improvement in others, which provided hope and encouragement. Sibitz *et al* (2007) explored prerequisite factors for people to benefit from the seminar and identified 'illness state' (being stable not ill) as being important to benefit from a group intervention.

What are the barriers to change?

### *6.6 Thinking 'logically' and Cognitive Behavioural Therapy*

In McGowan, Lavender & Garety (2005) two therapists talked about the value of clarity of thought, and of being able to help clients to think more clearly (these were clients who were thought to progress in therapy). One therapist felt the client's inability to think logically hindered their progress in therapy:

*Reflecting on your experiences for cognitive therapy requires some capacity to kind of think through things at kind of semi-logical level anyway...and I just really don't think [client] could do that.*

Dilks, Tasher & Wren (2008) found that a barrier to change was when clients got 'stuck' in immediate experience and therefore were unable, at that point, to take an observing position in relation to their distress and concern. The authors suggested the effect appeared to be one of reducing access to the shared (negotiated) view of the world.

### *6.7 Timing & rationale*

Messari & Hallam (2003) found that clients switched between the '*this is truly happening*' and '*I am ill*' discourses. One participant in Messari & Hallam's (2003) study stated they found therapy unhelpful as they did not understand the purpose of it.

### *6.8 Not moving towards a shared model or understanding*

In McGowan, Lavender & Garety (2005) several therapists felt the barrier to their clients progressing in therapy was related to them holding two explanations simultaneously and not

being able to accept one (e.g., the illness model), or indeed sliding into multiple explanations.

One therapist stated about his client:

*He's quite happy with this twin track explanation that what the problem is that he has a mental illness and there are evil spirits attacking him*

Therapists felt the clients who did not make progress were able to hold views that appeared contradictory without feeling they were contradictory (e.g., a supernatural model and an illness model).

Therapists also felt that clients and therapists not developing a shared task was also a barrier to change and progress. One therapist wrote:

*Despite my continued asking of him what he wanted, I felt that he was talking the talk... it wasn't necessarily an alliance in that sort of mutual sense that both of us knew that there was work to do*

A similar theme also emerged where therapists in the McGowan, Lavender & Garety (2005) investigation felt that a barrier to change may have been that clients had a different agenda to the therapist. The authors conclude that overall, their results suggested that failure to progress in therapy was related to a difficulty in entering the therapist's frame of reference.

### *6.9 Specific therapeutic techniques*

Pain, Chadwick and Abba (2008) investigated clients' experience of case formulation in psychosis. They found that some clients did not like the case formulation, and this could be a barrier to change.

Likewise in Chadwick, Williams and Mackenzie's (2003) investigation into the impact of case formulation in psychosis they found that six clients reported a negative emotional response to the formulation. Some described their experiences as saddening, upsetting and worrying with one person saying:

*My problems seemed so long-standing, I didn't realise they went back to me childhood.*

Dunn, Morrison & Bentall (2002) looked at the experience of completing homework. When talking about non-completion of homework once client said '*they might have just said I was a time waster, just wasting time playing around.*'

### *6.10 Cognitive abilities of the clients*

A major barrier identified by clients in Dunn, Morrison & Bentall's (2002) investigation was their memory. Six clients in the research commented they were unable to complete the homework due to having a bad memory. One client also talked about thinking about not attending their therapy session as they had not completed their homework.



Linked to memory problems is the idea of concentration. Sibitz *et al* (2007) found a barrier for clients to progress within a group format was that some participants had difficulty concentrating and therefore missed information and interactions.

### *6.11 Continuity and holding on*

Therapists in the McGowan, Lavender & Garety (2005) felt that a barrier to change was where there was an absence of continuity, in one case the therapist described how continuity was initially extremely difficult as the client was unable to maintain the idea that the therapist was a permanent object who would return:

*It's only relatively recently after a year and a half of working with him that he thinks I might come back. Previously he thought that a missed session was me gone. And he would be really shocked when I returned.*

### *6.12 Chapter Summary*

This chapter identified facilitators and barriers to change. The facilitators were clients understanding what needed to change and then moving towards an illness model. Clients' ability to remember sessions was also an indication of positive change. Other facilitators including feeling understood, feeling safe and entering the intervention at the appropriate time. Therapeutic techniques were found to be both facilitative and a barrier to change. Other barriers included clients not being able to think 'logically', not moving to a shared understanding of psychosis and an absence of continuity.

## **7. Discussion**

### *7.1 Considerations of quality*

All the research papers were assessed for quality issues in the domains of sensitivity to context, commitment and rigour, transparency and coherence and impact and importance (see appendix 1). All papers were felt to be methodologically robust enough for inclusion in the review. Research quality in each of the domains assessed varied from paper to paper, and no paper reviewed was deemed to be exceptional quality on all domains. Conclusions drawn from the research should therefore be treated with caution.

### *7.2 What is it like to provide or receive psychological interventions for psychosis?*

Clients felt listened to and many identified with the respectful nature of therapy. For some clients this was in stark comparison to other interventions they had received. Clients also experienced interventions as educational; they were able to learn about themselves and about psychosis from the clinician. The psychoeducational components of interventions therefore seemed to be important. Interestingly, clients highlighted they were aware of the therapist not being neutral, and that therapists had their own agenda, even when therapists had stated they were willing to think about a range of explanations from the clients experiences. Clients understood this as the therapist trying to convince them that their experiences were part of an illness, rather than another explanation (for example a spiritual or extra-terrestrial understanding).

Group interventions provided experiences that were different to individual interventions. Some clients felt there were able to contribute to the group and share experiences and

knowledge with other people. In group interventions clients also felt part of the group and for some this was their first experience of feeling similar to others. The group intervention may therefore provide normalisation and help clients to feel that they are not alone in experiencing psychotic phenomenon and the associated distress, isolation and stigma.

Clinicians reported feeling positive when their work was validated. One format for achieving this was via case formulation. Importantly, having formulations validated by clients also increased clinicians' confidence in the model of therapy. Research has found that clinician confidence in the therapeutic model is one of the key factors in successful therapy (Orlinsky, 2004). Some clinicians experienced a transformation when delivering therapy and felt that they had learnt from their patients. Clinicians employing cognitive-behavioural therapy experienced their approach as collaborative, even though they had a specific agenda which may have been different to that of the clients.

### 7.3 Engagement and therapeutic alliance

An important factor in engagement was identified as the wider context. In individual therapy this may be engaging in order to 'co-operate' with the establishment (in inpatient settings). In group contexts this may be meeting with others similar to themselves (e.g. age and experiences). Research reviewed here suggested that developing a shared task and having a good relationship aided the therapeutic alliance, with specific therapy tasks (such as homework and case formulation) potentially blocking the alliance. There was little information on therapeutic alliance and readers are directed to Evans-Jones *et al* (2009) for further information.

From the research reviewed it was evident that there were gaps in the data regarding engagement. There was no information on how engagement was developed or maintained, and given that the client group can be hard to engage, this information would have been useful. A further consideration is that it may be hard to assess engagement as people have already agreed to the intervention. One question may be, were those who did not agree to the intervention less engaged? It is acknowledged that engagement wasn't the central question in this review and therefore papers selected did not focus on engagement in psychosis. The reader is directed to Lecomte *et al* (2008) and Priebe *et al* (2005) for research into engagement with this client group.

#### 7.4 How is psychosis understood?

Within the UK, current understandings of psychosis are prevailing that it is an illness, although there are differing explanations of how and why this illness develops and how it is maintained (e.g., biopsychosocial frameworks like the stress-vulnerability model, Zubin & Spring, 1977; Strauss & Carpenter, 1981 and the dopamine hypotheses; Carlsson & Carlsson, 1990). However, the idea that people need to take medication for psychosis, as it is a form of 'madness,' prevails. There has been a shift over the past few decades in the treatment of psychosis, and psychological treatments (predominantly CBT) have emerged as essential and effective interventions for distressing psychotic phenomenon (Fowler, 1992; Haddock, Bentall, 1996; Kingdon & Turkington, 1991; Kuipers *et al*, 1997). A psychological understanding of psychosis has led to a shift in focus from treating 'symptoms' to developing psychological formulations and working with the distress that people experience. However, there is still the idea that psychosis is an illness and therapists hold this view in mind when working with clients. The idea that psychosis is an illness is given preference over other

explanations offered by clients (e.g., a supernatural explanation). Clients may therefore not feel understood by their therapist given their personal beliefs.

One of the research papers reviewed conceptualised psychosis differently. The author Laufer (2010) worked and conducted his research in the USA. He described psychosis as an ‘interpersonal disorder’, rather than a biological one. He felt that people with psychosis were ‘like us’, not biologically different and cited that as a reason why psychological therapy is not largely advocated in the USA (because accepting that people with psychosis are ‘like us’ is threatening and scary). Therapists in this research highlighted how they had learnt from their patients and how they felt they had grown as people. Their model of therapy was from a psychodynamic orientation and their experiences were very different to therapists using CBT. Psychodynamic therapists talked about learning from clients and having a transformative experience, whereas CBT therapists talked of convincing clients to accept an illness model.

From the client’s perspective, group interventions provided participants with the opportunity to dispel some of their prejudices around mental illness. Some clients felt their negative stereotypes of people with mental health problems were challenged following the group intervention.

### 7.5 Facilitators and barriers

Several facilitators for change were identified from the reviewed research. One facilitator was clients having an understanding of what needed to change, and being able to move towards an illness model. Elements which helped to move towards a shared understanding were the client’s ability to remember sessions and having continuity across the therapy

sessions. Other facilitating elements included the clients feeling understood, feeling safe and entering the intervention at the appropriate time. Therapeutic techniques (in CBT) were found to be both facilitative and a barrier to change. Other barriers included clients not being able to think 'logically', poor cognitive skills, not moving to a shared understanding of psychosis and an absence of continuity. Since thinking logically and cognitive skills are important in CBT, problems in these domains are obvious barriers to change.

### 7.6 The influence of power

It is important to reflect on where the articles in this review were published as this could have biased results. 9 papers were published in UK journals and 1 paper published in a European journal. All journals published predominantly research from the field of clinical psychology and psychotherapy. 5 papers were published in British Psychological Society journals. In the UK at present there is a CBT dominance, this is both within the field of psychosis (as evident in the NICE guidance recommendations) and also the wider field of psychological therapies (e.g., Increasing Access to Psychological Therapies (IAPT) where CBT is the main therapeutic model being taught and delivered). Therefore there is an inherent bias in the research reviewed, as research was published in UK journals which are likely to be dominated by the CBT model. Only 1 paper identified used a different therapeutic model and that was conducted in the USA. CBT is therefore a powerful model with Department of Health and NICE backing. This dominance possibly restricts research utilising other models from being conducted and/or published.

It is also essential to consider the experience of psychological interventions within the context with which they occur. The impact of being an inpatient is particularly important here as

clients in the Messari & Hallam (2003) talked about ‘conforming’ and engaging in therapy as want to ‘get out.’ Minimising the power dynamic in therapy and creating a collaborative relationship is often a goal and this may be intensified in situations where people are required to ‘conform’ in order to be able to leave an institution.

Therapists practicing CBT talked about the collaborative nature of the intervention when they were attempting to modify clients’ beliefs and move them towards an illness model. Such ‘modification’ discourses are not collaborative because therapists have an ultimate agenda and are not neutral. Furthermore, some clients are aware of the position the therapists have taken (e.g., therapist agreeing to look at both explanations; ‘I am ill’ and ‘this is real’, but they have the ultimate aim of promoting the ‘I am ill’ explanation). There are clear ethical issues in attempting to modify someone’s beliefs without their explicit knowledge and consent, such issues have been explored by Nelson (1997). This may be difficult for the therapist to reconcile when working with clients, and clients may feel they are unable to trust their therapist.

The research reviewed highlighted negative consequences of specific tasks within the CBT framework. For example powerlessness was experienced with requests for clients to complete homework. Homework has been described as essential in CBT, not an optional extra (Beck *et al*, 1979). If someone does not complete the homework set for them what does this mean? Some clients felt that they have failed, and attributed their failure to internal characteristics (they were ‘lazy’, or had a ‘bad’ memory) rather than external characteristics, for example the therapist had asked them to do too much or the intervention was not at the correct time. The dynamic created between the therapist and the client when asked to complete these tasks

is also important as this may be a repetition of previous relationships (e.g., parent/child; teacher/student), in which the client has felt disempowered and/or distressed.

In a group intervention, clients talked about now having ‘power’ over the voices. Clients felt they had more agency over the voices after the group sessions and the techniques they were taught. Clients are unlikely to experience this agency and control if they had a medical intervention (medication), where they are likely to conceptualise themselves as ‘ill’ and having no/limited control over how they feel about the voices.

### 7.7 Clinical implications

It is important to situate the sample of CBT studies within the context of developments within the field. In recent years a generic cognitive model has been applied to the understanding of treatment for psychosis (Morrison, 2010). Such models suggest that interpretations are influenced by our core beliefs (formed as the result of life experiences), and such interpretations will have consequences for how people feel and behave (Beck, 1976). Developments within the field have led to further cognitive models being developed, which place a greater emphasis on the way people interpret events being central to their distress and disability, rather than the psychotic experiences themselves (Chadwick et al, 1994; Garety *et al*, 2001; Morrison, 2001). Further developments in the field are now incorporating mindfulness-based CBT for psychosis, of which there is a growing body of evidence for its effectiveness in reducing distress (Chadwick *et al*, 2005; Taylor *et al*, 2009). CBT for psychosis is therefore a rapidly changing field with the approaches identified as effective in quantitative research being rolled out by clinicians in mainstream clinical practice. The studies assessed in this review may therefore be relatively ‘old’ given the fast moving pace of



this area, and findings should be considered within the context of the type of CBT undertaken at that time.

Recently researchers have also begun to look at the important components of CBT in psychosis, given the large variety of approaches and conceptual underpinnings (Morrison & Barratt, 2010). This need to explore components is evidence of a wide variety of CBT approaches and practices. This new line of research is assessing the ideas of CBT practitioners, and is important to also include the opinions and experiences of service users receiving CBT for psychosis.

There has been a shift from treating the symptoms of psychosis to addressing the distress people may experience. Currently the NHS is moving towards Payment by Results (PBR) which measures and advocates treatment on the basis of symptoms. A psychological model may therefore not fit with this new approach given the move away from the treatment of symptoms in psychosis, to the treatment of distress. Furthermore clients have identified being treated as 'human', respected and as an individual's as important factors in their treatment. This is incongruent to the national and service level top-down approach which seeks to reduce people to diagnostic labels with treatment tariffs and prescriptive approaches. Clinicians will have to be mindful of these different ideas and approaches when working within a service structure such as the NHS.

Messari & Hallam (2003) found that clients switched between the '*this is truly happening*' and '*I am ill*' discourses. Research has found that conviction in delusions may fluctuate over time (Brett *et al*, 1987). They also found that the timing was important and clients were able to engage in the intervention when they were not actively psychotic. The timing of interventions is important and clinicians should fully assess people and consider the timing

of the intervention. McGowan, Lavender & Garety (2005) found that in the group of clients considered to have progressed in therapy '*continuity in therapy*' was important. This 'continuity' therefore is important for clinical practice and the impact of missed sessions (e.g., due to sickness, did not attend and planned breaks) should be considered. Chadwick, Williams and Mackenzie (2003) found that some clients experienced a negative emotional response to seeing their longitudinal case formulation. Seeing the formulation left some clients feeling sad and distressed that their problems were long standing, this may have left them feeling hopeless that things can change. Clinicians should be mindful of the negative impact of sharing formulations (especially those of a longitudinal nature) with clients.

Group interventions were experienced by clients as very positive; they were normalising, and provided a space for people often isolated to meet others. Clients felt truly understood by group members, something they may not have experienced previously. Clients also talked about having their own prejudices about mental health challenged. Clients stated that they learnt from others but also had the opportunity to share knowledge and experience. This led to people having a positive experience which increased their self-esteem. Group interventions seemed to provide social and emotional support. Social support has been found to moderate stress (Cobb, 1995). As stress is an important factor in psychosis (Zubin & Spring, 1977, Nuechterlein & Dawson, 1984) group interventions may provide a barrier to stress via the interactions of group members who feel understood and supported by their peers. Group interventions therefore seem an appropriate way to engage people, share information and offer psychological-based interventions.

### 7.8 Further research

Convictions in delusions fluctuate over time and this is an important factor in therapy since facilitators for change have been identified as being able to move to the therapists' frame of reference (psychosis as an illness). It is not clear if this being measured, and future research could attempt to measure fluctuations in delusions and the impact this has on psychological interventions. From a methodological perspective most of the papers reviewed did not provide in-depth analysis and lacked a deeper reflection on the context in which the interventions were conducted. This would be helpful when thinking about the influence of power. Finally, the research reviewed here did not focus on the therapeutic relationship; interestingly we know this to be one of the most important elements for change in psychological therapy (Orlinsky, 2004). Therapeutic relationship was not the key area of interest within the papers. It is noted that investigations into CBT for psychosis are now including measures of therapeutic relationship to assess this important variable. It would be very interesting to explore this in more detail, as this seems to be missing from current research in the field.

## References

- Beck, A.T. (1976). *Cognitive Therapy and the Emotional Disorders*. New York: International Universities Press.
- Bentall, R.P. (1996) From cognitive studies of psychosis to cognitive behaviour therapy for psychotic symptoms. *Cognitive-Behavioural Interventions with Psychotic Disorders*. Routledge.
- Brett-Jones, J., Garety, P. A., & Hemsley, D. (1987). Measuring delusional beliefs: A method and its application. *British Journal of Clinical Psychology*, 26, 257-265.
- Carlsson, M. and Carlsson, A. (1990). Schizophrenia: A Sub cortical Neurotransmitter Imbalance Syndrome? *Schizophrenia Bulletin*, 16, (3), 425 – 430.
- Chadwick, P., Williams, C. & Mackenzie, J. (2003). Impact of case formulation in cognitive behavioural therapy for psychosis. *Behaviour Research and Therapy*, 41, 671-680.
- Chadwick, P., Taylor, K. & Abba, N. (2005) Mindfulness Groups for People with Psychosis, *Behavioural and Cognitive Psychotherapy*, 33: 351-359.
- Cobb, S. (1995). Social Support as a Moderator of Life Stress. In Maxwell Eward, A (Eds) *Toward an Integrated Medicine: Classics from Psychosomatic medicine* (pp. 337-398). American Psychiatric Press. Washington.
- Davidson, L. (2003). *Living outside mental illness: Qualitative studies of recovery in schizophrenia*. New York: New York University Press.
- Dickerson, F. B. (2000). Cognitive behavioural psychotherapy for schizophrenia: A review of recent empirical studies. *Schizophrenia Research*, 43, 71-90.
- Dilks, S., Tasker, F. & Wren, B. (2008). Building bridges to observational perspectives: A grounded theory of therapy processes in psychosis. *Psychology and Psychotherapy: Theory, Research and Practice*, 81, 209-229.

Drury, V, Birchwood, M., & Cochrane, R. (1996). Cognitive therapy and recovery from acute psychosis: A controlled trial I: Impact on psychotic symptoms. *British Journal of Psychiatry*, *169*, 593-601.

Dunn, H., Morrison, A. & Bentall, R. P. (2002). Patients' experiences of homework tasks in cognitive behavioural therapy for psychosis: A qualitative analysis. *Clinical Psychology and Psychotherapy*, *9*, 361-369.

Evans-Jones, C., Peters, E. & Barker C. (2009). The therapeutic relationship in CBT for psychosis: client, therapist and therapy factors. *Behavioural & Cognitive Psychotherapy*. *37*(5), 527-540.

Fowler, D. (1992). Cognitive behavioural therapy in the management of patients with schizophrenia: Preliminary studies. In A. Werbart & J. Cullberg (Eds.) *Psychotherapy of schizophrenia: Facilitating and obstructive factors* (pp. 145-153). Oslo: Scandinavian University Press.

Fowler, D., Garety, P., & Kuipers, E. (1995). *Cognitive behavioural therapy for psychosis*. Chichester, UK: Wiley.

Goodliffe, L., Hayward, M., Brown, D., Turton, W. & Dannahy, L. (2010). Group person-based cognitive therapy for distressing voices: Views from the hearers. *Psychotherapy Research*, *20*(4), 447-461.

Haddock, G., Bentall, R. P. & Slade, P. D. (1996). Psychological treatment of auditory hallucinations: Focusing or distraction? In G. Haddock & P. Slade (Eds.), *Cognitive behavioural interventions with psychotic disorders* (pp. 45-70). London: Routledge.

Jones, K. (2004). Minimalist passive interviewing technique and team analysis of narrative qualitative data. In F. Maggs-Rapport (Ed.), *New Qualitative Methodologies in Health and Social Care*. London: Routledge.

Kingdon, D. G., & Turkington, D. (1991). The use of cognitive behavioural therapy with a normalising rationale in schizophrenia. *Journal of Nervous and Mental Disease*, 179, 207-211.

Kuehl, B. P., Newfield, N. A., & Joanning, H. (1990). Toward a client-based description of family therapy. *Journal of Family Psychology*, 3(3), 310-321.

Kuipers, E., Garety, P., Fowler, D., Dunn, G., Bebbington, P., Freeman, D., & Hadley, C. (1997). The London-East Anglia randomised controlled trial of cognitive-behavioural therapy for psychosis: I. Effects of the treatment phase. *British Journal of Psychiatry*, 171, 319-327.

Laufer, B. (2010). Beyond countertransference: Therapists' experiences in clinical relationships with patients diagnosed with schizophrenia. *Psychosis*, 2(2), 163-172.

Lecomte, T., Speidel, A., Lecterc, C., MacEwan, G. W., Greaves, C. & Bentall, R. P. (2008). Predictors and profile of treatment non-adherence and engagement in services problems in early psychosis. *Schizophrenia Research*, 102 (1), 295-302.

McGowan, J. F., Lavender, T. & Garety, P. A. (2005). Factors in outcome of cognitive-behavioural therapy for psychosis: Users' and clinicians' views. *Psychology and Psychotherapy: Theory, Research and Practice*, 78, 513-529.

Messari, S. & Hallam, R. (2003). CBT for psychosis: A qualitative analysis of clients' experiences. *British Journal of Clinical Psychology*, 42, 171-188.

National Institute for health and Clinical Excellence (NICE) guidelines (2009). Schizophrenia, quick reference guide.

Nelson, H. E. (1997). *CBT with Schizophrenia: a practice manual*. Cheltenham, UK: Stanley Thornes.

Newton, E., Larkin, M., Melhuish, R. & Wykes, T. (2007). More than just a place to talk: Young people's experience of group psychological therapy as an early intervention for auditory hallucinations. *Psychology and Psychotherapy: Theory, Research and Practice*, 80, 127-149.

Nuechterlein, K. and Dawson, M. E. (1984) A Heuristic Vulnerability-Stress model of Schizophrenia *Schizophrenia Bulletin*, 10,300-12

O'Toole, M. S., Ohlsen, R. I., Taylor, T. M., Purvis, R., Walters, J. & Pilowsky, L. S. (2004). Treating first-episode psychosis – the service-users perspective: A focus group evaluation. *Journal of Psychiatric and Mental Health Nursing*, 11, 319-326.

Orlinsky, D. E., Ronnestad, M. H., & Willutski, U. (2004). Fifty years of psychotherapy process-outcome research: Continuity and change. In M. J. Lambert (Ed.) *Handbook of psychotherapy and behaviour change* (5th Ed.). New York: John Wiley & Sons.

Pain, C., Chadwick, P. & Abba, N. (2008). Clients' experience of case formulation in cognitive behavioural therapy for psychosis. *British Journal of Clinical Psychology*, 47, 127-138.

Priebe, S., Watts, J., Chase, M. & Matonov, A. (2005). Process of disengagement and engagement in assertive outreach patients: qualitative study. *British Journal of Psychiatry*, 187, 438 – 443.

Rennie, D. L. (1994). Clients' accounts of resistance in counselling: A qualitative analysis. *Canadian Journal of Counselling*, 28(1), 43-57.

Sibitz, I., Amering, M., Gossler, R., Unger, A. & Katsching, H. (2007). Patients' perspectives on what works in psychoeducational groups for schizophrenia. *Society, Psychiatry, Psychiatric Epidemiology*, 42, 909-915.

Strauss, J. S. & Carpenter, W. T. (1981). *Schizophrenia*. New York: Plenum. Smith, J. A, Flowers, P, & Larkin, M. (2009). *Interpretative Phenomenological Analysis: Theory, Methods and Research*. Sage.

Tarrier, N., Beckett, R., Harwood, S., Baker, A., Yusupoff, L., & Ugarteburu, I. (1993). A trial of two cognitive-behavioural methods of treating drug-resistant residual psychotic symptoms in schizophrenic patients: I. Outcome. *British Journal of Psychiatry*, 162, 524-532.

Taylor KN , Harper, S, Chadwick, P (2009). Impact of Mindfulness on Cognition and Affect in Voice Hearing: Evidence from Two Case Studies *Behavioural and Cognitive Psychotherapy*, 2009, 37, 397–402

Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology and Health*, 15(2), 215-228.

Zubin, J. & Spring, B. (1977). Vulnerability: a new view of schizophrenia. *Journal of Abnormal Psychology*, 86, 103-126.



## **The Experiential Impact of Hospitalisation in Early Psychosis**

## **Abstract**

*Background:* We know that psychiatric hospitalisation can be distressing (Morrison *et al*, 1999), and can have a negative impact on self-esteem (Bers *et al* 1993). Early Intervention in Psychosis services aim to keep young people out of hospital by providing community based services. Nevertheless people with an early psychosis may require hospitalisation. Little is known about the impact of hospitalisation on people where they are likely to have been hospitalised in a crisis and may have had the expectation that hospitalisation was unlikely given the ethos of the services supporting them.

*Aims:* The research aimed to gain an understanding of what it was like for young people to be hospitalised. A secondary objective was to identify both positive and negative elements of hospitalisation and feed these back to the service to aid service development and improvement.

*Method:* The research made use of Interpretative Phenomenological Analysis (Smith *et al*, 1999), which is a qualitative approach concerned with the opinions, experiences and feelings of individuals.

*Results:* Findings showed participants' had a variety of experiences of hospitalisation. The themes which emerged were: '*So, where are you taking me?*', which explored the meaning of having no explanations, the '*Mixed perceptions of the hospital*', which sought to understand what it was like when on the ward and '*The challenge of making meaning,*' which explored the participants' attempts to work out where they fitted in terms of the hospital and wider society, and what it meant to them to have a mental health episode.

*Conclusions:* Hospitalisation can be experienced as both positive and negative. Changes to the process could include providing more information to people being hospitalised and providing a more consistent and therapeutic ward environment.

## **1. Introduction**

Thornhill *et al* (2004) have described psychosis as “experiences such as hearing voices other people do not hear, seeing or sensing things other people do not see or sense, holding unusual beliefs (delusions) or beliefs about malevolent intention of others which seem unwarranted (paranoia).” Over a lifetime it is estimated about 1% of the population will develop psychosis (NICE, 2009). The average age of onset for men is in their early 20’s with onset occurring slightly later in women.

Young people with a psychosis are often supported by Early Intervention Services (EIS) and services aim to keep people out of hospital and to foster recovery through a range of psychosocial, occupational and medical interventions. Interventions are therefore community based, with people being seen in their own homes or clinic rooms within their local area. There are times however when young people with psychosis will require a hospital admission due to their mental health. Previous research has found that psychiatric hospitalisation can be distressing and even traumatising (Morrison *et al*, 1999; Meyers *et al*, 1999). Little is known however about the impact of hospitalisation on people where they are likely to have been hospitalised in a crisis and may have had the expectation that hospitalisation was unlikely given the ethos of early intervention services. Understanding what the impact of hospitalisation is for these young people will be the focus of the research.

### *1.1 Experiences of Inpatient Mental Health Care*

Client experiences of inpatient mental health services have been investigated by a range of authors. Myers *et al* (1990) investigated the views of 258 patients in four English psychiatric hospitals. The authors found that 63% of patients would prefer to be nursed in a single sex

ward, and 45% had experienced a delay in accessing their own money when hospitalised. 65% of participants in their sample made negative comments regarding their experiences of inpatient care. Participants highlighted dissatisfaction with experiences including not having access to doctors, trainee nurses not being mature enough to provide 'real' help, staff being 'too jolly' and the feeling of not having any freedom.

Morrison *et al* (1999) found that 44% of people who had been admitted to an inpatient psychiatric ward exhibited levels of post-traumatic stress disorder (PTSD). The authors also found that PTSD symptoms were higher in patients without a history of compulsory admissions to hospital. Along with psychiatric wards being associated with PTSD, there is some evidence of the ward experience negatively affecting self-esteem (Warner *et al*, 1989; Roe, 2003). Roe (2003) suggests that some forms of treatment (such as hospitalisation) convey a powerful negative statement about competence and thus pose a challenge to individuals' self-esteem. Bers *et al* (1993) reported that self-descriptions of adolescent patients living in a psychiatric facility were negative when compared to controls. Warner *et al's* (1989) research highlighted that self-esteem was particularly low among those who perceived high levels of stigma attached to their mental health issues.

Hansson *et al* (1993) investigated patients' views of ideal inpatient care. They found that patients placed the highest emphasis on empathic staff. This included staff being caring, being interested in patients, trying to understand patients, respecting people, devoting time to patients and creating a safe treatment environment. The patients in this investigation placed the least importance on the characteristics of the physical environment and daily routines of the ward. Goodwin *et al* (1999) assessed 110 service user views of inpatient mental health

care and also found that patients place a high value on a sense of being cared for and expressed gratitude to staff that were approachable, kind and sympathetic.

Whilst psychiatric hospitalisation is understood to be distressing for the individual experiencing the psychotic episode there are few studies that examine the psychological effects and the phenomenological experience of such admissions. In Hardcastle *et al's* (2007) book, narrative accounts of the experiences of mental health inpatient care are collected. Chapter 6 'feeling out of control' tells the story of Kevin, a patient who describes being confused and disorientated when in hospital. Kevin wrote how his '*admission into the old asylum was frightening because I did not understand why I had to be there.*' Kevin also talked about the importance of learning about himself from other patients through group work and interactions on the ward. Other themes within the narratives included patients feeling there was a lack of interaction with staff and a feeling that staff did not spend time getting to know them. People also talked about the physical environment, particularly the 'mix' of people on the wards (and people with different diagnoses) and the effect this had on patients. The effect was that people would 'feed off' off one another when they were 'high' (in a state of mania). When feeling low or depressed, having to be around people who are high was very distressing. Some narratives also made a comparison across time, when some people had the experience of being a patient in old asylums and more recent experience of the new hospital wards, with people feeling more restricted on the newer wards.

O'Toole *et al* (2004) investigated service user views of community based first episode psychosis services. The researchers found that patients were complimentary of the EI service but held negative views of their experience of inpatient psychiatric care. Participants

described inpatient care as ‘horrible,’ ‘scary,’ ‘depersonalising’, and a place where ‘opinions didn’t matter.’ Furthermore, the participants felt their inpatient care experiences were associated with high perceived stigma (defined by Goffman, 1963 as 'the process by which the reaction of others spoils normal identity'), labelling (where people are defined by their behaviours, Becker, 1973) and exacerbation of symptoms. This was in contrast to the community based service where participants felt they strongly identified with the service philosophy and goals, and attributed their recovery to the positive nature of the treatment they had received.

### *1.2 Interpretative Phenomenological Analysis and Research in Psychosis*

The study made use of Interpretative Phenomenological Analysis (IPA) (Smith *et al*, 1999), which is a qualitative approach concerned with the opinions, experiences and feelings of individuals. The approach is committed to the examination of how people make sense of their major life experiences. IPA is phenomenological as it is concerned with exploring experience in its own terms. It is also interpretive and informed by hermeneutics (the theory of interpretation, Husserl, 1982). IPA takes the stance that human beings attempt to make sense of their experiences and therefore the accounts which participants provide will reflect their attempt to make sense of their experience (Smith, Flowers & Larkin, 2009). The researcher therefore searches for the meaning the experience had for the participant.

Interpretative Phenomenological Analysis (IPA) has been employed to investigate a variety of experiences within psychosis. Perry *et al* (2007) investigated patient experiences of ‘hope’ in first episode psychosis. The authors found that a search for meaning and a sense of belonging were crucial in maintaining hope, and hopelessness was associated with experiences of the

psychiatric hospital. The researchers found hospitalisation was associated with being treated without respect, not having control and having a lack of information about this process. The authors demonstrated the value of using IPA in helping to develop an understanding of a complex subject matter.

Knight *et al* (2003) used IPA to investigate stigma in psychosis. Themes identified in this research included 'judgement' which explored participants actual and anticipated reactions from others and how prejudice experienced by people in their research had effected their self-concept and daily experiences. A second theme was 'comparison' where participants compared their lives to others and highlighted how they had felt they had developed through having the experience of psychosis. The final theme was 'personal understanding of the issue', which focussed on mechanisms of coping.

Finally, Rhodes and Jakes (2001) used qualitative methods including IPA to investigate the correspondence between delusions and personal goals. By employing qualitative methodologies the authors found that an individual's delusions seemed to reflect their fundamental concerns. These investigations employing IPA methodology have shown how this method can explore complex phenomenon in great detail and add to our understanding of what it is like to have a psychosis. IPA was therefore thought to be the most appropriate method to employ for this investigation. This was due to the private and idiosyncratic nature of individuals' journeys of hospitalisation and the complex nature of events and experiences.

### *1.3 The Current Research*

This research is one part of a three-part study exploring the experience of hospitalisation from the perspective of the client, the family and the inpatient staff team. This research focused on the experiences of the clients and aimed to explore the views of people who have been hospitalised when experiencing an early psychosis. The research question was:

*What is the Experiential Impact of Hospitalisation in Early Psychosis?*

The research aimed to gain an understanding of what it was like for young people to be hospitalised. A secondary objective was to identify both positive and negative elements of hospitalisation and feed these back to the service to aid service development and improvement. It was hoped this would help services meet the requirements in the Government's Mental Health Strategy (No Health without Mental Health, 2011), which has the aim that 'More people will have a positive experience of care and support.'

## **2. Method**

Before the research was conducted full ethical approval was gained from the National Health Service Ethics Committee, please see Appendix 1 for letter of ethical approval.

### *2.1 Participants*

The aim of the research was to find a homogeneous sample of individuals for whom the research question was relevant. IPA researchers suggest the number of participants should be enough to provide a development of meaningful similarity and difference between cases (Smith *et al*, 2009). With this in mind a total of 6 participants were interviewed for the research. Participants were selected as they had the joint experience of being an inpatient on a mental health ward across the Coventry and Warwick locality, when they were experiencing



an early psychosis. As the research was concerned with the experiences of those who had an early psychosis, participants were sought from the Early Intervention in Psychosis service. Care co-ordinators in the Early Intervention team identified potential participants, and gave them an information sheet about the research. Participants wishing to take part in the research were then contacted by telephone by the researcher. Participants were not included if they were actively experiencing psychosis, were unable to speak English or were unable to consent for themselves as outlined in the Mental Capacity Act (2005). For participants, psychosis had emerged between 18 and 12 months before the interview. All participants were hospitalised under section. Two participants were hospitalised after being detained by the police, one participant presented at Accident and Emergency and was transferred to the mental health hospital the following day and three participants' hospitalisation was arranged via the early intervention in psychosis community team. Table 1 displays demographic characteristics of participants.

Table 1. Participant Demographic Information

<b>Name*</b>	<b>Age</b>	<b>Gender</b>	<b>Ethnicity</b>	<b>Number of admissions</b>	<b>Length of last admission</b>	<b>Current Vocational Status</b>	<b>Length of time since hospitalisation**</b>
Mark	22	Male	White-British	1	5 days	Employed	13 months
Simon	33	Male	White-British	1	21 days	Student (College)	6 months
Luke	18	Male	Mixed race (White-Afro Caribbean)	3	5 days	Student (College)	2 months
David	27	Male	White-British	1	8 days	Unemployed	5 months
Jason	20	Male	White-British	3	3 months	Unemployed	3 months
Karen	27	Female	White-Polish	1	4 days	PhD student	7 months

\*Names have been changed for confidentiality.

\*\*At interview

All participants had a diagnosis of first episode psychosis (ICD-10; F20). Participants gave written consent to take part in the research. A total of 10 people were approached to take part in the research, with 4 declining to participate. Of the Four people who declined to take part in the researcher three were male and one was female. Two people stated they did not want to 'go over' their experiences again and therefore did not want to talk about them with a researcher. The other two people gave no explanation, and just stated they did not want to take part. Since two participants had experienced multiple hospitalisations, participants were asked to talk about the last time they were hospitalised.

### *2.2 Data collection*

Interviews were conducted by the researcher in the participants' homes, as this was the most convenient location for participants. Participants were told the researcher was not part of the mental health team, or the inpatient hospital team and that the research was being conducted as part of a doctorate in clinical psychology. Interviews lasted between 30 and 90 minutes. All interviews were recorded using a Dictaphone and transcribed by the researcher.

### *2.3 Interview Schedule*

IPA studies require 'rich' data, meaning that participants should be granted the opportunity to tell their stories, speak freely, develop their ideas and express their concerns. In-depth interviews have tended to be the preferred means of collecting such data (Reid, Flowers & Larkin, 2005). A semi-structured interview schedule was therefore developed via consultation with research supervisors. Questions were open-ended, serving as prompts to lead the discussion. At the beginning of the interview, participants were asked to describe what they were experiencing in their lives shortly before their hospital admission. This aided

rapport building and helped participants to remember their journey and inpatient experience.

The discussion then focussed on five main areas. Questions for each of those areas were;

- *Can you tell me what it was like for you being in hospital?*
- *Can you tell me about any parts of your hospital stay you found helpful/unhelpful?*
- *Can you tell me what you think it was like for your family around this time?*
- *Can you tell me a little about how you spent your time in hospital*
- *Can you tell me what happened when you were discharged from hospital?*

Extra prompts were used where required to explore the participants' stories and to follow-up interesting areas of discussion. Questions were used as a guide only and a non-directive approach was adopted to allow participants to develop their own narrative around their experiences (please see Appendix 2 for interview schedule, participant information sheet and consent form).

#### *2.4 Analysis*

IPA was chosen as the method of analysis because it aims to undertake an examination of human experiences, and enables experiences to be expressed in participants' own terms, rather than via a predefined category system (Smith *et al*, 2009). Analysis in IPA is described as an 'iterative and inductive cycle' (Smith, 1996, 2007) where the analytic focus is directed towards the participants' attempts to make sense of their experiences. The analysis followed the detailed strategies for IPA which are outlined by Smith *et al* (2009). Strategies employed by the researcher in the analysis of the data were; line by line analysis of the experiential claims,

concerns and understanding of each participant; identification of emergent patterns in the data; and the development of a structure illustrating the relationship between themes. For validity checking, a subsample of the transcripts were read and coded by all members of the research team (the team included 3 trainee clinical psychologists, a clinical psychologist and an academic psychologist, who were experienced in IPA methodology. This revealed the appropriateness of the themes identified the clustering and the appropriate representation of original content with end categories (see Appendix 3 for initial table of themes extracted from the data).

### **3. Results**

Each transcript was analysed and transcripts were compared with each other to establish the dominant stories of participants' experiences. Comparisons contained both shared and contrasting experiences. Three over-arching super-ordinate themes were generated. These themes were entitled: *'So, where are you taking me? - The meaning of having no explanations'*, *'Mixed perceptions of the hospital'* and *'The challenge of making meaning'*. Each theme is presented in detail with extracts from the original transcripts. Each of the super-ordinate themes contains further subthemes which are explored after each main theme. In order to stay close to the data, extracts from participants are used throughout to ensure their voices are heard.

#### **3.1 Super-ordinate Theme 1: 'So, where are you taking me?' (Mark: Page 24, Ln, 380) – The meaning of having no explanations**

Participants provided rich accounts of their feelings of confusion, paranoia and fear when first encountering mental health systems and experiencing the process of hospitalisation. When

being transported from the general hospital to the psychiatric hospital Mark described asking the staff ‘*so, where are you taking me?*’ He did not get an answer to his question. It was this question which seemed to convey the sense of not knowing and getting no explanations that 5 out of the 6 participants described. Within this super-ordinate theme a further sub-theme emerged ‘*what is happening to me?*’ This related to how participants attempted to make sense of the changes happening within themselves.

Karen talked about being in a police cell and feeling ‘*terrible and majorly confused*’ (Page 2, Ln 29). Simon too had no sense of what was happening so was left worrying that he would never get out of the police cell he found himself in: ‘*you think they are going to keep you there all your life, you know what I mean.*’ (Page 8, Ln 115). Simon therefore made sense of his experience as being under-attack and in danger. Simon articulated his sense of fear and confusion when talking about being taken to the hospital:

*“I just thought ‘I’m gonna die,’ I was in the back of the van going somewhere and I didn’t know where I was going, that was when I became quite panicky and obviously I got took to the (name of unit) which I didn’t know was the (name of unit), I hadn’t got a clue, all I knew was that the police was the highest authority at the time and they were taking me somewhere else” (Page 9, Ln 139).*

Mark made sense of not being given an explanation of his hospital admission by thinking he was special and as such was being taken somewhere that was unique: “*they wheeled me into the clinic and I still didn’t know where I was and because of my mind state [sighs]...I thought I was taken to a special clinic for people who were in a unique mind state,*” (Page 25, Ln

399). Mark had inferred that the lack of explanation meant he was going somewhere secret and 'special.' This was dashed however when Mark was confronted with the reality, leaving him in a state of confusion:

*“And they went and put me in this horrible little bare room with a really hard bed, with bars on the windows and they said, erm, ‘we’re going to leave the door partly open, because we want to er, make sure you’re okay.’” (Page 26, Ln 406).*

In contrast Luke was aware of the process and where he was going: *“yeah they did tell me, I thought at first I was going to the (name of unit) hospital but I was taken to (name of unit) intensive care unit” (Page 3, Ln 39).* Luke had previous experience of mental health services and hospitalisation and so the process may have made more sense to him as he knew what to expect.

Medication was also an area where participants conveyed confusion. Simon was given medication at the Police station and described how he *‘wasn’t interested’* in taking tablets as he *‘thought everything was against [him]’ (Page 7, Ln 104).* Having no explanation for the medication meant Simon didn’t take them, and also fed into his worries that he was in danger and people wanted to hurt him. Mark talked about being given medication and being unsure why he was given the drugs, given his current state and symptoms:

*“If he had given me that during the manic episode maybe it would of had a, a better effect because it, it’s all about inhibiting the, er, the dopamine, but of course I definitely*

*had excess dopamine during that point because that would have been related to the more euphoric aspect and stuff but, I didn't after erm, I was just anxious" (Page 44, Ln 698).*

Simon's experience of medication on the ward was negative with the lack of explanation compounding the situation and leaving him with no explanation of what was going on:

*"It's horrible, you feel like a spastic, it's like that bad, you think, well you don't even realise at the time it's the drugs you just think you're that ill you don't know what's going on [laughing], yeah, but now I know what it was and I must have been on quite a few different things when I went in there, it just seemed like they give me everything you know, or they tried to' (Page 19, Ln 289).*

The above extract shows how Simon was confused by the side effects of the medication. Not knowing what was happening made Simon think that what he was experiencing was part of his illness.

### **3.2 What is happening to me?**

The sense that participants had of themselves as changing is related to the idea of having no explanation. Participants experienced their mental health episode as confusing and the episode meant a loss of control for all of the participants. Participants used metaphors here such as *'I lost the plot'* (Simon: Page 8, Ln 120) and they were in *'no fit state'* (David: Page 3, Ln 34). David described a bewildering state of *'getting more agitated'* and *'more distressed'* (Page 1, Ln 12) and did not (at the time) have an explanation for the change in himself. Simon made sense of his mental health episode as *'losing'* something of himself and being a different person. There is a sense of disbelief that he could have acted the way he did, and Simon described *'uncontrollable emotions'* (Page 4, Ln 51), which led him to have no

power over his behaviour. Simon experienced the loss as ‘horrible’ and felt it could have been potentially fatal:

*“[I] started to get my mind back and I thought I was never going to get it back, you know what I mean, that was the problem, because you lost your mind, it’s a horrible thing to have to happen because once you lose your mind you lose everything else, you know you easily could die in that state, easy without a doubt” (Page 4, Ln 51)*

Karen talked about experiencing a ‘major feeling of confusion’ (Page 1, Ln 14) not being able to sleep and being stressed. Karen described searching desperately for an explanation of the change in herself and attended the GP and the general hospital before she was able to gain some understanding of what was going on. Mark talks about the experience being new to him and something that was so overwhelming that he just wanted to hide away:

*“It was so horrible, erm one of the worse probably mind sets I had ever been in, I just couldn’t stand anything, I didn’t want to do anything. I just wanted to hide under my covers and you know not do anything, it was horrible and I’m not an anxious person so I’m not, it, it’s not something that’s familiar to me, that kind of anxiety, and it was horrific” (Page 39, Ln 619)*

### **3.3 Theme Summary**

The theme explored the meaning participants made out of not having an explanation for both the physical process of what was happening to them and the changes they were experiencing within themselves. Having no explanation meant participants made sense of their experiences



in ways which including thinking they were ‘special’ and being taken to a secret location, but also that they were under threat and in danger. Participants made sense of their mental health experience as a process of losing control and losing part of their ‘normal’ selves. This was confusing and, for some, horrific.

### **3.4 Super-ordinate Theme 2 – Mixed perceptions of the hospital**

This theme explores how participants experienced their hospital stay. This encompasses four elements. *‘It could have been a prison to me’* and *‘It got a bit chaotic at times’* describe aspects of the ward participant’s experienced as negative and confusing. *‘You just felt like they really did care’* and *‘Getting away from normal life’* describe participant’s positive experience of the hospital.

### **3.5 ‘It could have been a prison to me’ (Simon: Pg 20 Ln 36)**

The language participants used to describe their hospital experience included being *‘in prison’*, being *‘on lock-down’* and being *‘cut off from the world.’* This conveyed a sense of confinement, restriction and segregation to describe the hospital. The analogy of the hospital being a prison was therefore fitting and evoked images of being trapped and having limited choices. David talked about the process of being discharged from hospital stating that *‘two Doctors had to pass [him] out’ (Page 12, Ln 185)*, conjuring images of the military and strict rules. Luke talked about the time he spent outside of the hospital and the requirement for him to return, this was very frustrating for Luke, who interpreted the restrictions’ placed on him to mean that he was therefore ‘stuck’ and ‘in prison’:

*“Ahhh, it was just so annoying as I was used to just staying at home and seeing my friends and doing whatever I want and then going back and being stuck in the place like I was back in prison” (Page 18, Ln 281).* Luke also made sense of the restrictions as a way the ward isolated him from the outside world: *“they took my phone away, so I couldn’t get in touch with anyone for a whole week, so I just felt like cut off from my whole world, yeah it was supposed to be for my own good so I didn’t make any stupid phone calls but...”*

Jason also found the rules restrictive and felt he was being unfairly treated (and therefore the rules were unjust), which interrupted his interactions with the outside world: *“they were needlessly strict in the rules not, not letting me out...it means I could only spend so long outside of the hospital with my brother who used to live down the road” (Page 9, Ln 132).*

Mark found the experience of being in hospital ‘horrific’ and described how he felt like a prisoner when in hospital. It was feeling like a prisoner which caused him to have such a strong, negative reaction to the experience:

*‘I mean because my whole, to be honest I would classify my whole experience in there as quite horrific, but that’s more of a personal thing than necessarily how they treated me, it was just horrible being in there, you know, erm, it was like erm you know, you feel like a little bit of a, I felt like a little bit of a prisoner you know’ (Page 51, Ln 812)*

Mark struggled with the restrictions that were placed on him and the lack of control he had over his situation. In contrast to the other accounts, David understood the restrictions in terms of safety:

*“You’ve got somebody with you as there was some people who were very ill and depressed and if they were self-hurting, say if it was 7 o’clock at night and it was pitch black I mean they could have thought anything and freaked out” (Page 16, Ln 245).*

### **3.6 ‘It got a bit chaotic sometimes...’ (Luke: Page 16, Ln 243)**

This theme captures participants’ experiences of being on a ward which could be chaotic. This theme also explains the way I felt when reading some of the narratives due to their chaotic nature. When reading some transcripts, especially those of Simon and Mark I felt ‘lost’ at times due to the story jumping around and being fast paced. The sense of chaos was intense and required me to stand back and view the transcripts in their entirety to gain a fuller understanding of participants’ experiences.

Luke described ‘chaotic’ nights, which meant he was unable to talk to staff when he needed to. David talked about the number of patients on the ward when he was ‘ill’ and felt that if there were too many ‘you will freak out as it feels they are coming for you’ (Page 14, Ln 218). David also talked about a chaotic environment and how this scared him: ‘being somewhere where you don’t know and you’ve just got there and you’ve got people rushing by you at first, it was only because I was there for a month that I got to know people and so...I got to know why they were running around me’ (Page 18, Ln 280). This suggests David may have felt unsafe on the ward and when there were too many people it became overwhelming and scary. This was especially the case when David was first on the ward as he had a limited understanding of the environment.

Simon also encountered a chaotic environment. He talked about the confusion he experienced when his room was changed:

*“It’s nice to know that that’s your room and if it keeps changing it can, for somebody who is unstable it can make you a bit more unstable if you know what I mean, as you are looking for stability, you are looking to try and bring stability into a person who is unstable, so you need to try and, routine’s very important I think for people who are in that sort of mind frame really... daily routines, food and stuff was good, er, just with the beds and stuff because people kept coming in you might have you know, you might have to change your room for a different room ever night and it was a bit unsettling” (Page 23, Ln 507)*

Simon was experiencing change and inconsistencies in both himself and his environment which he found disorientating and unsettling, meaning it was hard to ‘get better’. Jason also felt confused. He talked about an incident that happened which left him feeling in a state of uncertainty:

*“There was a women’s lounge, erm when someone else, when someone else was watching the golf on one of the TVs I went into the women’s lounge as no one was using it and er, I was forcefully removed from it, but you know, no one else was using it, well no one had used it for a few days until now, and I was dragged across the entire hospital” (Page 5, Ln 68)*

Jason was confused by the staff's behaviour because he did not feel he had deserved the treatment he received. Being 'dragged across the entire hospital' also meant that Jason felt publically embarrassed. Furthermore, not having an explanation for the staff's behaviour meant their behaviour was less predictable and therefore the environment more chaotic.

Mark talked about the environment as noisy. He felt frustrated because it meant he was unable to sleep, the environment did not seem conducive to getting better. Mark makes sense of the chaotic ward environment as the staff not having 'control' over their patients; there was confusion about who was in charge, which felt scary and un-containing:

*"I couldn't sleep at all with this heavy metal music on, and I was like 'can you get that music turned off' and they were going 'yeah, yeah we will ask her to turn it down' and it would be turned down for a couple of minutes and then she would turn it straight back up again and its, it annoyed me so much, and I started to get angry at this point because I thought can't you control your patients or something, she's listening to heavy metal music at like 2 in the morning, and I thought, a, that was a big problem there I mean, they never seemed to, they just let the patients do whatever they wanted as long as they weren't like, hurting someone directly, which really annoyed me because some of the patients were really disruptive and this was throughout the rest of the week as well"*  
(Page 28, Ln 434)

Mark felt angry towards the staff, who he felt were not 'controlling' the other patients on the ward. This resulted in Mark not being able to get the rest he craved, and left Mark feeling confused about who was in charge.

### **3.7 'You just felt like they really did care' (Simon: Page 39, Ln 619)**

Along with negative experiences of the ward, participants also experienced positive elements. The theme *'you just felt like they did care'* explores how participants experienced the staff as caring and supportive. Luke talked about the staff being 'really nice', 'easy to approach' and people he could 'talk to.' Karen described how the most helpful thing about the ward was always having the staff there and being able to talk to them when she wanted. David felt he was well supported and that the staff listened to what he had to say. He felt that the staff kept *'communication open,'* keeping his *'brain active'* (Page 10, Ln 155). Simon described how he found some female staff members caring, and attributed this caring characteristic to the fact these staff were mothers and therefore were providing 'genuine' care:

*"Some of the women in there they had their own kids and everything that and you just felt like they really did care that there was genuine, that there was with some of them, you know what I mean, you know they really did, it was good in that way you get, you get the odd people like that don't you in the world"* (Page 39, Ln 618)

Simon felt 'looked after' and missed the staff once he had left the ward. The impact on Simon was such that he went back to see the staff to say thank you: *'I probably missed some of the staff and that and I did eventually go back to say hello to everybody and thank them for there you know and looking after me'* (Page 39, Ln 610). The staff provided Simon with what Bion (1959) described as 'containment', because they created a psychologically safe environment for Simon to express his feelings, be listened to, and an environment where staff did not become overwhelmed by Simon's intense feelings.

Although Mark did feel cared for (he described how his basic needs were met) in contrast to the other participants, he did not feel *supported* by the staff. Mark experienced the staff as treating everyone the same and felt his individuality was lost in the institution of the ward:

*'You see the thing is the carers were good in terms of, well most of them, were good in terms of, of erm, that they provided your basic needs and everything and made sure they were all met, but there was no personal care, in that they just treated every patient there the same erm, and of course every patient is different in a, a psychiatric ward and they have different kinds of needs in terms of, you know'* (Page 42, Ln 666)

Mark also felt the staff tried to do too much for him, there is a sense of being infantilised or treated like a child. This did not feel right for Mark, who wanted to be treated like an individual and like an adult:

*'I felt very well looked after, all you needed to do was say 'can I get a drink, of milk' or anything and you know they would go and get it for you, a lot of the time I would say 'no, I'll go and get it myself' because I didn't, I don't like being doted on like that, it doesn't feel right'* (Page 55, Ln 816)

Mark found it frustrating to have lost control and be in a place where he was being cared for. In contrast Jason did not feel cared for, he felt neglected by staff and stated they: *'never really spent any time talking to us.'* (Page 6, Ln 91). One of the striking things about this theme is that the variability of participants' experiences was underpinned by diverse needs (e.g. care,

support, interaction, consistency, independence, autonomy) and the diverse understandings of ‘care’ and ‘support.’

### **3.8 ‘Getting away from normal life’ (Luke: Page 10, Ln 158)**

David described the ward as ‘respite’ and a place away from day to day life where he could begin to understand and explain his experiences. Luke talked about the ward as ‘*getting away from normal life*’ (Page 10, Ln 158) and being a place where he could have his own space and time. Luke described having no such space in his ‘normal’ life where there was ‘*family stress*’, and ‘*it was a bit manic at the times*’ (Page 1, Ln 3). For Luke then, the ward meant getting away from the stress:

*“yeah just getting away from normal life and having a chill out time like little holiday, that was helpful, erm just having your own space definitely, not sharing with anyone and having your own chill out time, that definitely helped” (Page 10, Ln 158)*

This is a striking counterpoint to the chaos described elsewhere.

### **3.9 Theme Summary**

This theme explored participants’ experiences of being on the ward. There is a tension between the ward being prison-like and chaotic and yet also being caring and a place to get away from things. Interestingly, the restrictive nature of the ward may provide the containment needed for participants at this time. For some the chaotic nature of the ward may represent the internal chaotic states participants found themselves in, and their search for routine and normality therefore represented a desire to return to their ‘normal,’ predictable



selves, and a return to being in control. For others the ward represented a calm environment where participants could find a quiet space for themselves to get away from their 'real' lives.

### **3.10 Super-ordinate Theme 3 – The Challenge of Making Meaning**

This theme represents participants' confusion when experiencing hospitalisation and mental health difficulties and their attempt to try and make some kind of sense out of those experiences. Participant 'sense making' was achieved via self-reflection and interactions (learning) from other patients on the ward. This theme incorporates two elements: *'this was not something I could relate to'* and *'Moving on'*.

### **3.11 'This was not something I could relate too' (Mark: Page 54, Ln 849)**

When discussing other patients on the ward, 4 out of the 6 participants saw themselves as different to the other patients. In describing other people on the ward participants used words such as *'weirdo's'*, *'nasty'* and *'scary people'* who were *'not very pleasant to be around'* and could be *'aggressive'*. Karen and Mark described trying to *'stay away from'* the other patients as they were *'scary.'* Jason described himself as *'not a real patient'* and Mark expressed concern that he was *'being classified in the same way as them.'* Describing other patients in this way suggested that participants did not identify with them and therefore positioned themselves as 'outsiders' in the world of the mental health hospital. This allowed participants to position themselves as 'normal' and not like the people with mental health problems.

Simon made sense of his experiences of being on the ward with other people by favourably comparing himself to them, seeing himself as not the *'worst case'*: *"I can imagine I'm not the*

*worst case scenario, you know there's people out there that would probably kill somebody you know what I mean it's scary really, it's not very nice" (Page 11, Ln 164). Jason minimised his behaviour when he described himself as 'aggressive, but not violent at all' (Page 1, Ln 6). There is recognition from Simon and Jason that they were experiencing a different sense of self that possibly needed treatment, but there were others worse than them (and therefore they were different).*

In Mark's account below he described his fears of being classified 'in the same way as them.' Goffman (1963) has explained this fear in terms of stigma, where people are stigmatised and marginalised in society for being 'different' or having undesirable characteristics or behaviours. Mark may feel stigmatised as the hospital environment is stigmatising and an environment which treated everyone the same. Mark also talks about his concerns about being influenced by others psychosis and how this could make him 'worse':

*'The people there they were so, so heavily you know in psychosis it was very disturbing to be around them and feel like I'm in the same place as these people and you feel like you are being classified in the same way as them and it scares you a bit as you almost feel like somehow being around them is going to make you worse, because you know I'd just recovered and I was getting progressively better from what had happened, but being around these people it was like, somehow is their behaviour going to influence me you, you know am I going to start to think that that behaviour is normal and start to behave like that? And it was scary being around a lot of them as they were so, erm, I mean they weren't, they weren't under the influence of a type of psychosis where they're sort of*

*quiet and mumbling to themselves, they were very loud, er, aggressive people'*(Page 53, Ln 834)

Mark was concerned about 'catching' psychosis and being influenced by others. Mark described the dilemma he found himself in once he had started to recover. He was treated like another patient by those on the ward, but he felt that he was unable to empathise with and relate to them:

*'it was just horrible being around them, especially because they would just talk to me act, act like I was a peer or something and I'm like, I'm almost totally, I'm pretty much totally sane now you know, and they would talk to me as if, they would like confide in me about these little things where they thought they were getting plotted against by the people in the clinic and stuff, one of them thought they were trying to turn her into a cabbage, not literally, but into you know some kind of human cabbage one that cant, you know what I mean and she was like telling me about how she secretly pretended to take her drugs and then you know hid them under her tongue and then spat them out and stuff like that, and I, I was like how am I supposed to respond to this, as this was not something I could relate to'* (Page 53, Ln 842)

The two quotes above illustrate Mark's concerns about how people will view him in relation to the other patients (as like them). It also shows the dilemma some participants faced when trying to position themselves and find their place within the ward, and who to relate too. For the participants, hospitalisation meant they were confronted with a series of threats to their self-identify.

In contrast David talked about ‘us’ (the patients) and ‘them’ (the staff) when describing interactions on the ward, using such language suggests that he identified more with the patient group, than the staff group. David described learning from the other patients, who he felt were ‘like’ him. The experience of being with others ‘like’ him helped him to understand himself and his experiences better:

*David: “And there was other people like me as well*

*Interviewer: okay, and did you spend much time with those other people on the ward?*

*David: I did, I did, that’s what made me realise I might have psychosis and I started reading about it and all my symptoms matched up, where I was getting agitated, where I was checking doors, but it only happened around Christmas time where there were more lights”*

*Interviewer: okay, so you can learnt from other people*

*David: yeah, or try and read what the signs are*

*Interviewer: was being with a mix of people helpful?*

*David: yes, if I was on my own I wouldn’t have known what to, what would have happened as I wouldn’t have been able to explain it”*

*(Page 5, Ln 65)*

David felt he learnt from the other patients but Luke, who had been hospitalised in the past talked about his role as an educator, giving advice to other people who came onto the ward:

*‘Everyone is in the same boat, everyone’s got their problems so it’s good to talk to everyone about what they’d do and how they did when there, and things like that and*

*yeah it's nice to help people out as well like because I was getting better when people were coming in so I could give them advice like stay calm and you know' (Page 15, Ln 232)*

Luke was the only participant to talk about the importance of 'helping' other people on the ward. There is an interesting juxtaposition when Luke's account is positioned next to David's explanation of how useful being around other patients was in beginning to understand himself. It is a nice example of how people can interact on the ward and how those interactions can have positive outcomes.

### **3.12 Moving on**

For some participants there was emphasis on the importance of a 'link' to the 'outside' when moving on and 'getting better.' Simon stated that it was after his friend's visits that *'it started to sink in and I think that's when it got better'* (Page 22, Ln 342). Mark too talks about the influence of people from outside the hospital and how those interactions helped in his progression back to health:

*'My Dad when he would come to visit me. He would just sit there with me and talk to me as if I was normal and I found that a lot more therapeutic, and he continued to visit me every day when I was in there which really helped, and I recognised the fact that I, to be able to overcome the sense of anxiety, first off I was going to have to taper down on this diazepam dose, secondly I was going to have to make myself venture out' (Page 41, Ln 642)*

David talked about a progression towards improving health, and how being able to ‘mix’ with the other patients helped him to get his confidence back. David described himself as not being 100% when on the ward and needing time to get better. As with Simon, ill health was understood to be something that was ‘missing.’ Simon talked about doing the things that he used to do; he described a slow process and ‘building’ up to full strength:

*‘I got out and I just started to get back into things slowly but, I tried to do a lot of fitness and build my fitness up, I was going for walks to start with for the first couple of weeks and then I was doing runs and I was trying to ride a bike for miles, you know and it was helping with the physical exercise I found that was a really big turning point’ (Page 38, Ln 601).*

Simon uses the example of physical fitness to describe his staged-progress back to health, and getting back to being 100%. This struggle Simon experiences in regaining his ‘lost’ abilities is illustrated in the following extract:

*‘I was reading bits in my room and things like that but I couldn’t concentrate for too long, I struggled, I had problems with concentration, I could do a jigsaw puzzle you know, someone brought me a jigsaw puzzle and I just opened the box and thought ‘I can’t do that’, and I put the lid back on you know I, I couldn’t do certain things and it took me actually a long time to get back to actually doing something, my friend, after I came out one of my friends bought me a chess set and I sat by myself and played with it, with a computer thing to see, and I got, but that, and eventually I got my length of*

*concentration back up a bit you know, but I found it really difficult to just sit and do something for a bit of time' (Page 29, Ln 456).*

Mark reflects on his experiences and attempts to make sense of them by trying to understand what is meant by 'madness'. For Mark the experience has also led to personal growth and he describes how it will shape the way he sees things and deals with problems in the future:

*'What really helped me about the whole experience, is first of all like I said I wouldn't take it back, like I learned a lot about myself and about... about insanity in a way, because that's what I kind of experienced, to a large extent I experienced an insane mind set, a big part of what I believe about being insane, is based on making erm, complete conclusions about things based on no evidence at all... that's where the insanity aspect comes from, just making an assumption about something but like I said it was very enlightening, I learnt a lot about myself from that and also I feel, since that experience I feel like a stronger person because once you've gone through something like that, erm, it makes a lot of the other things in life a lot easier to deal with you know' (Page 64, Ln 1050).*

Mark felt he had learnt from the experience and he would be able to deal better with any future problems he encounters.

### ***3.13 Theme Summary***

This theme explores the way in which participants attempted to find meaning in their experiences. The meaning involved identifying where they fitted in relation to other people with mental health problems, alongside how they progressed to health. Most participants understood themselves to be different to people with mental health problems, and viewed the other patients on the ward negatively. Participants also attributed socially undesirable characteristics to other patients. An understanding of the illness as ‘losing’ something was expressed by several participants and one participant felt they had become a ‘stronger’ person after the episode, suggesting that he was able to integrate his experiences into his life.

## **4. Discussion**

The research aimed to understand what it was like for young people to be hospitalised with an early onset psychosis. The findings show that participants had a variety of experiences of hospitalisation. The themes which emerged were: ‘So, where are you taking me?’, which explored the meaning of having no explanations, the ‘Perceptions of the hospital’, which sought to understand what it was like when on the ward, and ‘The challenge of making meaning,’ which explored the participants’ attempts to work out where they fitted in terms of the hospital and wider society, and what it meant to them to have a mental health episode. Strong comparisons emerged throughout the individual narratives, along with exceptions which were unique to individual participants.

Participants experienced both positive and negative experiences during their experience of hospitalisation. As a trainee psychologist who has previously worked with young people who



have a psychosis, and who has visited mental health wards I assumed that all experiences would be negative. I felt that I was able to identify and bracket off this assumption before analysing the data, an essential process in IPA. Given the interpretive nature as it is important to be aware of your own judgements and assumptions when analysing the data.

#### *4.1 The implication of no explanation*

One of the strongest features of participants' accounts was the sense of confusion and disorientation felt, both within themselves and with the process of hospitalisation. This confusion was also experienced by me when reading the transcripts and listening to participants' stories. For participants it was the apparent lack of explanations which led to disorientation and confusion about what was happening to them. This led participants to feel confused and fearful. They attempted to make sense of their experiences in the best way they could. Previous experiences seemed to be essential in the process of trying to understand their situation, as some participants made sense of the experiences as being in danger and under-threat, where one felt he was 'special.' Another participant did not experience confusion because he was aware of the process, having been through it several times. Perry *et al* (2007) found that participants felt 'hopeless' when in hospital one reason identified was having a lack of information. In this research, participants felt lost and confused and there was a sense of bewilderment and also fear. The confusion that participants felt about not having an explanation is similar to Kevin's account of being in hospital in Hardcastle *et al* (2007).

#### 4.2 What was hospitalisation like?

Participants experienced both positives and negatives within the hospital environment, these seemingly contradicted each other. Negatives of being in hospital centred on the restrictions and chaotic environment, with positives experiences of feeling cared for by staff and having a place to get away from. One hypothesis for this contradiction maybe that it is actually the restrictive environment which provides the containment (both physical and psychological) that people need when they are in a state of confusion. Alternatively it may be that some people are more resilient and able to ‘switch off’ from the environment around them.

Participants used emotive language to describe the hospital, which evoked images of a prison. It seemed important for participants to convey to me their negative experiences of restriction and having their freedom taken away. This was also found by Myers *et al* (1990) with 65% of patients in their study making negative comments regarding their experiences of inpatient care; one element was around not having any freedom. Participants in Perry *et al* (2007) also referred to inpatient care as restrictive and prison-like. Morrison *et al* (1999) have found that people admitted to inpatient psychiatric wards can exhibit levels of post-traumatic stress disorder, suggesting that the experience of hospitalisation can be distressing and traumatic. Participants in this research have highlighted the stressful and chaotic elements of hospitalisation, which had led some to feel scared and confused. These negative and potentially traumatising experiences were highlighted as occurring in both the hospital itself, and for some participants during the pathway to hospitalisation (for example when in police custody).

Both Hansson *et al* (1993) and Goodwin *et al* (1999) found that patients in their research placed the highest value on a sense of being cared for by staff and expressed gratitude to staff that were approachable, kind and sympathetic. This is something which emerged in this research. All but one participant talked about the importance of staff interactions, and there was a strong sense of being cared for by the staff and how beneficial this was for participants when they were on the ward. This kind of caring appeared to help contain participants, this was particularly the case for Simon who experienced the caring staff as maternal.

#### *4.3 How did people make sense of the experience?*

Like in Perry *et al* (2007) participants in this research sought to distance themselves from other patients on the ward using words such as ‘weirdo’s’ and ‘nasty people’ when they described them (3.11 *‘this was not something I could relate too’* (Mark: Page 54, Ln 849). O’Toole *et al’s* (2004) investigation found inpatient care was described as ‘horrible,’ ‘scary,’ ‘depersonalising’, and a place where ‘opinions didn’t matter’. O’Toole (2004) also found that their participants’ inpatient care experiences were associated with high perceived stigma, labelling and exacerbation of symptoms. Previous research has found that stigma and social exclusion are major concerns for those with mental health problems (Farnia, 1998; Hayward & Bright, 1997). Even if some participants did not identify themselves with the other patients (and therefore as someone with a mental health problem), they were worried about being stigmatised due to being associated with people who have a mental health problem (courtesy stigma – Goffman, 1963). Perceived stigma has also been associated with low self-esteem amongst adolescents hospitalised for psychosis (Warner *et al*, 1989). Therefore by positioning themselves as ‘different’ participants in this investigation they may have been attempting to guard against an attack on their self-esteem and sense of self.

One participant (Jason) did not appear to own or accept his experience of being hospitalised and having a psychosis. Jason may therefore be an example of someone using the strategy of ‘sealing over.’ Research has found that experiencing a psychosis can lead people to develop strategies to cope including to ‘integrate’ their experiences (reflect on them) or ‘seal over’ (try to forget about them) (McGlashan, 1987; McGlashan & Carpenter, 1977). Jason did not engage in the search for meaning from his experiences. In fact he distanced himself from others on the ward, seeing them as ‘not like him,’ suggesting he was trying to differentiate himself from other patients and not reflect on his experiences. The research is not clear whether there are advantages to either strategy in the early stages of psychosis, although sealing over has been identified as a way to reduce adverse emotional states in the early phase (Jackson *et al*, 1998).

O’Toole (2004) also found that participant’s experiences of inpatient care were in contrast to the community based service where participants felt they strongly identified with the service philosophy and goals and attributed their recovery to the positive nature of the treatment they had received. This has also been established in this research as in ‘*the challenges of moving on*’ (section 3.12), where participants talked about improving when outside of the hospital or linking with the outside of the hospital walls being central in the progression back to mental health. Research in recovery from psychosis has found predictors of recovery include a stable social life and normal social functioning, e.g., having a social network, attending college, or having a job (Albert *et al*, 2010). Therefore, maintaining social ties and relationships throughout the period of hospitalisation may be important for people, and enable them to have a stable social life after discharge.

Perry *et al* (2007) discussed how one person in their research experienced hospital as beneficial due to the feeling that they ‘belonged.’ This was also the case for one person in this research. David felt he gained a greater understanding of himself and learnt about his mental health problem when being in hospital. David identified himself ‘with’ the other patients and talked about positive interactions with other patients on the ward. Kevin in Hardcastle’s *et al* (2007) collection of narrative also found this experience on the ward helpful.

#### *4.4 Clinical/Service Implications*

The effect of having no explanations was distressing for participants and 3 participants felt that having more information would have been beneficial in the process of hospitalisation. More information could be provided to people, at all stages of the process. Due to the confusion, some participants felt at the time that it may have been beneficial to present the information to them in a variety of forms (rather than just verbally). Having a routine and predictable environment also seemed important for participants; changing rooms and a chaotic environment were experienced negatively by participants who craved consistency. Being mindful of the effect that this can have will help the ward staff make decisions regarding ward activities and moving patients’ rooms.

The Government’ Mental Health Strategy (No Health without Mental Health, 2011) has the aim that ‘More people will have a positive experience of care and support.’ Their aim is that care and support, wherever it takes place, should offer access to timely, evidence-based interventions and approaches that give people the greatest choice and control over their own lives, in the least restrictive environment, and should ensure that people’s human rights are

protected. This research has demonstrated that people can have negative experiences of inpatient care and therefore services may need to change in order to meet this goal.

The experience of one participant, Luke was as an 'educator' (helping others understand their mental health problems and the system). This was a positive experience for Luke, who enjoyed helping others. It may be that this kind of role for some patients could be extended and developed on the ward environment.

#### *4.5 Methodological Considerations*

This research was one part of a three part study, investigating the experience of hospitalisation from the perspective of the patients, family members and inpatient nursing staff. The advantages of using this approach is that a rich, detailed picture can be built up, which explores the experience from different perspectives. Linking the three studies together will also help inform service development to help services meet the needs of these different groups. One disadvantage to this approach is confidentiality, and the possibility that accounts may be recognised and individuals identified. The research team have addressed this limitation by changing the names of all participants and not stating the names of the three inpatient units.

The use of Interpretative Phenomenological Analysis has been shown to be an appropriate methodology for investigating the complex experience of hospitalisation. The approach has allowed the move beyond identifying themes to actually attempting to understand what it was like for these young people to be hospitalised. It is acknowledged that the research is based on a small sample, results are not generalisable; however this is not the aim of qualitative

research. All but one of the participants were male meaning a female perspective may have been lacking.

The process of analysis was designed in an attempt to decrease bias in the research. The research team met and collectively checked the interpretations which helped to identify over-interpretation and validate the themes identified within the data. It is also important to hold in mind that the participants were recalling their previous experiences of hospitalisation within the context of currently receiving care from the Early Intervention in Psychosis Service (EIS). Research has shown that patients prefer EIS and view such services more positively than hospitalisation (O'Toole *et al*, 2004). This may have affected how people recall their hospital stay and they may view it more negatively as they are comparing it to their current treatment.

It is important to reflect here on those participants who were approached to take part in the research but declined. Ten people were approached and 4 declined to take part. It may be that those declining to be involved may have the coping style of 'sealing over,' and did not want to talk about their experiences. If this is the case it is likely the research will be biased in that most of those (but not all) taking part will use integration coping strategies and therefore we are only getting one side of the story/experience. It is important to bare this in mind and future research may seek to attempt to include these people in the data.

#### *4.6 Future Research*

Given that 5 out of the 6 participants were male it may be appropriate for future research to include more female accounts as these may be different to the male experiences. Likewise the sample was predominantly White-British therefore interviewing people from different cultural

backgrounds may provide a rich account of the experience from different perspectives. It is important to gain the stories of those from the hard to reach groups, for example those groups which employ the strategy of sealing over and may have therefore refused to take part in the research. People refusing to take part may have very different experiences to those willing to talk about their hospitalisation. Given people refusing are by definition hard to reach this may pose a challenge to try and engage people in the research, but it may be a rewarding one. This may also lead to a better understanding of hospitalisation for young people who have a psychosis.



## References

- Albert, N., Bertelsen, M., Thorup, A., Peterson, L., Jeppesen, P., & Kraup, G. (2010). Predictors of recovery from psychosis: Analyses of clinical and social factors associated with recovery among patients with first-episode psychosis after 5 years, *Schizophrenia Research*, 125, 257-266
- Becker, H. (1973). *Outsiders*. New York, NY: Free Press.
- Bers, S., Blatt, S.J., Sayward, H.K., & Johnson, R.S. (1993) Normal and pathological aspects of self-descriptions and their change over long-term treatment. *Psychoanal Psychol.* 10: 17-37.
- Bion, W. R. (1959). Attacks on linking. In *Second Thoughts*. London: Karnac (1993).
- Goffman, E. (1963). *Stigma: notes on the management of a spoiled identify*. Englewood Cliffs, NJ: Prentice Hall.
- Goodwin, I., Holmes, G., Newnes, C., & Waltho, D (1999). "A qualitative analysis of the views of in-patient mental health service users." *Journal of Mental Health*, 8, 1, 43-54.
- Hansson, L., Bjorkman, T., & Berglund, I (1993). "What is Important in Psychiatric Inpatient Care? Quality of Care from the Patients Perspective?" *Quality Assurance in Health Care*, 5(1), 41-47.
- Hardcastle, M., Kennard, D., Grandison, S., & Fagin, L. (2007). *Experiences of mental health in-patient care: Narratives from service users, carers and professionals*. New York, NY, US: Routledge/Taylor & Francis Group.
- Hayward, P. & Bright, J. (1997) Stigma and mental illness: a review and critique. *Journal of Mental Health*, 6, 345 -354.

Husserl, E. (1982). *Ideas Pertaining to a Pure Phenomenology and to a Phenomenological Philosophy* (F. Kersten, Trans.) Dordrecht: Kluwer.

Knight M. T., Wykes, T & Hayward, P (2003). “‘People don’t understand’: An investigation of stigma in schizophrenia using Interpretative Phenomenological Analysis” *Journal of Mental Health, 12*(3), 209-222.

Jackson, H., McGorry, P. & Edwards J. (1998). Cognitively-orientated psychotherapy for early psychosis (COPE). Preliminary results. *British Journal of Psychiatry, 172*, 93-100.

Farina, A. (1998). *Stigma*. In *Handbook of Social Functioning in Schizophrenia* (eds KT

Mueser & N. Tarrier). Boston, MA: Allyn & Bacon.

McGlashan, T. H. (1987). Recovery style from mental illness and long-term outcome. *Journal of Nervous and Mental Disease, 175*, 681-685.

McGlashan, T.H. & Carpenter, W. (1977) Art and recovery style from psychosis. *Journal of Nervous and Mental Disease, 164*, 182-190.

Mental Capacity Act (2005). Code of Practice. London.

Meyer, H., Taiminen, T., Vuori, T., Aijala, A., & Helenius, H. (1999). Posttraumatic Stress Disorder Symptoms Related to Psychosis and Acute Involuntary Hospitalization in Schizophrenic and Delusional Patients. *The Journal of Nervous & Mental Disease, 187*(6), 343-352.

Morrison, A., Bowe, S., Larkin, W., & Nothard, S (1999). The Psychological Impact of Psychiatric Admission: Some Preliminary Findings. *The Journal of Nervous and Mental Disease, 187*(4), 250-253.

Myers, D. H., Leahy, A., Shoeb, H., & Ryder, J (1990). "The Patients' View of Life in a Psychiatric Hospital. A Questionnaire Study and Associated Methodological Considerations." *British Journal of Psychiatry*, 156, 853-860.

NICE Clinical Guideline (2009); Schizophrenia. *Core interventions in the treatment and management of schizophrenia in primary and secondary care*

No Health Without Mental Health: Cross Government Mental Health Outcomes Strategy (2011). Department of Health. London.

O'Toole, M. S., Ohlsen, R. I., Taylor, T. M., Purvis, R., Walters, J., & Pilowsky, L. S (2004). "Treating first episode psychosis – the service users' perspective: a focus group evaluation" *Journal of Psychiatric and Mental Health Nursing*, 11, 319-326.

Thornhill, H., & Clare, L. & May, R. (2004). Escape, enlightenment and endurance. Narratives of recovery from psychosis. *Anthropology and Medicine*, 11, 181 – 199.

Perry, B. M., Taylor, D., & Shaw, S. K. (2007). "You've got to have a positive state of mind": An Interpretive Phenomenological Analysis of hope and first episode psychoses. *Journal of Mental Health*. 16(6); 781-793.

Reid, K., Flowers, P., & Larkin, M. (2005), "Exploring Lived Experience." *The Psychologist*, 18:1, 20-23.

Rhodes, J. E., & Jakes, S (2000). "Correspondence between delusions and personal goals: A qualitative analysis." *British Journal of Medical Psychology*, 73, 211-225.

Roe, D. (2003). A Prospective Study on the Relationship between Self-Esteem and Functioning During the First Year after Being Hospitalized for Psychosis. *The Journal of Nervous and Mental Disease*, 191: 45-49.

Smith, J. A. (1996), "Beyond the divide between cognition and discourse: using interpretive phenomenological analysis in health psychology". *Psychology and Health*, 11, 261-271.

Smith, J.A., (1999). Identity development during transition to motherhood: An interpretive phenomenological analysis. *Journal of Reproductive and Infant Psychology*, 38, 409-426.

Smith, J. A (2007). Hermeneutics, human sciences and health: Linking theory and practice. *International Journal of Qualitative Studies on Health and Well-Being*, 2, 3-11.

Smith, J. A, Flowers, P, & Larkin, M. (2009). *Interpretative Phenomenological Analysis: Theory, Methods and Research*. Sage.

Warner, R., Taylor, D., Powers, M., & Hyman, J. (1989). Acceptance of the mental illness label by psychotic patients: Effects on function. *American Journal of Orthopsychiatry* 59: 398-409.

## **Public Domain Briefing Paper**

### **The Experiential Impact of Hospitalisation in Early Psychosis**

**Kelly Fenton**

This research was conducted by Kelly Fenton in partial fulfilment of the Doctorate in Clinical Psychology at the University of Birmingham. Research supervision was provided by Dr. Michael Larkin (University of Birmingham).

#### **Overview**

This research is divided into two main parts. The first part is a literature review assesses the question of what it is like to receive or provide a psychological intervention for psychosis. The review considers a few specific studies on the topic and describes the findings that they each contribute.

The second part is a research project that was conducted with young people who have been hospitalised with an early psychosis. The participants were interviewed about their experiences of being hospitalised, including what it was like going to hospital, what it was like living there and their experiences of being discharged. The interviews were analysed using Interpretative Phenomenological Analysis (IPA), which is a qualitative research approach. Three main themes were developed which described different aspects of the participant's experiences of being hospitalised. Participants had different experiences of being hospitalised and their experiences suggest hospitalisation can be both helpful and unhelpful.

## **Background**

There is evidence to suggest that psychiatric hospitalisation can be distressing (Morrison *et al*, 1999), and can have a negative impact on a young person's self-esteem (Bers *et al* 1993). Many young people with an early psychosis will be under the care of an Early Intervention in Psychosis Service. These services aim to support people in the community. Little is known about the impact of hospitalisation on people where they are likely to have been hospitalised in a crisis and may have had the expectation that hospitalisation was unlikely given the ethos of the early intervention services.

The current research aimed to gain an understanding of what it was like for young people to be hospitalised, from their perspective. A secondary objective was to identify both positive and negative elements of hospitalisation and feed these back to the service to aid service development and improvement.

## **Method**

Ethical approval was gained from Solihull Local Research Ethics Committee and the NHS Trust's Research and Development department. Potential participants were identified by their care co-ordinator and given information about the research. Informed, written consent was gained from all participants. Ten people were approached and six people agreed to take part in the research. Interviews took place at the participant's homes. The interviews were transcribed and then analysed according to IPA guidelines.

## **Results**

Findings showed participants' had a variety of experiences of hospitalisation. Three themes emerged. The first theme, *'So, where are you taking me?'* explored the meaning of having no explanations. For some participants having no explanation made them fearful and confused as they did not know what was happening. One participant felt that having no explanation meant he was being taken to somewhere special as he was unique; this was dashed when he was taken to the psychiatric hospital. The second theme, *'Mixed perceptions of the hospital'*, sought to understand what it was like when on the ward. Participants had both positive and negative experiences of the ward; some found it a chaotic place which was likened to a prison, while others experienced it as a respite and a change to get away from 'normal' life. The final theme was, *'The challenge of making meaning,'* which explored the participants' attempts to work out where they fitted in terms of the hospital and wider society, and what it meant to them to have a mental health episode.

## **Evaluation and Implications**

The investigation found mixed experiences of hospitalisation. Changes to the process could include providing more information to people being hospitalised and providing a more constant ward environment. Those interviewed for the research may have been people who had wanted to talk about their experiences, rather than those who just wanted to forget about it, and so the full picture around hospitalisation may not have been gathered.

## **Appendices – Literature Review**



## **Appendix 1 Quality assessments of research papers**

<b>Journal article &amp; Author</b>	<b>Sensitivity to Context</b>	<b>Commitment and Rigour</b>	<b>Transparency and Coherence</b>	<b>Impact and Importance</b>
<p>Factors in outcome of cognitive-behavioural therapy for psychosis: Users' and clinicians' views</p> <p><i>McGowan, Lavender &amp; Garety (2005)</i></p>	<p>Good evaluation of relevant literature and how research would contribute the field.</p> <p><i>No consideration of the socio-political context of the research.</i></p>	<p>In depth outline of selection criteria and explanation of methodology employed.</p> <p>Included demographic information.</p> <p>Data collection adequate for investigation.</p>	<p>Explanation of methodological quality controls (e.g., fine-grained analysis of data, inter-rater reliability).</p> <p><i>No reflections from the authors of how work may have been influenced from outside pressures.</i></p> <p>Grounded theory appropriate method due to new area under investigation.</p>	<p>Provides a comprehensive account of failure to progress in CBT for psychosis.</p> <p>Relevant to the community intended for.</p>
<p>CBT for psychosis: A qualitative analysis of clients' experiences</p> <p><i>Messari &amp; Hallam (2003)</i></p>	<p>Good reflections on the position of the researcher (as both a mental health professional and a trainee psychologist) and how this may affect the research.</p> <p>Good review of background literature including the research methodology chosen.</p>	<p>Good explanation of the process of conducting discourse analysis.</p> <p><i>Not clear on the length of time engaged in the topic as author was a trainee clinical psychologist.</i></p>	<p>Good understanding and explanation of methodological issues such as credibility, transparency and dependability.</p> <p>Authors explicitly state they did not use 'medical' words in the interviews so clients could express own understanding of the phenomenon.</p> <p>Client quotes used explicitly throughout the paper.</p>	<p>Comprehensive account of the experience of therapy for psychosis.</p> <p>Authors discuss the 'positioning' of the therapists from clients accounts which is consistent with the discourse analytical approach.</p> <p>Power in accounts explicitly discussed which is consistent with the analysis employed.</p> <p>Relevant to community.</p>

<b>Journal article &amp; Author</b>	<b>Sensitivity to Context</b>	<b>Commitment and Rigour</b>	<b>Transparency and Coherence</b>	<b>Impact and Importance</b>
<p>Building bridges to observational perspectives: A grounded theory of therapy processes in psychosis</p> <p><i>Dilks, Tasker &amp; Wren (2008)</i></p>	<p>Good reflection on the position of the researcher to both the topic and the clients.</p> <p><i>Little information on socio-cultural setting, although discussion of the methodology in relation to the research with the phenomenon in question.</i></p>	<p>Good outline of why qualitative methods are suitable for the research and why grounded theory is the appropriate method for analysis.</p> <p>Explanation of author's engagement with the topic from working clinically with the client group.</p> <p>Included demographic information.</p> <p>Adequate sample.</p>	<p>Clear links between the research question and method of investigation with development of themes explicitly stated.</p> <p>Grounded theory appropriate method due to new area under investigation.</p> <p>Explicit quotations from participants included.</p>	<p>Comprehensive results and discussion section with clear explanation of the findings.</p> <p>Directly relevant to the community intended for and clinicians working in the area.</p>
<p>Clients' experience of case formulation in cognitive behavioural therapy for psychosis</p> <p><i>Morberg Pain, Chadwick &amp; Abba (2008)</i></p>	<p>Good review of the topic and previous research in the area.</p> <p><i>No reflections of the socio-cultural setting or on the position of the authors in relation to the topic and participants.</i></p>	<p><i>Some demographic information included no mention of culture/race or social class. Unclear which methodology is employed by researchers (other than qualitative).</i></p> <p>Explicitly document coding procedure.</p> <p>Author well known in the field showing prolonged engagement with the topic and has published research on the same topic.</p>	<p><i>Responses coded and themes expressed in percentages, no direct quotes from participants.</i></p>	<p>Results show affects of case formulation on clients within therapy.</p> <p>Relevant to a specific community, although not in depth.</p>

<b>Journal article &amp; Author</b>	<b>Sensitivity to Context</b>	<b>Commitment and Rigour</b>	<b>Transparency and Coherence</b>	<b>Impact and Importance</b>
<p>Impact of case formulation in cognitive behavioural therapy for psychosis</p> <p><i>Chadwick, Williams &amp; Mackenzie (2003)</i></p>	<p><i>Limited background information provided. No reflections of the socio-cultural setting or on the position of the authors in relation to the topic and participants.</i></p>	<p>Author well known in the field showing prolonged engagement with the topic.</p>	<p>Research included both qualitative and quantitative methodology. <i>Qualitative component was not analysed using robust qualitative methodology.</i></p>	<p>Some findings which may be useful for the community intended. <i>Findings quite limited due to simplistic data analysis techniques.</i></p>
<p>Patients' Experiences of Homework Tasks in Cognitive Behavioural Therapy for Psychosis: A Qualitative Analysis</p> <p><i>Dunn, Morrison &amp; Bentall (2002)</i></p>	<p>Good understanding of the topic and review of relevant background literature. <i>No reflections of the socio-cultural setting or on the position of the authors in relation to the topic and participants.</i></p>	<p>Author's well known in the field showing prolonged engagement with the topic. Good outline of why qualitative methods are suitable for the research and why grounded theory is the appropriate method for analysis. Adequate sample.</p>	<p>Clear links between the research question and method of investigation with development of themes explicitly stated. Quotations from participants used throughout to explain themes in the data.</p>	<p>Extensive discussion of research findings. Directly relevant to the community intended for and for clinicians working in the area.</p>
<p>Patients' perspectives on what works in psychoeducational groups for schizophrenia</p> <p><i>Sibitz, Amering, Gossler, Unger &amp; Katsching (2007)</i></p>	<p><i>No reflections of the socio-cultural setting or on the position of the authors in relation to the topic. Intervention evaluated was developed by authors but potential bias not discussed.</i></p>	<p>Authors clinicians working in the field and have developed groups showing a prolonged engagement in the topic. <i>Data collection may be bias as authors 'selected' participants themselves.</i></p>	<p>Explored negative and positive feedback using quotations from participants. <i>Qualitative component was not analysed using robust qualitative methodology.</i></p>	<p>Results discussed at length and were relevant to the community intended for and for clinicians working in the area.</p>

<b>Journal article &amp; Author</b>	<b>Sensitivity to Context</b>	<b>Commitment and Rigour</b>	<b>Transparency and Coherence</b>	<b>Impact and Importance</b>
<p>More than just a place to talk: Young people's experiences of group psychological therapy as an early intervention for auditory hallucinations</p> <p><i>Newton, Larkin, Melhuish &amp; Wykes (2007)*</i></p>	<p>Good reflections on the position of the researcher and how this may affect the research.</p> <p>Good introduction of the topic and awareness of relevant literature and empirical research.</p> <p>Understanding of the theories and phenomenon of psychosis.</p>	<p>Small sample of in depth interviews which had epistemological coherence.</p> <p>Demographic information included.</p> <p>Author's well known in the field showing prolonged engagement with the topic.</p> <p>Explanation of the development of interview schedule and the interview procedure.</p> <p>Critique of methods used in the research.</p>	<p>Clear links between the research question and method of investigation, development of themes explicitly stated.</p> <p>Quotations from participants used throughout to support themes.</p> <p>Explanation of using IPA which fits with topic. Data generated focused on the experience of participants which fits the IPA method.</p>	<p>In depth analysis and discussion of the research findings with explanations from the wider socio-cultural context.</p> <p>Directly relevant to the community intended for and for clinicians working in the area.</p>
<p>Beyond countertransference: Therapists' experiences in clinical relationships with patients diagnosed with schizophrenia</p> <p><i>Laufer (2010)</i></p>	<p>Background socio-cultural context presented within the introduction with the authors position explicitly highlighted.</p>	<p>Small sample of in depth interviews which had epistemological coherence.</p> <p><i>No demographic information provided.</i></p>	<p>Quotations from participants' used throughout to highlight themes.</p> <p>Explanation of using Interpretative Phenomenological Analysis (IPA) which fits with topic.</p> <p>Data generated focused on the experience of participants which fits the IPA method.</p>	<p>Directly relevant to the community intended for and for clinicians working in the area.</p>

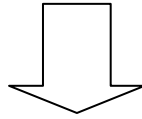
<b>Journal article &amp; Author</b>	<b>Sensitivity to Context</b>	<b>Commitment and Rigour</b>	<b>Transparency and Coherence</b>	<b>Impact and Importance</b>
<p>Group person-based cognitive therapy for distressing voices: Views from the hearers</p> <p><i>Goodliffe, Hayward, Brown, Turton &amp; Dannahy (2010)</i></p>	<p>Good introduction of the topic and awareness of relevant literature and empirical research.</p> <p><i>No reflections of the socio-cultural setting or on the position of the authors in relation to the topic and participants.</i></p>	<p>Clear rationale for using Grounded Theory (GT) as the method of analysis. Demographic information provided.</p>	<p>Discussion of how evaluated the 'quality' of the research using qualitative criteria. Use of participant quotes to highlight themes in the data. Development of themes explored which fits the GT approach.</p>	<p>Directly relevant to the community intended for and for clinicians working in the area.</p>

\*Two authors of this paper supervised this literature review.

## Appendix 2 Question refining

## Literature Review Question Flow-Chart

**Identification or research question.** Question identified through discussion with supervisor. Literature Review Question: *The Experience of Receiving and Delivering Psychological Interventions for Psychosis: A Narrative Review*



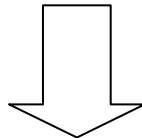
**Identification of related questions to be answered.** Questions devised through previous experience & reading around the area; 9 questions identified:

(Main Chapter)

Q1. *What is it like to receive/provide a psychological intervention for psychosis*

(Sub-Chapters)

Q2. *What is understood to be the most facilitative of change for clients*  
Q3. *What is understood to be the most challenging or obstructive to change for clients*  
Q4. *What aspects of the intervention have helped/hindered engagement*  
Q5. *What is understood to aid/block the development of the therapeutic relationship*  
Q6. *What are the specific therapeutic techniques employed during intervention & how are outcomes measured*  
Q7. *What are the impact of cultural/demographic factors in the experience of psychological interventions*  
Q8. *What is the influence of power*  
Q9. *How is psychosis conceptualised by professionals and understood by clients*



**Extrapolation of each question to guide what to look for in the literature.** The following is a list of things to look for in papers for each question:

Q1. What was identified as helpful/unhelpful, how do it make clients feel (empowered, in control, ill), how does it compare with other treatments, how has this been explored in the data, how was the data collected.

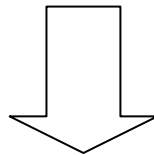
Q2. What are identified as important elements of change, is change attributed to internal or external factors or both, what change (if any) occurred, how and when was change measured, how is this explored in the data, how was the data collected by whom.

Q3. What are identified as important barriers for change, are barriers attributed to internal or external factors or both, are the therapist barriers explored, how are the barriers explored, how was the data collected.

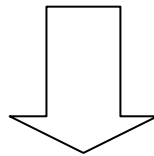
Q4. How is the engagement understood by therapist/client, what was the impact of the therapeutic model, who collected the data, how was data collected, what are clients motivations for engaging in therapy – are these discussed, impact of group members, what impact does engagement have on the intervention



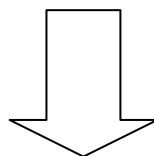
Q5. How does the relationship develop, how is the relationship maintained, what is the impact of the therapeutic model, how is the data collected, is this mentioned.  
Q6. What are the specific techniques used during intervention, how do techniques relate to delivering/receiving therapy, do techniques tackle symptoms or distress, how relevant are the outcome for the client, who decides the outcomes  
Q7. Are demographics documented (age, ethnicity, gender, sexuality, SES), how do these factors influence the experience of intervention, how are they discussed  
Q8. What is it like for people being in the mental health system, where was the research published, influence of power related to treatment, compliance, class differences, sectioning, medical model, CBT articles & wider power (dominance), are these issues explored in the data, power in CBT (as an approach)  
Q9. How is psychosis understood – biological, social, how is it described in the literature, approach of author, where published, was the conceptualisation helpful/unhelpful, impact on clients understanding & progress, influence on intervention.



**Systematic search of resources to identify appropriate articles:** 9 relevant articles identified



**Systematic extraction of data from articles.** Extraction table developed and completed using guide.

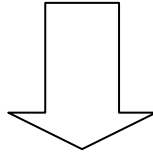


**Reading & summarising the extraction table**

*Removal of Q7.* From reading the table a gap in the literature was identified with Q7, with very little information to answer this question. This question was therefore dropped & the gap in the literature flagged up.

*Amalgamation of questions 4 and 5.* From reading the table a large cross-over was identified between the two questions and the fitted together well so were amalgamated into one question.

**Remaining questions = 7**

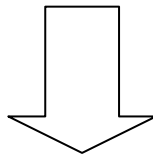


### **Meeting with academic supervisor**

*Amalgamation of questions 2 and 3.* These questions (barriers and facilitators to change) were felt to complement each other and would be best dealt with in a single chapter.

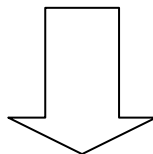
*Removal of Q8.* It was felt the influence of power was pertinent in all of the sub-chapters and as such it would be better to deal with this issue throughout the chapters as opposed to a stand-alone chapter.

**Remaining questions = 5**



### **5 questions in order of chapter:**

- Q1. *What is it like to receive/provide a psychological intervention for psychosis*
- Q2. *What is understood to help or hinder therapeutic engagement and what blocks or aids are there to the therapeutic alliance?*
- Q3. *How is psychosis conceptualised by professionals and understood by clients*
- Q4. *What are the specific therapeutic techniques employed during intervention & how are outcomes measured?*
- Q5. *What is understood to be the barriers and facilitators for change*



### **Writing the review**

When writing the chapters it became apparent that some of the information was reparative and it would be logical to integrate Q4 within other chapters. The final chapters were therefore:

- Chapter 1: What is it like to receive/provide a psychological intervention for psychosis*
- Chapter 2: What is understood to help or hinder therapeutic engagement and what blocks or aids are there to the therapeutic alliance?*
- Chapter 3: How is psychosis conceptualised by professionals and understood by clients?*
- Chapter 4: What is understood to be the facilitators and barriers of change?*

## **Appendices – Empirical Paper**

### **Appendix 3 Letter of ethical approval**

## **Appendix 4 Interview Schedule, Information sheet & consent form**

## Interview Schedule

**(Introduction Q.) Please can you tell me a little bit about the mental health difficulties you've had or are currently experiencing**

### Prompts

- *Tell me about when you first noticed something was different*
- *What did other people (friends and/or family) say to you about what they thought was going on?*
- *How did you feel?*

**(Question 1.) Please can you (briefly) tell me the story of how you came to be in hospital?**

### Prompts

- *What was happening in your life during this time (what were you doing at the time for work/education/living etc?)*
- *Can you tell me about how the decision for you to go into hospital was made?*
- *What do you remember about getting to hospital, who took you?*
- *What do you remember about when you first arrived? Who did you meet? How were you feeling?*
- *Can you tell me about any information you were given?*
- *What things were helpful to you during this time?*
- *What things weren't helpful?*

**(Question 2.) Can you tell me about what it was like for you being in the hospital?**

### Prompts

- *Did you have your own room? What was that like?*
- *Tell me about the communal areas, what were they like?*
- *Can you tell me about any time you spent with the other patients?*
- *Can you tell me about the staff? Can you tell me about people coming to visit you? Was this often, how was this for you?*
- *Can you tell me about what treatment you received? What was helpful? Not helpful?*

- *Can you tell me about what you did with the staff? What was helpful?  
Not helpful?*

**(Question 3.) Can you tell me about any parts of your hospital stay you found helpful?**

Prompts

- *Is there anything you would change about your time in hospital?*

**Can you tell me about any parts of your hospital stay you found unhelpful?**

Prompts

- *What do you think would be better?*

**(Question 4.) Can you tell me about what you think it was like for your family during this time?**

Prompts

- *Tell me about any times your family members visited you*
- *What was helpful for your family to do?*
- *What was unhelpful for your family to do?*

**(Question 5.) Can you tell me a little bit about how you spent your time when in hospital?**

Prompts

- *What did you do during the daytime?*
- *What time did you go to bed? Was this your choice?*
- *What things did you find helpful?*
- *What things did you not find helpful?*

**(Question 6.) Can you tell me what happened when you were discharged from the hospital?**

Prompts

- *Were you in hospital for a long time?*

- *Can you tell me about the decision to leave hospital? How was this decided? Can you tell me who was involved? Were you involved in the process?*
- *How did you feel about leaving the hospital?*

**(Final Q.) What would you tell Early Intervention/Hospital staff that would make the process better?**

- *What would you suggest to improve the service/hospital?*



## **Appendix 5 Initial themes table extracted from the data**

## **Appendix 6 Instructions for authors**